



THE NEW FACE OF THE HIV/AIDS EPIDEMIC IN THE UNITED STATES: THE DISPROPORTIONATELY HIGH INCIDENCE OF HIV/AIDS INFECTION AMONG BLACKS

Chai Park, M.P.H.*

Introduction

The annual rate of new HIV/AIDS diagnoses has plummeted from over 150,000 in the mid 1980s to slightly under 40,000 today.¹ While this downtrend is significant and represents the success of the public health community's efforts on some level, it belies the fact that the disease once known as gay cancer and later gay-related immune deficiency (GRID)² has undergone a makeover in the worst possible way. Twenty-five years since AIDS was first recognized in America in gay, white males, it has acquired epidemic status among people of color, particularly women of color.

* J.D. Candidate, 2008, Notre Dame Law School; M.P.H., 2004, Yale University; B.A., 2000, Smith College; 2006 Summer Fisher Fellow in AIDS/HIV Policy. This work was made possible by a grant from the Ann and George Fisher Foundation and Lifelong AIDS Alliance in Seattle, Washington. The views and opinions expressed in this paper are solely those of the author. The author wishes to thank Tina Podlodowski, Jesse Gilliam, Ania Beszterda, and staff of Lifelong AIDS Alliance, and her family, friends, and professors for their tireless support.

¹ See CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV PREVENTION STRATEGIC PLAN THROUGH 2005 20 (2001), <http://www.cdc.gov/hiv/pubs/prev-strat-plan.pdf>. The term "incidence" refers to the rate at which new diagnoses occur in a given population during a specified period.

² HUMAN RIGHTS WATCH, HIV/AIDS & HRC: TWO DECADES OF FIGHTING FOR LIFE 3 (2000), <http://www.hrc.org/Template.cfm?Section=Home&Template=/ContentManagement/ContentDisplay.cfm&ContentID=31573>. That AIDS was previously called gay cancer or GRID is likely related to epidemiologists' early understanding of the disease. The effects of AIDS were first documented by the CDC in 1981 after five gay males in Los Angeles presented with *Pneumocystis carinii* pneumonia, a somewhat rare form of pneumonia that almost exclusively affects immunosuppressed individuals. Centers for Disease Control and Prevention, *Pneumocystis Pneumonia – Los Angeles*, MORBIDITY MORTALITY WKLY. REP. (Jun. 5, 1981), http://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm. On July 3, 1981, the New York Times released news of an outbreak of Kaposi's sarcoma, a very rare cancer, among gay males in New York and San Francisco. Lawrence K. Altman, *Rare Cancer Seen in 41 Homosexuals*, N.Y. TIMES, Jul. 3, 1981, at A20, available at <http://www.nytimes.com/1981/07/03/health/03AIDS.html>.

According to the 2000 U.S. Census,³ blacks or African Americans (hereinafter blacks) constitute 12.3% of the U.S. population.⁴ Yet, of the estimated 38,730 people diagnosed with HIV/AIDS in the 35 states and territories with long-term, name-based HIV reporting in 2004,⁵ 50% were black; 30%, white; 18%, Hispanic; 1%, Asian or Pacific Islander; and less than 1% were American Indian or Alaska Native.⁶ That blacks, constituting just 12.3% of the population in 2000, accounted for 50% of HIV/AIDS diagnoses in 2004 demonstrates the disproportionate impact that this epidemic has had on certain racial or ethnic groups.

Moreover, this racial disparity is greater among women than it is for men. Black women accounted for 67.9% of the 44,437 HIV/AIDS diagnoses in adult or adolescent females between 2001 and 2004, inclusive, in the 35 states and territories with long-term, name-based HIV

³ In 1997, the Office of Management and Budget (OMB) issued a notice requiring federal agencies, including the U.S. Census Bureau, to use a revised race classification system. *See* Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, 62 Fed. Reg. 58,782 (Oct. 30, 1997). While the *black* category was changed to *black or African American*, the definition remained the same. *Id.* According to the OMB, a black or African American person is one “having origins in any of the black racial groups of Africa.” *Id.* The OMB further notes that “[t]erms such as ‘Haitian’ or ‘Negro’ can be used in addition to ‘black or African American.’” *Id.* Further, the OMB delineated five race categories: American Indian or Alaska Native, Asian, black or African American, Native Hawaiian or other Pacific Islander, and white. *Id.* The OMB permits the self-report of more than one race. *Id.* The ethnicity categories are Hispanic or Latino and Non Hispanic or Latino. *Id.* Notably, the OMB specified that “self-identification is the preferred means of obtaining information about an individual’s race and ethnicity, except in instances where observer identification is more practical (e.g., completing a death certificate),” and that in issuing its notice of decision, the OMB’s intent is not to “identify or designate certain population groups as ‘minority groups.’” *Id.* The U.S. Census Bureau relied on self-identification to collect race and ethnicity data for the Census 2000. ELIZABETH M. GRIECO & RACHEL C. CASSIDY, U.S. CENSUS BUREAU, OVERVIEW OF RACE AND HISPANIC ORIGIN 2 (Mar. 2001), <http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf>. While the U.S. Census Bureau reported that 2.4% of all respondents self-identified two or more races, *id.*, for the purposes of this paper, I have elected to use only those figures representing individuals who self-reported one race. And because much of the sociological and epidemiological research to date on race and health considered Hispanic/Latino a race, and not an ethnicity, I will treat Hispanic/Latino a race for the purposes of this paper.

⁴ *See* U.S. CENSUS BUREAU, PROFILE OF GENERAL DEMOGRAPHIC CHARACTERISTICS: 2000 1 (May 2001), <http://www.census.gov/Press-Release/www/2001/2khus.pdf>. In 2000, Hispanics accounted for 12.5% of the population; Asians or Pacific Islanders, 3.8%; and American Indians or Alaska Natives, 0.9%. *Id.*

⁵ These estimates are based on figures provided by 35 areas with confidential, name-based reporting. CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE REPORT: CASES OF HIV/AIDS INFECTION IN THE UNITED STATES 10 (2004), <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/pdf/2004SurveillanceReport.pdf>. They are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming, Guam, and the U.S. Virgin Islands. *Id.*

⁶ *Id.*

reporting.⁷ The racial difference is also significant, albeit less pronounced, in males, with black males accounting for 44.5% of the 111,203 adult or adolescent males diagnosed with HIV/AIDS in the same period.⁸

In recent years health disparities have received tremendous attention from researchers, government entities, media, and private foundations. While many studies have examined the individual-level factors that have put some racial or ethnic groups such as blacks at greater risk of HIV/AIDS infection, few have examined the structural-level factors or social inequities that have may have caused blacks to bear a significant proportion of the burden in this epidemic.

This paper will examine the causes of the disproportionately high incidence of HIV/AIDS in blacks and put forth possible legal and policy solutions to this disparity. Part I provides a brief background on health disparities and HIV/AIDS. Part II describes the likely causes of the disproportionately high incidence of HIV/AIDS in blacks. Part III is a presentation of legal and policy alternatives to ones already in place. Finally, in Part IV, I conclude that future HIV prevention efforts should better account for the special risk factors that blacks face in this epidemic, and that law and policymakers should be better informed of the social factors that have led to this disparity.

I. HIV/AIDS Incidence Among blacks as a Health Disparity

a. Brief background on HIV/AIDS

Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS) can be transmitted in a number of ways. HIV is most commonly transmitted through unprotected sex with an infected partner via the penis, rectum,

⁷ These figures were calculated using data provided in Table 1 of the CDC's HIV/AIDS Surveillance Supplemental Report. See Centers for Disease Control and Prevention, *Cases of HIV Infection and AIDS in the United States, by Race/Ethnicity, 2000-2004*, 12 HIV/AIDS SURVEILLANCE SUPPLEMENTAL REP. 1, 5-7 (2006).

⁸ *Id.* See accompanying text, *id.*

mouth, or the lining of the vagina or vulva.⁹ HIV can also be transmitted through contact with infected blood, blood products, contaminated needles, or from an HIV-infected mother to her baby during pregnancy or birth.¹⁰

Once infected, the virus can remain dormant within the infected cells, or it can continue to multiply, infect and kill the cells of the individual's immune system.¹¹ HIV attacks the CD4 positive (CD4+) T-cells in the blood that are key to the body's immune system, and the individual may remain asymptomatic while this happens.¹² In the United States, an HIV-infected adolescent or adult is diagnosed with AIDS if his or her CD4+ T-cell count is fewer than 200 per cubic millimeter of blood, his or her CD4+ T-cells account for fewer than 14% of all lymphocytes in his or her body, or if he or she presents with any of 25 AIDS-defining illnesses enumerated by the CDC.¹³

While there is no cure for AIDS, there are three classes of FDA-approved drugs for the treatment of HIV/AIDS: reverse transcriptase (RT) inhibitors that can slow the virus's ability to make copies of itself in the body; protease inhibitors that also work by attacking the virus's ability to replicate; and fusion inhibitors that block the virus's ability to enter and infect immune cells.¹⁴ Due to the virus's ability to develop resistance to these drugs, physicians must combine drug treatments for these treatments to remain effective.¹⁵ The combination of three or more

⁹ National Institute of Allergy and Infectious Diseases, *HIV Infection and AIDS: An Overview*, Mar. 2005, <http://www.niaid.nih.gov/factsheets/hivinf.htm>.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ See Centers for Disease Control and Prevention, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, MORBIDITY MORTALITY WKLY. REP. (Dec. 18, 1992), <http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm>. The 25 AIDS-defining illnesses include candidiasis, oropharyngeal (thrush); cervical dysplasia (moderate or severe); constitutional symptoms such as fever (38.5°C) or diarrhea lasting more than one month; pelvic inflammatory disease; Kaposi's sarcoma; and toxoplasmosis of the brain (encephalitis). *Id.*

¹⁴ National Institute of Allergy and Infectious Diseases, *supra* note 9.

¹⁵ *Id.*

drugs is called highly active antiretroviral therapy (HAART).¹⁶ Although these drugs have been credited with improving the prognoses of those infected with HIV or living with AIDS, they do not provide a cure. There are also significant debilitating side effects associated with the use of these drugs.¹⁷ Moreover, the high cost of HIV medications renders treatment prohibitively expensive for many, with cost estimates in 2002 ranging from \$13,000 per patient per year to \$34,000.¹⁸

Thus, due to the unavailability of an HIV vaccine and AIDS cure, as well as the pharmacological and access-related limitations of the treatments options that are already available, public health initiatives must focus on preventing HIV infection. Given the epidemiology of this disease, efforts to decrease the incidence of HIV infection in any population would involve, in large part, behavior change. But because each subpopulation faces different risk factors, a one-size fits all approach would prove ineffective. Worse such an approach may further exacerbate the disparities in HIV/AIDS incidence among certain groups, as it already has with blacks in America.

b. Health disparities, HIV/AIDS, and the race factor

It is important to define “health disparity” in the context of HIV/AIDS; how a disparity is defined affects the design of the laws and policies addressing the disparity, as well as the outcomes measures used to gauge the effectiveness of those laws and policies. Generally, there are three approaches to the definition of health disparities: (1) minority populations may be compared to non-minority populations; (2) the affected population(s) may be compared to the

¹⁶ *Id.*

¹⁷ *See id.* Side effects include anemia, diarrhea, painful nerve damage, and pneumonia. *Id.*

¹⁸ William M. Valenti, *The HIV Pharmacy: Managing Quality and Costs of HIV Care*, 12 AIDS READER 486, 486 (2002), available at http://www.medscape.com/viewarticle/444893_print.

general population; and (3) subgroups within a population may be compared to one another.¹⁹

For the purposes of this paper, I will use the third approach. Thus, the health disparity that I will examine is the disproportionately high incidence of HIV/AIDS infection among blacks in the United States, with the comparison groups being other racial subpopulations in this country. Similarly, the National Institutes of Health considers health disparities to be “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.”²⁰

According to the National Center for Health Statistics, the life expectancy of a black male and black female is 69.0 years and 76.1 years, respectively, whereas for white males and white females it is 75.3 years and 80.5 years.²¹ Moreover, researchers at UCLA have found that HIV/AIDS is the second leading cause of racial disparity in mortality, contributing 11.2% to the disparity, followed by diabetes at 8.5% and homicide, also at 8.5%.²² The researchers further noted that “[h]ad mortality from HIV disease improved equally, the racial disparity in mortality from HIV disease would have dropped further, contributing only 6.5%.”²³ Given these facts, it should not be surprising that HIV is the leading cause of death for black men between 25 and 44 years old.²⁴ Thus, effective HIV prevention efforts focusing on the needs of black people may lead to dramatic improvements in health outcomes for blacks and help reduce or eliminate the HIV incidence disparity.

¹⁹ See Olivia Carter-Pokras & Claudia Baquet, *What is a “Health Disparity”?*, 117 PUB. HEALTH REP. 426, 429 (2002), available at http://www.publichealthreports.org/userfiles/117_5/117426.pdf.

²⁰ National Institutes of Health, *What are Health Disparities*, ADDRESSING HEALTH DISPARITIES: THE NIH PROGRAM OF ACTION, <http://healthdisparities.nih.gov/whatare.html> (last visited Jul. 6, 2006).

²¹ National Center for Health Statistics, *United States Life Tables, 2003*, 54 NAT'L VITAL STAT. REP. 14, 4 (2006), available at http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_14.pdf.

²² Mitchell D. Wong et. al., *Contribution of Major Disease to Disparities in Mortality*, 347 NEW ENG. J. MED. 1585, 1588 (2002).

²³ *Id.*

²⁴ Deborah K. Witt, *Health Disparities in African American Males*, 33 PRIMARY CARE: CLINICS OFF. PRAC. 35, 36 (2006).

II. Race-Specific HIV Risks and Potential Causes of the Disparity

a. Modes of HIV transmission

For laws and policies to be effective in preventing HIV transmission within the subpopulation of interest, it is first important to understand how HIV is transmitted within the black population. Among black males who were diagnosed with HIV/AIDS between 2001 and 2004, 49% contracted the virus through male-to-male sexual contact, 25% through heterosexual contact, 19% through injection drug use (IDU), and 5% through male-to-male sexual contact combined with IDU.²⁵ Among black females, 78% contracted the virus through heterosexual contact and 19% through IDU.²⁶

So, while black men contracted HIV more frequently through male-to-male sexual contact than by heterosexual contact or IDU, 66.3% of all men who became infected through heterosexual contact were black.²⁷ And of the men who contracted HIV through male-to-male sexual contact, 36% were black.²⁸ As for women, 70.1% of all women who contracted the virus through heterosexual contact were black.²⁹

²⁵ See Centers for Disease Control and Prevention, *Trends in HIV/AIDS Diagnoses – 33 States, 2001-2004*, MORBIDITY MORTALITY WKLY. REP. (Nov. 18, 2005), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5445a1.htm>. This analysis was based on reported HIV cases from 33 states that have used name-based HIV/AIDS reporting for at least four years. *Id.* Among white males, 77% contracted HIV through male-to-male sexual contact, 10% through IDU, 6% through male-to-male sexual contact combined with IDU, and 6% through heterosexual contact. *Id.* Among Asians/Pacific Islanders, 65% contracted HIV through male-to-male sexual contact, 13% through IDU, 3% through male-to-male sexual contact combined with IDU, and 18% through heterosexual contact. *Id.* Among Hispanic males, 59% contracted HIV through male-to-male sexual contact, 19% through IDU, 4% through male-to-male sexual contact combined with IDU, and 17% through heterosexual contact. *Id.* And among American Indians/Alaska Natives, 61% contracted HIV through male-to-male sexual contact, 14% through IDU, 11% through male-to-male sexual contact combined with IDU, and 12% through heterosexual contact. *Id.*

²⁶ *Id.* Among white females, 68% contracted the virus through heterosexual contact, and 30% through IDU. *Id.* Among Asians/Pacific Islanders, 79% contracted the virus through heterosexual contact, and 16% through IDU. *Id.* Among Hispanics, 73% contracted the virus through heterosexual contact, and 23% through IDU. *Id.* And among American Indians and Alaska Natives, 69% contracted HIV through heterosexual contact, and 29% through IDU. *Id.*

²⁷ See *id.* I based these calculations on the figures provided in Table 1.

²⁸ See *id.* and accompanying text.

²⁹ See *id.* and accompanying text.

While it is important to understand the distribution of individuals with HIV/AIDS by race or ethnicity and transmission category, small differences in HIV transmission mode between racial or ethnic groups should not detract from the fact that 49,704 black men and 30,483 black women were diagnosed with HIV/AIDS between 2001 and 2004 in 33 states with long term, name-based reporting.³⁰ Even though a slightly smaller percentage of black women (78%) contracted HIV through heterosexual contact than Asian/Pacific Islander women (79%), 23,820 black women were infected through such contact, compared to 242 Asian/Pacific Islander women. Nonetheless, these differences in HIV/AIDS transmission patterns between racial or ethnic groups and sexes suggest that HIV/AIDS prevention efforts must take into account the different HIV/AIDS risks that each racial or ethnic group and sex faces.

b. Special HIV/AIDS risks

Race or ethnicity, alone, are not risk factors for HIV infection; rather, it is the case that people of certain races or ethnicities are more likely to be exposed to factors that increase their risk of HIV infection. The CDC has identified at least six “challenges associated with risk for HIV infection” for blacks: sexual risk factors, lack of awareness of HIV serostatus, substance use, sexually transmitted diseases, denial, and socioeconomic issues.³¹ This paper will focus on these and other risk factors that contribute most to the disproportionate burden that blacks bear in this epidemic. The implementation of laws and policies that effectively address these particular risk factors will lead to significant improvements for blacks in this epidemic.

³⁰ *Id.* The corresponding figures for white men and women are 38,218 and 7,262, respectively; 22,062 and 6,610 for Hispanic men and women; 1,036 and 304 for Asian/Pacific Islander men and women; and 543 and 223 for American Indian/Alaska Native men and women. *Id.*

³¹ See CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS AMONG AFRICAN AMERICANS 3-4 (Feb. 2006), available at <http://www.cdc.gov/hiv/aa/resources/factsheets/pdf/aa.pdf>.

i. Substance abuse as a risk factor

At least one study has found a correlation between substance abuse and high-risk sexual behavior such as multiple sex partners and unprotected sexual intercourse.³² Moreover, people who abuse drugs or alcohol are at increased risk of contracting sexually transmitted infections.³³ Injection drug use and high-risk sexual behavior are also important predictors of HIV infection among injection drug users.³⁴ While researchers in one study found that the demographic factors of their study participants were not statistically related to their HIV prevalence (14.4%) at the time of enrollment, it is worth noting that 79% of enrollees in the study were black, and that in the year preceding enrollment into the study, 47% had been homeless, 38% had been in drug treatment, and 70% had spent time in jail.³⁵

Further, the researchers found positive associations between HIV infection and injection risks, such as multiple daily injections, daily crack smoking, backloading, and use of used needles, and sexual risks, such as reporting more than 100 lifetime sex partners, a history of sexual assault, gay or bisexual identification, and trading sex for money or drugs.³⁶ Finding that risk factors tended to cluster within individuals, the researchers further noted, “it makes sense to consider a broad profile of risk rather than restricting descriptions of HIV acquisition to isolated practice.”³⁷ Thus, these risk factors should not be considered in isolation.

³² Arielle Baskin-Sommers & Ira Sommers, *The Co-occurrence of Substance Use and High-Risk Behaviors*, 38 J. ADOLESCENT HEALTH 609, 610 (2006). Specifically, the study found a significant correlation between alcohol and methamphetamine use and unprotected sex. *Id.* A significant correlation was also found between the alcohol and methamphetamine and multiple partners. *Id.*

³³ See generally Robert L. Cook et al., *Alcohol and Drug Use and Related Disorders: An Underrecognized Health Issue Among Adolescents and Young Adults Attending Sexually Transmitted Disease Clinics*, 33 SEXUALLY TRANSMITTED DISEASE 1 (May 2006) and Jonathan D.C. Ross & Keith W. Radcliffe, *Why Do Those Using Illicit Drugs Have Higher Rates of Sexually Transmitted Infection?*, 17 INT'L J. STD & AIDS 247 (Apr. 2006).

³⁴ See Meg C. Doherty, *Correlates of HIV Infection Among Young Adult Short-Term Injection Drug Users*, 14 AIDS 717, 724 (2000).

³⁵ *Id.* at 719-20.

³⁶ *Id.* at 720-21.

³⁷ *Id.* at 724.

As suggested by the inclusion of substance abuse as a focus area in the Department of Health and Human Services' Healthy People 2010 project,³⁸ there are disparities related to substance abuse. Yet, while substance abuse accounts for a substantial number of HIV infections among blacks, by itself, it does not explain the HIV incidence racial disparity; whereas 43.3% of blacks reported illicit drug use at least once in their lifetime, the figure was 58.4% for American Indian or Alaska Natives, 24.3% for Asians and 49.1% for whites.³⁹ Nevertheless, prevention efforts targeting substance abuse should decrease the overall number of HIV incidence across all racial and ethnic groups.

ii. Disproportionately high prevalence of sexually transmitted diseases

The CDC estimates that 19 million new sexually transmitted infections occur each year.⁴⁰ While sexually transmitted diseases (STDs) are common and preventable, the incidence rates of STDs in the United States exceed those in all other industrialized nations.⁴¹ Owing to biological factors, women are more susceptible to infections when exposed to sexually transmitted agents, and they are more likely to suffer more frequent and serious STD-related complications.⁴² In 2004, the rate of chlamydia infection in black women was seven times that of white women,

³⁸ One of the two stated goals of Healthy People 2010, an ongoing, nationwide project by the Department of Health and Human Services, is to eliminate health disparities. To achieve this, as well as the other goal of increasing the quality and length of healthy life, the project has defined specific objectives in 28 focus areas, of which substance abuse and HIV constitute two focus areas. *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH 17 (2d ed., Nov. 2000), *available at* <http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf>.

³⁹ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, RESULTS FROM THE 2004 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 238 (Sept. 2005), *available at* <http://oas.samhsa.gov/nsduh/2k4nsduh/2k4results/2k4results.pdf>. Illicit drugs include cocaine (including crack), hallucinogens, heroin, inhalants, marijuana/hashish, or non-prescribed use of medicines used to treat psychiatric conditions. *Id.*

⁴⁰ CENTERS FOR DISEASE CONTROL AND PREVENTION, TRENDS IN REPORTABLE SEXUALLY TRANSMITTED DISEASES IN THE UNITED STATES, 2004 1 (Nov. 2005), *available at* <http://www.cdc.gov/std/stats/04pdf/trends2004.pdf>.

⁴¹ *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTHY PEOPLE 2010 25-1, 25-7 (Vol. 2, 2d ed., Nov. 2000), *available at* <http://www.healthypeople.gov/document/pdf/Volume2/25STDs.pdf>.

⁴² *Id.*

while for black men, it was 11 times that of white men.⁴³ Also in 2004, black men and women accounted for 69.6% of all gonorrhea cases reported to the CDC, and 41% of all reported cases of primary and secondary syphilis.⁴⁴

The Department of Health and Human Services has identified five social and behavioral factors that may be contributing to these gender and racial and ethnic disparities: poor access to health care, poverty and marginalization, sexual coercion, sexuality and secrecy due to stigma, and substance abuse.⁴⁵ Strong evidence suggests that sexually transmitted diseases promote HIV transmission by increasing its infectiousness and leaving the STD-infected individual more susceptible to HIV transmission through a variety of biological mechanisms.⁴⁶ Thus, given the gender and racial disparities in sexually transmitted infection rates and the STD-HIV relationship, successful prevention efforts targeting sexually transmitted infections will likely ease the disproportionate burden that black men and women bear in this epidemic.

iii. Disproportionately high incarceration rate of blacks

The United States incarcerated 2,267,787 men, women, and youth in 2004.⁴⁷ With an incarceration rate of 738 individuals per 100,000 residents at midyear 2005, up from 725 per 100,000 at midyear 2004,⁴⁸ this country incarcerates a higher percentage of its residents than any

⁴³ CENTERS FOR DISEASE CONTROL AND PREVENTION, SEXUALLY TRANSMITTED DISEASE SURVEILLANCE, 2004 63 (Sept. 2005), available at <http://www.cdc.gov/std/stats/04pdf/2004SurveillanceAll.pdf>.

⁴⁴ *Id.* at 63-64.

⁴⁵ See DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 41, at 25-4 – 25-7.

⁴⁶ See Douglas T. Fleming & Judith N Wasserheit, *From Epidemiological Synergy to Public Health Policy and Practice: The Contribution of Other Sexually Transmitted Diseases to Sexual Transmission of HIV Infection*, 75 SEXUALLY TRANSMITTED INFECTIONS 3, 4 (1999). The researchers conducted a meta analysis of existing literature of STDs and HIV and found that STDs likely promote HIV infectiousness by facilitating the shedding of the virus in the genital tract, thereby increasing the concentration of HIV in genital secretions. *Id.* Bleeding genital ulcers due to STDs may also promote transmission of the virus. *Id.*

⁴⁷ Paige M. Harrison & Allen J. Beck, *Prisoners in 2004*, BUREAU JUST. STAT. BULL. 1 (Oct. 2005), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/p04.pdf>.

⁴⁸ Paige M. Harrison & Allen J. Beck, *Prison and Jail Inmates at Midyear 2005*, BUREAU JUST. STAT. BULL. 2 (May 2006), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim05.pdf>. The figure reported is current as of June 30, 2005. See *id.*

other country in the world.⁴⁹ One in every 136 U.S. residents was in prison or jail as of June 2005.⁵⁰ More males than females are incarcerated. Among male prisoners serving sentences of more than one year at midyear 2005, the incarceration rate was 925 per 100,000 U.S. residents, whereas for women it was 64 per 100,000.⁵¹ The inmate population in the nation's prisons continues to rise as prison admissions outpace releases.⁵² But contrary to popular belief, the rise in prison population is not due to a rise in violent crime; rather, it has been driven by public policy initiatives such as mandatory minimum sentencing and *three strikes* laws.⁵³

Blacks are incarcerated at a higher rate than any other racial or ethnic group; in 2004, 40.7% of prisoners under state or federal jurisdiction were black.⁵⁴ And an estimated 12% of black males between 25 and 29 years old were in prison or jail in 2005.⁵⁵ Moreover, blacks accounted for 47.5% of those sentenced for more than one year under state jurisdiction for drug offenses.⁵⁶ The number of black inmates in state prisons increased 707% between 1985 and 1995, while the corresponding figure for white inmates was 306%.⁵⁷ Given that fewer blacks report lifetime use of illicit drugs than whites or American Indians,⁵⁸ this disproportionately high percentage of blacks who are incarcerated for drug offenses suggests that blacks are arrested or prosecuted for drug offenses at a higher rate than whites, or that they bear a disproportionate share of the burden imposed by the increasing punitive drug laws.

⁴⁹ HUMAN RIGHTS WATCH, HUMAN RIGHTS WATCH BACKGROUNDER: INCARCERATED AMERICA 1 (2003), available at <http://www.hrw.org/backgrounder/usa/incarceration/us042903.pdf>.

⁵⁰ Harrison & Beck, *supra* note 47.

⁵¹ See Harrison & Beck, *supra* note 47, at 5.

⁵² See *id.* at 6.

⁵³ See HUMAN RIGHTS WATCH, *supra* note 49.

⁵⁴ Harrison & Beck, *supra* note 46, at 8. While blacks accounted for 40.7% of prisoners in that year, the percentages for whites and Hispanics were 34.3% and 19.2%, respectively. *Id.*

⁵⁵ Harrison & Beck, *supra* note 47, at 10.

⁵⁶ See Harrison & Beck, *supra* note 46, at 9. That figure was calculated based on the data provided in Table 12. See *id.*

⁵⁷ Kim M. Blankenship et al., *Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System*, 16 J. OF HEALTH CARE POOR UNDERSERVED 140, 143 (2005) (citing Marc Mauer, RACE TO INCARCERATE. (The New Press, 1999)).

⁵⁸ See Substance Abuse and Mental Health Services Administration, *supra* note 39, and accompanying text.

The disproportionately high incarceration rates of blacks is relevant to this discussion of HIV infection disparities because the results of at least one empirical study suggest that “the lion’s share of the racial differentials in [HIV] infection rates for both men and women are attributable to racial differences in incarceration trends.”⁵⁹ The incarceration rate disparity may be related to the racial disparities in HIV incidence rates in several ways.

First, a significant percentage of those living with HIV/AIDS pass through a correctional facility in any given year.⁶⁰ Researchers have estimated that 20% to 26% of people living with HIV passed through a jail or prison in 1997.⁶¹ In 2003, 1.9% of male inmates in state or federal prisons were known to be HIV positive,⁶² a figure that is likely an underestimate of the true HIV prevalence because not all inmates are tested for HIV during their incarceration. Whereas the prevalence of HIV in the general U.S. population is 0.43%,⁶³ in states like New York and Florida, the known HIV prevalence among male inmates was much higher, with 7.6% and 4.2% of inmates known to be HIV positive, respectively.⁶⁴ As for female inmates, 13.6% of female inmates in New York were HIV positive, with 7.4% HIV positive in Florida and 7.2% infected in Connecticut.⁶⁵ But, by itself, the relatively high prevalence of HIV among prisons and jails does not explain the higher risk of HIV transmission for inmates. The prevalence of these high-risk

⁵⁹ Rucker C. Johnson & Steven Raphael, *The Effects of Male Incarceration Dynamics on AIDS Infection Rates Among Africa-American Women and Men* 44 (Jul. 2005) (unpublished manuscript, available at http://are.berkeley.edu/johnson_raphael.pdf).

⁶⁰ See Theodore M. Hammett, *The Burden of Infectious Disease Among Inmates of and Releasees from US Correctional Facilities, 1997*, 92 AM. J. PUB. HEALTH 1789, 1791 (2002).

⁶¹ *Id.*

⁶² Laura M. Maruschak, *HIV in Prisons, 2003*, BUREAU JUST. STAT. BULL. 2 (Sept. 2005), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/hiv03.pdf>.

⁶³ Centers for Disease Control and Prevention, *HIV Transmission Among Male Inmates in a State Prison System – Georgia, 1992-2005*, MORBIDITY MORTALITY WKLY. REP. (Apr. 21, 2006) <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5515a1.htm> (citing G.M. McQuillan, *The Prevalence of HIV in the United States Household Population: The National Health and Nutrition Examination Surveys, 1988-2002*, (presented at the 12th Conference on Retroviruses and Opportunistic Infections, Boston, MA 2005)).

⁶⁴ Maruschak, *supra* note 62.

⁶⁵ Maruschak, *supra* note 62.

behaviors within jails and prisons creates a high-risk environment, especially for those who are HIV negative upon entry.

While the exact magnitude of high risk behavior in prisons is unknown, perhaps due in large part to the unreliability of official prison incident reports and inmates' unwillingness to report in-prison drug use or homosexual contact,⁶⁶ a recent CDC study found that 66% of males who became HIV positive while incarcerated had engaged in male-male sexual contact, whereas the corresponding figure for those who did not become infected was 13%.⁶⁷ The study also found that 59% of those who became HIV positive while incarcerated had received a tattoo in prison, while 41% of uninfected individuals reported receiving a tattoo in prison.⁶⁸ Further, 66% of males who became HIV positive during incarceration were black, while blacks accounted for 40% of uninfected individuals.⁶⁹ Moreover, other studies have estimated that between 3% and 28% of inmates are sexually assaulted while incarcerated.⁷⁰

Considered contraband in most prisons, traditional HIV preventive tools such as condoms or clean syringes are largely unavailable in prisons. Thus, it is perhaps not surprising that one study found that 48.4% of male inmates who contracted HIV while incarcerated became infected through sex with other men, while 33.3% contracted the virus through intravenous drug use or intravenous drug use coupled with homosexual contact.⁷¹ That same study showed that of the male inmates who had contracted HIV outside of prison, 16.0% had contracted HIV through sex

⁶⁶ Blankenship et al., *supra* note 57 at 143.

⁶⁷ Centers for Disease Control and Prevention, *supra* note 63. This study of men incarcerated in Georgia's prisons identified 88 men who became HIV positive, i.e., seroconverted, during incarceration. *Id.* Since 1988, the Georgia Department of Corrections required HIV testing of all inmates upon entry into the prison system and offered inmates voluntary annual testing between July 2003 and June 2005. *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ Christopher P. Krebs & Melanie Simmons, *Intraprison HIV Transmission: An Assessment of Whether it Occurs, How it Occurs, and Who is at Risk*, 14 AIDS EDUC. PREVENTION 53, 54 (2002).

⁷¹ *See id.* at 59.

with other men, while 39.9% were infected through intravenous drug use.⁷² Less is known about women who contract HIV while in prison.

While it is unclear why blacks become infected at higher rates than men of other races,⁷³ what is clear is that because blacks are disproportionately represented in the prisons, they are exposed to the high-risk prison environment at a greater rate. Efforts to reduce the racial disparity in incarceration and the risks of HIV transmission within prisons and jails should reduce the disproportionately high burden that blacks bear in the HIV epidemic.

iv. Poverty

Researchers have noted that the disproportionately high incarceration rate of black males contributes to the gender imbalance in the community, and that this shortage of men promotes rapid spread of HIV within a community through concurrent sexual partnerships.⁷⁴ But other researchers have attributed the disproportionately high incidence of STDs in blacks to the sexual networks and network patterns that are unique to them.⁷⁵ Meanwhile, several researchers have made note of the interplay between residential segregation and sexual networks and its role in the disparity, because people tend to have sex with others who live in their neighborhood.⁷⁶ Though these explanations are seemingly disparate, they all have one factor in common: poverty. With

⁷² *Id.*

⁷³ Centers for Disease Control and Prevention, *supra* note 67.

⁷⁴ See Adaora A. Adimora & Victor J. Schoenbach, *Contextual Factors and the black-white Disparity in Heterosexual HIV Transmission*, 13 EPIDEMIOLOGY 707, 709-10 (2002). Concurrent relationships are relationships that overlap temporally.

⁷⁵ See generally Edward O. Laumann & Yoosik Youm, *Racial/Ethnic Group Differences in the Prevalence of Sexually Transmitted Diseases in the United States: A Network Explanation*, 26 SEXUALLY TRANSMITTED DISEASES 250 (1999). The researchers offered two explanations for the disproportionately high prevalence of STDs within blacks. *Id.* The researchers noted because “peripheral” blacks, those who have had only one sex partner in the past year, are five times more likely to have sex with “core” blacks, those who have had four or more sex partners in the past year, than “peripheral” whites with “core” whites, STDs are more likely to spread within the blacks population. *Id.* The researchers also made note of the predominance of same-race sexual partnerships among blacks. *Id.*

⁷⁶ See Adaora A. Adimora & Victor J. Schoenbach, *Social Context, Sexual Networks, and Racial Disparities in Rates of Sexually Transmitted Infections*, J. INFECTIOUS DISEASES 115, 117 (supplement) (2005) (citing J.M. Zenilman et al., *The Geography of Sexual Partnerships in Baltimore: Applications of Core Theory Dynamics Using a Geographic Information System*, 26 SEXUALLY TRANSMITTED DISEASES 75 (1999)).

24.7% of blacks living in poverty, the poverty rate among blacks was almost twice the national poverty rate in 2004.⁷⁷

Poverty limits one's housing options. Despite a gradual decrease in racial segregation over a period of several decades, blacks represented over 57.3% of the population in neighborhoods with poverty rates at or above 40% in America's 100 largest central cities in 1990.⁷⁸ These severely distressed neighborhoods are believed to "exhibit social disadvantages, such as high rates of school dropout, out-of-wedlock births, persistent joblessness, and welfare dependency, that reinforce poverty and limit upward mobility."⁷⁹ Moreover, given the effects of the disproportionately high incarceration rate of black males, perhaps it should not be surprising that 73.0% of black households with children in neighborhoods with poverty rates at or above 40% were headed by females in 1990.⁸⁰

Poverty also limits one's access to education and health care or quality health care. Limited education options and access to health care, in turn, limit one's health literacy, as well as the ability of poor women to access appropriate prenatal care. Thus, it should not be surprising that 69% of cases of perinatal transmission of HIV were among blacks.⁸¹

⁷⁷ See Carmen DeNavas-Walt et al., U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, CURRENT POPULATION REP. 9 (Aug. 2005), available at <http://www.census.gov/hhes/www/poverty/poverty04.html>. While the poverty rate in 2004 was 24.7% for blacks, the corresponding figure for whites was 8.6%, 21.9% for Hispanics, and 9.8% for Asians. *Id.* The national poverty rate went up in 2004 from 12.5% in 2003 to 12.7%. *Id.*

⁷⁸ See John D. Kasarda, *Inner-City Concentrated Poverty and Neighborhood Distress: 1970 to 1990*, 4 HOUSING POL'Y DEBATE 253, 255, 264 (1993), available at <http://www.knowledgeplex.org/sh0owdoc.html?id=1116> (To download a PDF version of the paper, click on document preview or "click here to download the full document".) For more information on racial segregation as a major determinant of health in large, metropolitan cities, see Amy J. Schulz at al., *Racial and Spatial Relations as a Fundamental Determinant of Health in Detroit*, 80 MILBANK Q. 677 (2002). Schulz posits that macrosocial processes, i.e., historical conditions, political order, laws, social and cultural institutions, and ideologies such as racism, lead to race-based residential segregation which ultimately affects health outcomes. *Id.* at 682.

⁷⁹ Kasarda, *supra* note 78, at 270.

⁸⁰ *Id.* at 271.

⁸¹ See Centers for Disease Control and Prevention, *Racial/Ethnic Disparities In Diagnoses of HIV/AIDS – 33 States, 2001-2004*, MORBIDITY MORTALITY WKLY. REP. (Feb. 10, 2006), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5505a1.htm>.

Additionally, economic deprivation limits the poor's access to HIV preventive tools, by limiting their ability to obtain condoms or clean needles, or receive treatment for their drug addictions. Incarcerating the drug-addicted does not treat their addiction; it just exacerbates the problems of the poor.

v. Discrimination, stigmatization, and misperceptions

Perhaps because HIV/AIDS is most frequently transmitted through stigmatized behaviors such as male homosexual contact and injection drug use, and the epidemic was first recognized in gay, white males, HIV/AIDS preventive efforts have not had a significant effect on the epidemic among communities of color. Moreover, homosexuality and bisexuality are considered taboo subjects among many blacks because they do not comport with cultural norms or values.⁸²

As a result, blacks may be reluctant to identify or be identified as gay or bisexual, which has the effect of limiting the reach of HIV/AIDS prevention efforts targeting homosexuals or bisexuals. Researchers have further noted that “stigma and discrimination can create significant barriers to HIV testing, restrict utilization of prevention programs, and hinder the adoption of preventive behaviors such as condom use and disclosure of HIV status to sex partners.”⁸³ Thus, prevention efforts must also address the HIV/AIDS and homosexuality-related stigma that are pervasive among blacks.

III. Using the Law and Policy to Eliminate the HIV/AIDS Incidence Disparity

Given that the spread of HIV/AIDS is as dependent on certain biological risk factors as it is on the social and behavioral factors that leave some groups of people more vulnerable to the disease, a multi-pronged prevention intervention is necessary to halt the spread of HIV/AIDS, or,

⁸² Ronald A. Brooks et al., *Preventing HIV Among Latino and African American Gay and Bisexual Men in a Context of HIV-Related Stigma, Discrimination, and Homophobia: Perspectives of Providers*, 19 AIDS PATIENT CARE 737, 738 (2005) (citations omitted).

⁸³ *Id.*

at the very least, the disparate effects that this epidemic group has had on certain racial and ethnic groups in this country. While public health interventions that address substance abuse and HIV/AIDS prevention education may yield short-term improvements for blacks in this epidemic, in the long run, they are unlikely to eliminate a disparity that is firmly rooted in social inequities. Thus, policy and lawmakers must consider the social determinants of health disparities, as well as biological risk factors, when designing policies or laws to address this epidemic. The following is a list of suggested approaches to the epidemic.

HIV/AIDS public education efforts: Efforts to educate the public on the changing face of the epidemic must be multi-pronged

Eliminate misperceptions about the epidemic and strengthen outreach efforts

A general public education campaign must focus on several key points: While the majority of new HIV infections are in the developing world, AIDS in the United States is no longer a disease affecting mostly gay, white men. Yet, the misperception that it is a “gay disease” or a “disease in Africa” has likely limited the reach of HIV/AIDS prevention initiatives by contributing to public apathy among blacks and others who do not self-identify as gay or African. These misperceptions may also contribute to stigma and discrimination associated with HIV/AIDS and its risk factors.⁸⁴ Thus, work must be done to eliminate the misperceptions associated with HIV/AIDS risks. While education, alone, will not eradicate the disparate effects

⁸⁴ See Brooks et al., *supra* note 82, at 738. Researchers have suggested that stigma and discrimination “can create significant barriers to HIV testing, restrict utilization of prevention programs, and hinder the adoption of preventive behaviors such as condom use and disclosure of HIV status to sex partners.” *Id.* (footnotes omitted).

of this epidemic on blacks,⁸⁵ it could ultimately help reduce the stigma and discrimination associated with HIV/AIDS.

HIV/AIDS prevention outreach efforts targeting blacks must focus on several key elements. First, the public health community must work to restore African Americans' trust in medical and public health officials. The reluctance of blacks to trust the medical and public health community is understandable in light of certain historical events, most notably the Tuskegee Syphilis Study.⁸⁶ That a recent study found that 48.2% of black people enrolled in the study believed that HIV is a man-made virus, 26.6% believe that AIDS was produced in a government laboratory, and that 15.2% believe that AIDS is a form of genocide against blacks,⁸⁷ present significant challenges to HIV/AIDS prevention efforts. But one way to reestablish trust would be for the public health community and AIDS organizations to establish strong public partnerships with trusted figures in the black community.⁸⁸ Such figures may include members

⁸⁵ See Stephen Belenko et al., *HIV Risk Behaviors, Knowledge, and Prevention Service Experiences Among African American and Other Offenders*, 16 J. HEALTH CARE POOR UNDERSERVED 108, 119 (2005). A study focusing on HIV risk perception and behavior among black inmates, parolees, and probationers in New York City found that despite their "fairly extensive exposure to HIV education services," they still had significant gaps in their understanding of how HIV is transmitted.

⁸⁶ See generally Centers for Disease Control and Prevention, *The Tuskegee Timeline* (May 23, 2005), <http://www.cdc.gov/nchstp/od/tuskegee/time.htm>. To study the natural history of syphilis, between 1932 and 1972, the United States Public Health Service withheld adequate treatment for syphilis from poor black men with the disease. *Id.* Called the Tuskegee Study of Untreated Syphilis in the Negro Male, researchers enrolled men into the study under the guise treatment for "bad blood." *Id.* In exchange for their participation in the study, the men were offered free medical exams, free meals, and burial insurance. *Id.* The researchers continued to withhold adequate treatment from the men even after researchers had learned in 1947 penicillin was found to be an effective treatment. *Id.* Moreover, the men were never given the option of quitting the study. *Id.* The study resulted in the unnecessary suffering of many poor black men and their families.

⁸⁷ Laura M. Bogart & Sheryl Thorburn, *Are HIV/AIDS Conspiracy Beliefs a Barrier to HIV Prevention Among African Americans?*, 38 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 213, 215 (Feb. 1, 2005).

⁸⁸ See generally Kandree E. Hicks et al., *Building Holistic HIV/AIDS Responses in African American Urban Faith Communities*, 28 FAM. COMMUNITY HEALTH 184, 193-94 (2005). The results of a qualitative case study also showed that one of the major challenges facing the black community is the "complicated public health infrastructure that often deters community representatives from participating in local and national prevention efforts." *Id.* This suggests that forged partnerships between public health and AIDS organizations and key figures in the black community can also augment the reach of local and national prevention efforts.

of the clergy,⁸⁹ educators, beauticians,⁹⁰ barbers,⁹¹ and social workers. These individuals may be better positioned to disseminate HIV/AIDS prevention information and tools.⁹² Moreover, such

⁸⁹ In 2004, the AIDS Foundation of Chicago announced its Faith in Prevention Initiative to “help foster leadership and collaboration among faith-based organizations and promote prevention education and awareness in communities most affected by the epidemic.” Press Release, AIDS Foundation of Chicago, AIDS Foundation of Chicago Funds Faith-based HIV Prevention Initiative (Jul. 19, 2004), *available at* http://www.aidschicago.org/about_afc/7_19_2004.php. Funded as part of a grant from the U.S. Office of Minority Health, AIDS Foundation of Chicago awarded twelve churches \$10,000 each to help fund the churches’ HIV education and outreach efforts, HIV prevention ministries, support groups, and other activities. *Id.* Similar programs have been initiated in various cities across the country. While it is too soon to gauge the effectiveness of these programs, more must be done to gain the support of black clergy in the fight against AIDS. Historically, black clergy members have been criticized for being slow to respond to the HIV/AIDS crisis in their communities. *See generally* John Blake, *Black Churches to Target AIDS Epidemic*, ATLANTA CONST., Oct. 2, 1999, at 1D and Editorial, *Black Churches and AIDS*, L.A. TIMES, Jun. 3, 2005, at B12. Perhaps a sign of apathy, the Los Angeles Times editorial reported that a “well-known” AIDS activist in Los Angeles invited leaders of 300 Los Angeles area black churches to attend a summit on HIV/AIDS in minority communities, only to receive five responses in the end. *Id.* In noting that “[f]iery sermons condemning homosexuality remain the norm in many black churches,” the editors suggest that the reticence of black church leaders to get involved in the fight against HIV/AIDS may be due to the churches’ stance against homosexuality and stigma. *Id.* And, as the authors of one study noted, “[h]istorically, the Black church has been used by public health and medical professionals to gain access to those Blacks who are more difficult to reach through mainstream systems.” Stephen B. Thomas et al., *The Characteristics of Northern Black Churches with Community Health Outreach Programs*, 84 AM. J. PUB. HEALTH 575, 576 (1994). Thus, efforts to educate religious leaders about the changing epidemiology of HIV/AIDS and the psychological effects of their proselytizing on churchgoers, especially those who engage in same-sex sexual contact, may help boost churches’ willingness to participate in HIV/AIDS prevention efforts.

⁹⁰ An example of a partnership between beauticians and public health officials, in 1999, public health officials in Washington, D.C. distributed “ConPacts” to black patrons of beauty shops. Avram Goldstein, *Safe Sex, With Style*, WASH. POST (Jul. 29, 1999) at B4. Each “ConPact,” which a Washington Post staff writer described as an “elegant black and gold compact that looks perfectly at home in any lady’s purse,” contained a condom and a small folded brochure with the message, “If he says no, you should say no.” *Id.* Explaining the rationale behind the “ConPact” campaign, the director of the District of Columbia’s HIV/AIDS agency noted that black women spend many hours in beauty salons, and that they often discuss intimate matters with their beauticians. *Id.* Thus, he noted, beauty salons are the perfect place for open discussions about condoms. *Id.* It is also worth noting that Ogilvy Public Relations Worldwide, an international communications firm, was awarded several prestigious industry awards for its implementation of the “ConPact” campaign. *See* About Ogilvy PR: Industry Awards, <http://www.ogilvypr.com/about-ogilvy-pr/awards.cfm> (last visited Jul. 6, 2006).

⁹¹ An example of a partnership between a non-profit and barbers, BEAT AIDS, a San Antonio AIDS service organization enlisted at least four local barbers to educate their black patrons about HIV/AIDS and its risks. Vincent T. Davis, *Hearing the Buzz on AIDS*, SAN ANTONIO NEWS, Aug. 19, 2005, at 1B. At least one offered free haircuts to men who listened to BEAT AIDS’s nineteen-minute HIV prevention message. *Id.* Barbers also offered free haircuts to men who took HIV tests on designated dates. *Id.* The tests and haircut were funded by a \$5,000 grant from the Ryan White Fund and BEAT AIDS. *Id.*

⁹² *See* Brooks et al, *supra* note 82 at 740. *But see* Tamera Coyne-Beasley & Victor J. Schoenbach, *The African-American Church: A Potential Forum for Adolescent Comprehensive Sexuality Education*, 26 J. ADOLESCENT HEALTH 289, 293 (2000). Even among black clergy members who ranked HIV/AIDS as a priority issue for young church members, one-third objected to discussions of anal sex, bisexuality, homosexuality, and oral sex, which are topics important to any discussion of HIV/AIDS prevention. *Id.*

public partnerships may help reduce the stigma associated with the disease, and perhaps allow for more opportunities for open discussions of HIV/AIDS and its associated risks.⁹³

There is also a need for increased cultural competence among those involved in HIV/AIDS prevention efforts.⁹⁴ HIV prevention messages that may work for one community may not always be effective in other communities. So, to design effective prevention campaigns, there is a need for improved understanding among policymakers, public health workers, and AIDS service organizations of the relationship between cultural beliefs and behavior.⁹⁵

As an example of where culturally informed HIV prevention efforts could make a difference, the results of a qualitative study of young, heterosexual black men living in a low income housing project in Houston, Texas revealed that the study participants continued to engage in unprotected sex despite their understanding of the HIV/AIDS threat in their community.⁹⁶ Thus, the researchers suggested that knowledge of the epidemic and motivation to avoid infection are insufficient to promote behavior change in low-income black men.⁹⁷ Specifically, they noted the participants' recommendation that "HIV/AIDS [prevention] videotaped messages . . . include footage of the sensational effects of the disease."⁹⁸ And according to a qualitative study of drug-abusing black men and women living in rural and small cities, two misperceptions that were common among study participants were that healthy-looking

⁹³ *Id.* at 740-41. *See also supra* notes 89-91.

⁹⁴ Cultural competence can be best understood by its goal "to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency." *See* Joseph R. Betancourt et al., *Cultural Competence and Health Care Disparities: Key Perspectives and Trends*, 24 HEALTH AFF. 499, 499 (Mar./Apr. 2005).

⁹⁵ *See id.* at 501.

⁹⁶ Ekere J. Essien et al., *Strategies to Prevent HIV Transmission Among Heterosexual African-American Men*, 5 BMC PUB. HEALTH (Jan. 7, 2005), available at <http://www.biomedcentral.com/1471-2458/5/3>.

⁹⁷ *Id.*

⁹⁸ *Id.*

people did not have HIV, and that those with HIV spread the virus intentionally.⁹⁹ Therefore, those involved in HIV/AIDS prevention efforts must be able to implement programs that are sensitive to different cultural beliefs and practices.¹⁰⁰

Increase public support for increasing federal funding for prevention efforts

Educating the public about the changing face of this epidemic may also lead to increased public support for boosting public funding for targeted prevention initiatives focusing on blacks, at a time when the President has proposed to cut federal funding for HIV education and prevention efforts by \$4 million.¹⁰¹ Of the \$21 billion that the President has requested for domestic and global HIV/AIDS funding, domestic prevention efforts account for only 5% of the budget, while 70% of the total domestic budget is allocated to medical costs for those already living with HIV/AIDS.¹⁰²

Moreover, the President has proposed to cut federal funding for the Minority HIV/AIDS Initiative by almost \$4 million.¹⁰³ The result of a cooperative effort between the administration under President Clinton, the Department of Health and Human Services, the Congressional Black Caucus, and the Congressional Hispanic Caucus,¹⁰⁴ the Minority HIV/AIDS Initiative funds

⁹⁹ See Emma J. Brown and Mary Angelique, *Perceptions of HIV Risks and Prevention Strategies by Rural and Small City African Americans Who Use Cocaine: Views from the Inside*, 26 ISSUES MENTAL HEALTH NURSING 359, 371 (2005).

¹⁰⁰ Some ways to augment the cultural competence of public health care workers and AIDS service organizations include: increasing racial diversity among staff and requiring cultural competence training and accreditation among staff. See generally Betancourt et al., *supra* note 94, at 501-503.

¹⁰¹ See Jennifer Kates & Alyssa Wilson Leggoe, Kaiser Family Foundation, *U.S. Federal Funding for HIV/AIDS: The FY 2006 Budget Request*, HIV/AIDS POL'Y FACT SHEET (Feb 2005), available at <http://kff.org/upload/Fact-Sheet-U-S-Federal-Funding-For-HIV-AIDS-The-FY-2006-Budget-Request.pdf>.

¹⁰² See *id.*

¹⁰³ See Judith A. Johnson & Sharon Coleman, Congressional Research Service, *AIDS Funding for Federal Government Programs: FY1981-FY2006*, CRS REP. CONG. 6 (Mar. 23, 2005), available at <http://www.ncseonline.org/nle/crsreports/05mar/RL30731.pdf>.

¹⁰⁴ Office of Minority Health, United States Department of Health and Human Services, *Minority HIV/AIDS Initiative: President's Announcement*, <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=36> (last visited July 7, 2006).

prevention and treatment programs within minority communities.¹⁰⁵ The initiative is part of the Department of Health and Human Services' larger project, the Initiative to Eliminate Racial and Ethnic Disparities in Health by the year 2010.¹⁰⁶ That the President seeks to reduce funding for HIV/AIDS initiatives affecting minority communities at a time when the epidemic is disproportionately affecting blacks is alarming and ill-advised; at least one study has found a direct correlation between federal HIV prevention spending and increased HIV testing and awareness of prevention of mother-to-child HIV transmission.¹⁰⁷ Thus, a campaign designed to educate the public about this disparity and the Administration's response to this disparity may help raise support for increased public funding. It may also cure what has been called donor fatigue, the decline in private donations to HIV/AIDS-related causes.¹⁰⁸

Strengthen STD prevention efforts by allocating more funding

Due to the relationship between STD infection and HIV susceptibility, improved efforts to reduce STD incidence among blacks may also lead to a reduction in the HIV/AIDS racial disparity. While perhaps obvious, increased federal funding for STD and HIV prevention efforts will likely reduce STD and HIV incidence. A recent study conducted by researchers at several

¹⁰⁵ See Johnson & Coleman, *supra* note 103.

¹⁰⁶ Office of Minority Health, *supra* note 104.

¹⁰⁷ See Benjamin P. Linas et al., *Assessing the Impact of Federal HIV Prevention Spending on HIV Testing and Awareness*, 96 AM. J. PUB. HEALTH 1038, 1041 (2006).

¹⁰⁸ See generally Lynda Richardson, *AIDS is Still Here, but Donors Drift Off; As Disease Lingers, Public Interest Wanes and Service Groups Falter*, N.Y. TIMES, Jan 13, 1999, at B1. Richardson noted, "[w]ith the advent of life-prolonging treatments and a significant drop in AIDS-related deaths, AIDS groups in New York and across the country are struggling. Donor fatigue has set in, even though HIV, the virus that causes AIDS, continues to infect 40,000 new people a year in the United States." *Id.* "AIDS in America is no longer considered a problem; everybody thinks it's gone away [The epidemic is now affecting] people who nobody wants to give any money to, poor people, people of color, drug users. In the beginning, when gays were threatened, gays gave money. But gays don't feel so threatened anymore. They are giving money to fight for gay marriage and other gay issues." *Id.* (quoting Larry Kramer, one of the six co-founders of a large AIDS advocacy group in New York City) and Stephanie Strom, *Many Dismissing "Donor Fatigue" as Myth*, N.Y. TIMES, Apr. 30, 2006, at 1-22. While overall private donations may have gone down for HIV/AIDS-related causes, overall giving among the private sector has seen a similar decline. *Id.* This suggests that educating the private sector about this racial disparity, and the ramifications of this disparity, may yield increased private funding for HIV/AIDS prevention efforts.

federal agencies found a significant association between federal HIV and STD prevention spending and reductions in the incidence rates of gonorrhea.¹⁰⁹ The researchers further noted that “[b]ecause gonorrhea is a marker for risky sexual behavior, these findings are likely generalizable to other STDs, including HIV.”¹¹⁰

Strengthen and improve access to substance abuse prevention interventions and treatment

More efforts to prevent and treat substance abuse among black people will help reduce the disproportionately high burden that blacks bear in the HIV/AIDS epidemic. Although a smaller proportion of black people report lifetime use of illegal drugs,¹¹¹ they are incarcerated at a disproportionately high rate for drug offenses.¹¹² Thus, they are then exposed to prison and jail-related HIV risks at a disproportionately high rate. Therefore, preventing or treating substance abuse among black people may result in fewer prison sentences for black people. But, a more likely result is that fewer people will engage in substance abuse-induced high-risk sexual behavior or that people will engage in such risky behavior less often.

Address HIV/AIDS risks associated with the criminal justice system

Bring attention to the disproportionately high incarceration rate of blacks

That the majority of those incarcerated for drug offenses are black, though fewer blacks report lifetime drug use than whites or Hispanics, and that blacks are overrepresented in our nation’s prisons and jails,¹¹³ suggest three possible explanations. First, it may be that the laws,

¹⁰⁹ See Harrell W. Chesson et al., *Does Funding for HIV and Sexually Transmitted Disease Prevention Matter?*, 29 EVALUATION REV. 3, 18 (Feb. 2005).

¹¹⁰ *Id.* at 19.

¹¹¹ See Substance Abuse and Mental Health Services, *supra* note 39.

¹¹² See Harrison & Beck, *supra* note 47, at 9.

¹¹³ See Substance Abuse and Mental Health Services, *supra* note 39.

themselves, may have a disproportionate effect on black people.¹¹⁴ On the other hand, the disproportionately high incarceration rate and the resultant racial disparity in HIV incidence may be the result of the misuse of prosecutorial discretion or law enforcement.¹¹⁵ Alternatively, the sentencing disparities may result from society's prejudices manifested in biased jury decisions.

Whatever the cause,¹¹⁶ there is a need for sentencing reform. Given that this nation has the dubious distinction of having the world's highest incarceration rate, and that people of certain racial and ethnic groups are overrepresented in our prisons and jails,¹¹⁷ there is a need for re-examination of the factors that may be leading to these disparities.¹¹⁸ A reduction in these race-

¹¹⁴ See e.g., Blankenship et al., *supra* note 57, at 142. Professor Blankenship argued that much of the racial disparity in sentencing and growth of the incarcerated population can be attributed to the federal drug policy. Professor Blankenship noted, "U.S. policies toward drug offenses have become increasingly punitive since the 1980s. Measures such as mandatory minimum sentences, penalty enhancements for the sale and use of drugs in certain areas (drug free zones), disparities in the penalties associated with possession of crack and powder cocaine, and restrictions on syringe availability are examples of policies that increase the frequency of arrest and incarceration of drug offenders." *Id.*

¹¹⁵ See e.g., Kim M. Blankenship & Amy Smoyer, Yale University Center for Interdisciplinary Research on AIDS, *Public Health, Research, and Law Enforcement: The Case of HIV/AIDS Prevention*, CONFERENCE REP. (Spring 2004), available at http://cira.med.yale.edu/law_policy_ethics/cr_phrl.pdf. Professor Blankenship made note of several longitudinal studies that have demonstrated a causal association between fear of arrests and increased needle sharing among injection drug users (IDUs). *Id.* at 2. She noted that "[t]hese studies consistently demonstrate that IDUs are unwilling to carry syringes in the US for fear of being stopped by the police, that IDUs who share syringes report more arrests and legal difficulties than those who do not, and that laws limiting access to syringes are associated with high prices for syringes." *Id.* The recommendations put forth by participants at Yale's Center for Interdisciplinary Research on AIDS conference on law enforcement focused on building bridges between public health and law enforcement. *Id.* at 6. Specific recommendations include the promotion of mutual understanding between public health and law enforcement through education and dialogue, *id.*, and working with law enforcement to generate public acceptance for harm reduction, especially among the federal government. *Id.* at 9.

¹¹⁶ See generally Samuel L. Myers, Jr., *Racial Disparities in Sentencing: Can Sentencing Reforms Reduce Discrimination in Punishment?*, 64 U. COLO. L. REV. 781 (1993). In his examination of racial disparities in parole release dates, Professor Myers called attention to what he believed to be the two goals of punishment: punishment as a means of controlling crime, which he called the "efficiency" goal, and the goal of setting equitable penalties for wrongful acts, which he called the "equity" goal. *Id.* at 781. Professor Myers further noted that "[r]acial disparities in punishment are a by-product of the operation of a criminal justice system that labors under these conflicting objectives in sentencing and imprisonment." *Id.*

¹¹⁷ See HUMAN RIGHTS WATCH, *supra* note 49.

¹¹⁸ See Myers, *supra* note 116, at 783-84. Professor Myers also made note of the imperfections with existing econometric techniques used to measure racial discrimination, which he defined as "differential treatment of otherwise identically situated individuals." *Id.* at 783. Professor Myers's econometric study demonstrated that the parole guidelines, developed by the U.S. Board of Parole's Research Office, and in use prior to the federal sentencing reforms, led to racial disparities in parole release practices. *Id.* at 807. He found associations between release rates of black and white inmates and factors such as marriage and prior prison sentences. *Id.* Moreover, it remains to be seen whether the sentencing reforms have resulted in any quantifiable effect on racial disparities in

related sentencing disparities may result in fewer black people in prisons or jails. With fewer black people incarcerated, fewer will be exposed to incarceration-related HIV/AIDS risks.

Make prisons and jails safer for all

Whatever the motivation for putting someone behind bars – whether for retribution or deterrence – there is no reason that incarceration should expose inmates to higher risks of HIV infection. Apart from the constitutional prohibition against cruel and unusual punishment and related case law, there are more obvious, practical reasons for reducing incarceration-related HIV transmission risks. What trauma inmates experience or diseases they carry will not remain in prison after the inmates are released; they will carry these experiences and infections with them back into society.

According to the United States Department of Justice’s Bureau of Justice Statistics, individuals sentenced for felonies and sent to state prisons in 2002 had an average sentence for 4.5 years, but were likely to serve just 2.5 years of their sentence.¹¹⁹ As for people held in local jails, the average sentence was seven months.¹²⁰ Thus, it would not take long for infections to spread in non-incarcerated populations after an inmate is infected and later released. Moreover, as recent headlines demonstrate, corrections officers cannot always be trusted to protect inmates from other inmates, or themselves.¹²¹ Thus, it is up to lawmakers to implement enforceable laws that make prisons and jails safer than what they are at the present.

sentencing. *Id.* The author suggested that this uncertainty stems, in part, from the use of inadequate data in their statistical modeling. *See id.*

¹¹⁹ UNITED STATES DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *Criminal Sentencing Statistics*, <http://www.ojp.usdoj.gov/bjs/sent.htm> (last visited Jul. 6, 2006).

¹²⁰ *Id.*

¹²¹ *See* Abby Goodnough, *Judge Denies Bail to Three Charged in Prison Case*, N.Y. TIMES, Jun. 23, 2006, at A16. Six corrections officers indicted on charges of providing female inmates with contraband such as alcohol and marijuana in exchange for sex. *Id.* They were also indicted on charges of bribery and threatening inmates to remain silent. *Id.* When federal agents had arrived at the Florida prison to arrest the men, what resulted was a shootout between federal agents and corrections officers that left one guard and a federal agent dead. *Id.* The federal prosecutor on the case noted the importance of keeping these guards away from prison, and said of the inmates,

Make condoms available and easily accessible to all inmates

HIV and other STD prevention tools that are commonly available outside of prisons and jails are considered contraband in prisons. Only two states and a handful of jails permit condom distribution to inmates.¹²² On the other hand, other states and municipalities permit condom distribution to certain inmates for conjugal visits, in some cases only upon request. Moreover, where conjugal visits are permitted, they are often limited to those partners who were legally married before the inmate was incarcerated. Thus, perhaps, one may raise an equal protections issue. Phrased one way, why are certain married inmates permitted sexual encounters with their partners, sometimes with condoms supplied by corrections officials, while homosexual inmates are denied the same privileges? Phrased another way, certain married heterosexual inmates are provided protection from STDs, regardless of whether the condom's intended purpose is birth control, whereas homosexual inmates or inmates engaging in homosexual contact are, by default, not permitted to protect themselves. And given that an estimated 20 to 26% of people living with HIV passed through a correctional facility in 1997,¹²³ and that it is unlikely that the numbers have since changed significantly, there is a significant risk of contracting HIV from sexual encounters within prisons and jails.

Thus, condoms should be made available and easily accessible to all inmates. Already in at least 18 countries, mostly those in West Europe, legislators have permitted condom distribution within their prison systems.¹²⁴ Opponents to condom distribution fear that it would

“They are highly vulnerable They are subject to threats and coercion by the defendants and other unindicted co-conspirators.” *Id.*

¹²² Condom distribution is permitted in prisons in Vermont and Mississippi, and in jails in New York City, San Francisco, Washington, D.C, and Philadelphia. Elisabeth Kantor, *HIV Transmission and Prevention in Prisons*, HIV INSITE KNOWLEDGE BASE CHAPTER (Apr. 2006), <http://hivinsite.ucsf.edu/InSite?page=kb-07-04-13>.

¹²³ See Hammett, *supra* note 60.

¹²⁴ Kate Dolan et al., *Evaluation of the Condom Distribution Program in New South Wales Prisons, Australia*, 32 J. L., MED. & ETHICS 124, 124 (2004) (citing Timothy W. Harding & G. Schaller, *HIV/AIDS and Prisons: Update and Policy Review* (University Institute of Legal Medicine, 1992, at 25)).

increase sexual assaults in inmates, or that condoms would be used to smuggle contraband, such as drugs. While it is not clear whether sexual assaults rise with the increased availability of condoms, as of 2004, no negative consequences have been reported in the 18 countries where condoms distribution in prisons is permitted.¹²⁵ Notably, no condom distribution program in the United States has been discontinued once it has been instituted.¹²⁶

Make clean needles or needle-cleaning supplies available to inmates

Federal and state legislators must also acknowledge the injection drug use and tattooing that occurs in prisons and jails, and that these activities expose inmates to HIV and other infections. Despite the abundance of anecdotal evidence of widespread needle use among inmates, not one correctional facility in this country offers its inmates access to clean needles.¹²⁷ As of 1997, only ten state or federal prisons and eight jails make bleach available to inmates for “any purpose.”¹²⁸

As with condom distribution, opponents of clean needle or needle-cleaning supplies distribution in prisons fear that their distribution would encourage drug use or tattooing. However, a study published in the British Medical Journal found that the free and wide distribution of clean needles in a Swiss prison for women did not lead to increased drug use.¹²⁹ Moreover, needle-sharing among the inmates in that study went down to almost zero.¹³⁰ The

¹²⁵ Kate Dolan et al., *Evaluation of the Condom Distribution Program in New South Wales Prisons, Australia*, 32 J. L., MED. & ETHICS 124, 125 (2004) (citing G. Schaller and Timothy W. Harding, *AIDS Prevention in European Prisons (La prévention du sida dans les prisons européen)* 40 SOC. & PREV. MED. 298-301 (1995)).

¹²⁶ See Theodore M. Hammett et al., United States Department of Justice, Office of Justice Programs, 1996-1997 UPDATE: HIV/AIDS, STDs, AND TB IN CORRECTIONAL FACILITIES 49 (Jul. 1999), available at <http://www.ncjrs.gov/pdffiles1/176344.pdf>.

¹²⁷ See *id.* at 50.

¹²⁸ See *id.* at 49.

¹²⁹ See J. Nelles et al., *Provision of Syringes: The Cutting Edge of Harm Reduction in Prison?*, 317 BRIT. MED. J. 270, 271 (1998).

¹³⁰ See *id.*

success of this demonstration project led Swiss authorities to run similar programs in other prisons within the country.¹³¹

Thus, lawmakers should make clean needles or needle-cleaning supplies available to inmates in American prisons. Further, they should be made discreetly and widely available, so that inmates can access them without fear of legal sanctions. While efforts to reduce injection drug use and prison tattooing should remain strong, implementing this policy would likely lead to decreased needle sharing. Thus, fewer inmates may be exposed to HIV. And with fewer exposed inmates, fewer black inmates will be exposed to HIV.

Strengthen efforts to reduce poverty among black populations

Efforts must be made to reduce the prevalence of poverty among black people. Poverty has been associated with substance abuse, residential segregation by race,¹³² sexually transmitted diseases, race, and incarceration, all of which have been implicated in the disproportionately high incidence of HIV/AIDS in blacks. Thus, efforts to reduce the prevalence of poverty may yield significant results in the reduction of HIV/AIDS incidence among blacks.

¹³¹ *See id.* at 272.

¹³² *See generally* Laurie M. Anderson et al., *Providing Affordable Family Housing and Reducing Residential Segregation by Income: A Systematic Review*, 57 AM. J. PREVENTIVE MED. 47, 56 (2003). “The importance of housing policy that attempts to deconcentrate neighborhood poverty while providing affordable housing to low-income families can be seen in the strong emphasis placed on income mixing within the HOPE VI Urban Revitalization Demonstration Program (citation omitted), the federal government’s program for the physical and social revitalization of distressed public housing. Such an emphasis is in sharp contrast to the public housing program’s record of concentrating poverty by routinely constructing developments in impoverished areas and reserving units for the poorest of households, practices which are believed to be largely responsible for many of public housing’s most recognized failures: environments of violence, substance abuse, welfare dependency, teen pregnancy, unemployment, and lowered educational achievement among youth.” *Id.* The researchers expressed support for tenant-based rental assistance programs as a method to reduce residential segregation by income. *See id.* They based their recommendation on evidence linking the programs to a reduction in the residents’ exposure to property or personal crimes, and decreases in social disorder in the neighborhood. *Id.* The researchers, however, were unable to determine the effects of tenant-based rental assistance programs on outcomes such as physical or psychological health due to the limited availability of relevant studies. *Id.*

Eliminate laws criminalizing HIV exposure

At least twenty-four states have enacted laws that specifically criminalize HIV exposure.¹³³ And in some states, one may be prosecuted for HIV exposure regardless of whether transmission of the virus actually occurs.¹³⁴ While there is little empirical evidence as to the number of people who have been charged with criminal HIV exposure, let alone their demographic characteristics, there have been certain high profile HIV exposure prosecutions in this country, and at least two of the male defendants were black.¹³⁵

Whether these high profile prosecutions or the existence of HIV exposure laws have had a deterrent effect on HIV positive individuals' sexual behavior remains to be seen.¹³⁶ What also remains to be seen is whether prosecutors have unfairly targeted black male offenders. Or perhaps the media is to blame for publicizing these two cases. What is clear, however, is that there is tremendous room for discrimination based on race or sexual orientation in how laws criminalizing HIV exposure are enforced – from arrest to prosecution and sentencing. Thus, HIV exposure laws should be eliminated.

¹³³ See Zita Lazzarini et al., *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J. L., MED. & ETHICS 239, 241 (2002). For a summary of individual state criminal statutes on HIV exposure or transmission, see ACLU, STATE CRIMINAL STATUTES ON HIV TRANSMISSION – 2004, available at <http://www.aclu.org/FilesPDFs/hivcriminalization.pdf>.

¹³⁴ See *id.*

¹³⁵ In 1997 the public was inundated with media reports that, Nushawn Williams, described by the media as a black man “who is 5 feet 8 inches tall, weighs 185 pounds and had 2- to 4- inch-long braids,” James Barron, *Officials Link Man to 11 Teen-Agers with H.I.V.*,” N.Y. TIMES, Oct. 28, 1997, at A1, had exposed over 70 women to HIV through sexual contact. Joe Sexton, *Prosecutors Seeking Victims of Man Infected with H.I.V.*, N.Y. TIMES, Nov. 1, 1997, at B2. He was later sentenced to four to twelve years in prison for exposing at least 13 young women with HIV. Journal Sentinel Wire Reports, *Man Who Spread HIV Infection Sentenced*, MILWAUKEE J. SENTINEL, Apr. 6, 1999, at 4. More recently, in 2004 Anthony Whitfield, a 32 year old black man from Washington State, was sentenced to 178 years in prison after he was charged with 17 counts of first-degree assault with sexual motivation for having exposed seventeen women to HIV. Seattle Post-Intelligencer News Service, *HIV-Positive Man Who Infected 17 Women Sentenced to 178 Years*, SEATTLE POST INTELLIGENCER NEWS SERVICE, Dec. 22, 2004, available at http://seattlepi.nwsourc.com/local/204754_t1122.html. It is believed that Whitfield became infected with HIV while he was incarcerated in the 1990s. *Id.* For additional information on Whitfield's case, see Mark D. Fefer, *HIV: Criminal Intent*, SEATTLE WKLY., Dec. 1, 2004, available at http://www.seattleweekly.com/news/0448/041201_news_hiv.php.

¹³⁶ See Lazzarini et al., *supra* note 133, at 251.

Some may argue that repealing laws criminalizing HIV exposure would ignore the victims of HIV exposure, even those who are not infected. While removing laws criminalizing HIV exposure would limit the criminal justice system's role, these victims can still seek tort remedies in any of the nation's civil courts. In fact, there is a significant body of case law in this area. Thus, it is simply untrue that victims of HIV exposure would be uncompensated or that those intentionally exposing others to HIV would go unpunished.

HIV exposure laws only serve to further stigmatize and punish a population that must already endure significant discrimination and challenges. Stigma, as noted earlier in this document, only serves to exacerbate public health prevention interventions. Moreover, once convicted, these individuals enter a corrections system that already leaves them and others like them vulnerable to becoming HIV infected or developing AIDS and AIDS-related complications.

IV. Conclusion

In a country as rich and plentiful as ours, it is telling that a racial group that has been discriminated against since their ancestors were forcibly brought to this country in servitude now bears a disproportionately high burden in the HIV/AIDS epidemic. While the epidemiology of this disease has changed, the policies and laws that affect it have not. It is time that law and policymakers give heed to the scientific community's evidence-based approach, and craft laws and policies that adequately address this changing epidemic.