



UNITED STATES

# Rights at Risk

State Response to HIV in Mississippi

HUMAN  
RIGHTS  
WATCH



# **Rights at Risk**

## **State Response to HIV in Mississippi**

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# Map of Mississippi

## Top 20 Mississippi County HIV Rates and Corresponding Poverty Rates



## I. Executive Summary

Donna M. is homeless and living with HIV in Jackson, Mississippi. In a conversation with Human Rights Watch, she described how the intense stigma surrounding HIV in Jackson made living without housing an even more frightening experience. Even when Donna lived with relatives, fear that her HIV infection would be discovered kept her from being treated:

First I tore the labels off [my medicines], then I ended up throwing them away. I was scared [my family] would kick me out if they found them.

Robert B. is a gay man living with HIV near Jackson. He lost many of his health benefits after he moved from New York, but he also endures the constant pressure of homophobia.

Being gay with HIV in Mississippi is a terrible curse. I came here from New York and it is like going back 40 years in time. Everyone treats you like dirt.

More than 1.1 million people in the United States are living with HIV and an estimated 56,000 people become newly infected each year. Some of the highest HIV infection and AIDS death rates in the US are found in southern states such as Mississippi, where Donna M. and Robert B. are struggling for survival. Mississippi not only fails to invest in HIV/AIDS prevention and care, it also promotes punitive, stigmatizing, and discriminatory policies that undermine efforts to reach the populations most vulnerable to HIV. Mississippi has actively resisted increased federal funding for HIV/AIDS programs and services. This report presents the voices of people living with HIV in Mississippi and highlights state responses that leave people with HIV/AIDS without treatment at rates comparable to those in Botswana, Ethiopia, and Rwanda.

From Jefferson county in the West to Noxubee county in the East, a picture emerges in Mississippi of people with HIV and AIDS unable to meet their basic needs including housing, transportation, and access to health care. Despite these hardships, Mississippi's investment in HIV/AIDS programs and services remains minimal. The state relies almost exclusively on federal programs to provide care and services for HIV and AIDS. Despite clear evidence, often prepared by its own state agencies, that relying on limited and incomplete federal programs is not sufficient to meet Mississippians' urgent needs, the state fails to maximize the federal benefits it could receive for housing, medical care, and other services vital for people living with HIV and AIDS. Most disturbing is Governor Haley Barbour's attempt to block health care reform that would expand Medicaid benefits for people living with HIV in the state.

Throughout Mississippi, people living with HIV, their advocates, health providers and public officials describe an extreme stigma surrounding HIV that is, for many, more frightening than the disease itself. Human Rights Watch found that Mississippi laws and policies promote prejudice and discrimination against those vulnerable, and perceived to be vulnerable, to HIV, thereby contributing to the problem. Numerous legal provisions, including constitutional amendments, discriminate against homosexuals and state sex education laws marginalize lesbian, gay, bisexual, and transgender (LGBT) youth. In Mississippi, the criminal law penalizes those with HIV for failing to disclose their positive status, an approach that public health experts deem likely to undermine, rather than promote, the public health.

Mississippi's sex education policies also play a harmful role in the state's HIV epidemic. The state has the highest rates of sexually transmitted disease (STD) and teen pregnancy in the nation and alarming rates of HIV infection among young black men who have sex with men (MSM). Yet Mississippi's legislature remains stubbornly committed to failed messages of abstinence in sex education, ignoring evidence that such approaches have little effect on reducing HIV or STD transmission. Despite the fact that students in Mississippi are having sex earlier than in any other state, the state suppresses information about condom use and effectiveness in sex education, denying youth access to accurate and relevant health information that can prevent HIV infection.

The sex education curricula in Mississippi also mandates negative messages about "homosexual activities," creating hostile school environments for LGBT youth and interfering with their right to health. Combined with other state laws that discriminate against homosexuals, Mississippi promotes a culture of homophobia that, according to state public health officials, endangers the health of gay, bisexual, and other men who have sex with men by keeping them away from HIV testing and treatment services.

The HIV/AIDS epidemic in the Southern US has been particularly devastating for minority communities. Nowhere is the dramatic racial impact of the epidemic more apparent than in the state of Mississippi, where African-Americans are only 37.5 percent of the population, but comprise 76 percent of those newly infected with HIV. Mississippi's failure to embrace evidence-based approaches in the face of increasing health threats to minority populations conflicts with fundamental principles of human rights.

An alarming rise in HIV infection among young black men who have sex with men recently prompted an investigation by federal and state health authorities, who recommended implementation of comprehensive sex education at an early age in order to increase awareness of risk and to promote condom use as a proven method of prevention. These



recommendations have been utterly ignored in the public schools despite evidence that once infected these young men are unlikely to access adequate health care. Similarly, though African-American women have the second-highest HIV infection rate in the state, Mississippi's "Just Wait" abstinence campaign does not provide evidence-based HIV prevention education to this very vulnerable population.

The factors identified in this report are not the only contributors to the HIV epidemic in Mississippi, an impoverished state with poor rates of overall health, education, and development. Stigma and discrimination, fueled by community attitudes, religious beliefs, and other societal forces are also contributing factors. But government action plays a significant role, and the harmful policies highlighted here undermine efforts to combat the HIV/AIDS epidemic and disregard national and international guidelines on best practices for effective management of the disease. These policies combine to create a high-risk environment where it is difficult for many people to avoid HIV infection and to access life-saving treatment and support. If there is to be meaningful progress in access to HIV services, Mississippi's obligation to protect public health and human rights should be the immediate focus of both federal and state governments.

## II. Recommendations

### To the State of Mississippi

#### *To the Governor of Mississippi:*

- Support provisions of the Patient Protection and Affordable Care Act of 2010 (health care reform legislation) that would increase access to health services for people living with HIV/AIDS in Mississippi, including expansion of community health centers, improvement of access to health care providers, and expanded eligibility for Medicaid.

#### *To the Mississippi State Legislature:*

- Increase state investment in HIV/AIDS prevention, care, and essential services such as housing and transportation.
- Expand the income eligibility threshold for Medicaid and expand HIV-related benefits and services including coverage for drug dependence treatment and increased coverage for prescription drugs.
- Ensure that state agencies are authorized to maximize federal funding for HIV-related services including Medicaid, HIV prevention, housing, and transportation.
- Repeal statutory requirements for abstinence-only sex and HIV education and replace them with requirements for comprehensive sex education that includes scientifically accurate information about HIV/AIDS and condoms as a method of prevention and ensures that teachers, administrators, and other state officials are not permitted to restrict accurate information about HIV prevention. Ensure that all sex and HIV/AIDS education materials are inclusive of lesbian, gay, bisexual, and transgender youth.
- Repeal HIV-specific criminal laws that penalize behavior related to HIV disclosure, exposure, and transmission in light of evidence that these laws undermine public health and human rights.
- Repeal statutory prohibitions on adoption by homosexuals.
- Repeal the constitutional amendment banning marriage between couples of the same sex.
- Remove all statutory references to invalid criminal laws prohibiting sodomy between consenting adults.
- Increase support for legal services for low-income residents including those living with HIV and AIDS.

*To the Mississippi Department of Health:*

- Take all necessary steps to ensure that department policy reflects a commitment to protect the human rights of all who come into contact with the STD/HIV Office or other public health services, including the establishment of a Patient's Bill of Rights, the revision of all relevant forms to comply with human rights standards, the improvement of training and supervision of Disease Intervention Specialists (DISs) and other Department of Health employees, the establishment of a consumer advisory board, and the realization of other recommendations set forth in the report prepared by the State Health Access Research Project (SHARP).
- Increase efforts to maximize federal funding for HIV/AIDS prevention, treatment, and essential services such as housing and transportation.

*To the Mississippi Department of Human Services:*

- Ensure adequate access to affordable services for sexual and reproductive health. Terminate the "Just Wait" abstinence program and replace it with comprehensive sex education that includes complete, scientifically accurate information about HIV/AIDS and other sexually transmitted diseases.

*To the Office of Mississippi Medicaid:*

- Increase the income eligibility threshold to ensure adequate access to health services for low-income people living with HIV/AIDS.
- Repeal the state requirement for face-to-face interviews for initial and continued Medicaid eligibility.
- Support the expanded income eligibility for Medicaid provided by the Patient Protection and Affordable Care Act of 2010. Apply for a waiver under section 1115 of the Social Security Act to receive federal matching funds for immediate expansion of Medicaid to people living with HIV who are not disabled.

**To the United States Government**

*To the Congress of the United States:*

- Ensure adequate funding for implementation of the National AIDS Strategy including improved access to prevention, treatment, and essential services such as housing and transportation.
- Ensure adequate HIV/AIDS funding for all regions and ensure that funds for both medical care and housing are targeted to regions, states, and communities that

reflect current epidemiological data and where prevention, treatment, and essential services such as housing and transportation are most needed.

- Repeal legislation supporting or funding abstinence-only education and continue to support and fund comprehensive sex education that includes scientifically accurate information about HIV/AIDS and the use of condoms as a method of prevention. Ensure that all such materials are inclusive of lesbian, gay, bisexual, and transgender youth.

*To federal agencies including the US Centers for Disease Control and Prevention, Office of National AIDS Policy, and Department of Health and Human Services:*

- Establish clear policy guidelines regarding laws that criminalize behavior related to HIV disclosure, exposure, and transmission to ensure public awareness that these laws undermine public health and human rights while failing to promote either public health or criminal justice. Provide technical assistance to states to repeal and/or revise these laws as recommended in the National AIDS Strategy.
- Continue the current trend away from funding abstinence-only education and ensure that adequate guidelines, funding, and technical assistance are available at the state and local levels to provide comprehensive sex education that includes scientifically accurate information about HIV/AIDS and condoms as a method of prevention.
- Consider establishing a “race to the top” program, similar to that in place for education in the United States, that provides financial incentives for states whose HIV/AIDS policies result in measurable progress while complying with public health and human rights standards.

## **To the United Nations**

*To the United Nations Committees on Human Rights, Economic, Social and Cultural Rights, and Racial Discrimination; and to the United Nations Special Rapporteurs on the Right to the Highest Attainable Standard of Health and Contemporary forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance; and the United Nations Human Rights Council:*

- Call upon the United States to comply with its international obligations to eliminate disparate racial impact in public health including the disparate racial impact of the HIV/AIDS epidemic.
- Call upon the United States to improve oversight, establish incentives, and take other necessary steps to ensure compliance with human rights obligations at the state and local level.

### **III. Methodology**

The research for this report originated as part of a larger project focused on human rights violations related to HIV/AIDS in the southern United States. For that project hundreds of individuals were interviewed throughout the South during the period July 2009-October 2010. In December 2010 Human Rights Watch released the briefing paper “Southern Exposure: HIV and Human Rights in the Southern United States” highlighting the intersection of socio-economic conditions and human rights abuses that make that region the nation’s epicenter of HIV/AIDS. Because socio-economic conditions and policies in Mississippi exemplify many of the findings of that report, the more than 65 interviews conducted in Mississippi became the subject of this report. Human Rights Watch interviewed approximately 40 people living with HIV/AIDS, both individually and in groups, with all interviews occurring with the consent of all participants. Pseudonyms are used for all people living with HIV quoted in the report in order to protect their privacy and confidentiality.

Human Rights Watch also interviewed HIV advocates and employees of HIV service organizations, health care providers, HIV case workers, public health officials, state legislators, teachers, and members of the judiciary. The Mississippi Department of Health cooperated fully with Human Rights Watch and provided planning and other documents for review. All documents referenced in this report are publicly available or on file with Human Rights Watch.

The findings of the report were discussed with the State Health Officer and staff of the STD/HIV Office of the Department of Health while the report was still in draft form. Human Rights Watch repeatedly requested meetings with the Office of the Governor to discuss the findings of the report but received no response.

## IV. Background

HIV/AIDS continues to pose a major public health threat in the United States. Every nine-and-a-half minutes someone in the US is infected with HIV; 56,000 people are newly infected each year. More than 1.1 million people are living with HIV, and almost half of Americans know someone infected with the virus.<sup>1</sup> AIDS is caused by the human immunodeficiency virus, or HIV. HIV progressively destroys the body's ability to fight infections and certain cancers by killing cells in the immune system called CD4+ T (CD4) cells. Regular monitoring of CD4 cells and the amount of HIV in the body, or viral load, is essential to determining appropriate treatment. Antiretroviral therapy (ART) treats HIV with a combination of medications, each of which attacks the virus's life cycle in a different way. Based on laboratory test results, doctors also prescribe different prophylactic drugs to prevent patients from developing opportunistic infections such as *pneumocystis pneumonia* (PCP).<sup>2</sup>

A key aspect to achieving the benefit of ART is full adherence to the therapy regimen. Due to the rapid multiplication and mutation rate of HIV and other factors, very high levels of adherence to antiretroviral schedules are necessary to avoid viral resistance. In comparison with patients who are adherent to ART, non-adherent people have higher mortality rates, less improvement in CD4 cell count, and spend more days in the hospital. Viral resistance not only affects the health of the individual but also that of the community, as resistant strains can be transmitted to others.<sup>3</sup>

In the United States, racial and ethnic minorities bear the overwhelming burden of the disease. Comprising just 13 percent of the US population, 46 percent of people living with HIV/AIDS are black. Blacks are disproportionately represented in every transmission category, including men who have sex with men, women, heterosexual men, injection drug users, and children.<sup>4</sup> The President's Office of National AIDS Policy has called the toll of the

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<sup>1</sup> US Centers for Disease Control (CDC), Estimates of New HIV Infections in the United States, August 2008; Hall, H., et al, "HIV Infection- United States, 2005 and 2008," in CDC, Morbidity and Mortality Weekly Report, "CDC Health Disparities and Inequalities Report- United States 2011," January 14, 2011, p. 87.

<sup>2</sup> Department of Health and Human Services, Guidelines for the use of Antiretroviral agents in HIV-1 infected adults and adolescents, January 2011.

<sup>3</sup> Ibid.

<sup>4</sup> CDC, HIV/AIDS Surveillance Report 2007; CDC, HIV/AIDS Surveillance by Race/Ethnicity, slide set, 2007.

epidemic on the black community “staggering.”<sup>5</sup> Latinos and Asian-Pacific Islanders also have rates of HIV infection out of proportion to their numbers in the general population.<sup>6</sup>

The South is at the epicenter of the HIV epidemic in the United States,<sup>7</sup> with more people living with HIV and dying of AIDS than in any region in the country. The South has:

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

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

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

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<sup>5</sup> G. Millett, Office of National AIDS Policy Blog, “White House Meeting on Black Men and HIV,” June 4, 2010, <http://www.whitehouse.gov/blog/2010/06/04/white-house-meeting-black-men-and-hiv> (accessed October 25, 2010).

<sup>6</sup> CDC, HIV/AIDS Among Hispanics/Latinos, August 2009 <http://www.cdc.gov/hiv/hispanics/index.htm>, (accessed October 25, 2010); CDC, HIV/AIDS Among Asians and Pacific Islanders, August 2008, <http://www.cdc.gov/hiv/resources/factsheets/API.htm> (accessed October 25, 2010).

<sup>7</sup> As used in this report, “the South” refers to the 17 states of Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Texas, Tennessee, Virginia and West Virginia, unless otherwise noted. This is the definition utilized by the majority of primary reference databases cited in this report including the US Centers for Disease Control and Prevention, the US Census Bureau and the Kaiser Family Foundation HIV/AIDS database. These sources, in turn, are relied upon in secondary documents cited such as the National AIDS Strategy for the United States and the Southern AIDS Coalition Manifesto and Update.

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

<sup>9</sup> Southern AIDS Coalition, “Southern States Manifesto,” p. 3. For additional epidemiological data on HIV/AIDS in the southern US, see, Fleming, P.L. et al, “The epidemiology of HIV/AIDS in women in the southern US,” *Sexually Transmitted Diseases* July 2006: 33(7) pp. S32-38; Reif, S. et al, “HIV Infection and AIDS in the Deep South,” *American Journal of Public Health*, June 2006: (96) 6: 970-3. For an analysis of HIV and human rights in the South, see Human Rights Watch, “Southern Exposure: HIV and Human Rights in the Southern United States,” New York, November 2010.

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

<sup>11</sup> CDC, HIV/AIDS Surveillance Report 2007.

People living with HIV in the South die of AIDS at a higher rate than in other regions.<sup>12</sup> A recent study found that being black, female, and living in the South were all associated with “substantially higher rates of death from AIDS” than in other geographic areas including other countries such as Canada, Australia, and Brazil.<sup>13</sup> In the South, many people are diagnosed with HIV late in the progression of the disease, at or near the point of full-blown AIDS, when treatment is less effective.<sup>14</sup> In many southern states, including Mississippi, more than half of people who test positive for HIV do not get adequate care. This is significantly higher than the national percentage of 33 percent of people living with HIV who are not in care.<sup>15</sup>

The concentration of the HIV epidemic in the South is not new or sudden: between 2000 and 2003 the number of AIDS cases rose 35.6 percent in the six states that comprise the Deep South, while rising 5.2 percent nationally.<sup>16</sup> By 2003 the South led the country in people living with HIV, people dying of AIDS, and diagnoses of AIDS.<sup>17</sup> Yet federal funding for HIV/AIDS, chronically inadequate to address the nation’s epidemic, has shortchanged the southern region for decades by relying on a formula based on cumulative AIDS cases, including deaths from the disease since the 1980s, rather than targeting money toward areas with rising rates of infection.<sup>18</sup> The Obama Administration’s National AIDS Strategy acknowledges this problem and declares an intention to rectify it, but it remains to be seen whether that intention will translate into a revised funding formula or the equally important goal of adequate funding for HIV nationally.<sup>19</sup> Moreover, changes in federal policy alone are not enough. In many states in the South, socio-economic conditions combine with discriminatory, stigmatizing, or ineffective state laws and policies that are incompatible with human rights and put people at risk for HIV infection or exclude them from care.<sup>20</sup> Strong

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<sup>12</sup> CDC, HIV/AIDS Surveillance Report 2006.

<sup>13</sup> Meditz, A., et al, “Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection,” *Journal of Infectious Diseases*, 2011, p.1-10.

<sup>14</sup> Krawczyk, C. et al, “Delayed Access to HIV Diagnosis and Care: Special Concerns for Southern United States”, *AIDS Care* (2006) 18:Supplement 1: S35-44; Meditz, et al, “Sex, Race, and Geographic Region,” p. 4.

<sup>15</sup> Office of National AIDS Policy, *National AIDS Strategy for the United States*, p. 7. “In care” for HIV is defined by the US Health Resources and Services Administration (HRSA) as receiving a minimum number of viral load and CD4 tests during a one-year period. See, HRSA, “A Practical Guide for Measuring Unmet Need for HIV-Related Primary Medical Care,” <http://hab.hrsa.gov/tools/unmetneed>, (accessed January 4, 2011).

<sup>16</sup> Whetten, K. et al, “Overview: HIV/AIDS in the Deep South Region of the United States,” *AIDS Care* 2006; 18 (Supp.) 51-55. Whetten defined Alabama, Georgia, Louisiana, North Carolina, South Carolina and Mississippi as the Deep South.

<sup>17</sup> Kaiser Family Foundation, “The HIV/AIDS Epidemic in the United States,” September 2005.

<sup>18</sup> *National AIDS Strategy*, p. 15; United States General Accounting Office, “Ryan White Care Act of 1990: Opportunities to Enhance Funding Equity”, November 1995. Southern AIDS Coalition, “Southern States Manifesto,” p. 16.

<sup>19</sup> United States Office of National AIDS Policy, “National AIDS Strategy for the United States” July 2010.

<sup>20</sup> See Human Rights Watch, *Southern Exposure: HIV and Human Rights in the Southern United States*, 2010 <http://www.hrw.org/node/9447>.



federal and state leadership is required to address state policies if the goals of the National AIDS Policy are to be realized.

## HIV/AIDS in Mississippi

Mississippi is a state of 2.9 million people living in 82 counties. More than half of the population lives in rural areas, and Jackson, the largest city, has fewer than 250,000 people.<sup>21</sup> Mississippi is not a healthy state. Mississippi ranked last of 50 states and the District of Columbia in two recent evaluations of “overall health” that examined a wide variety of factors including poverty and access to health care, quality of care, education levels and health literacy, obesity and nutrition, infant mortality, and life expectancy.<sup>22</sup> On a “human development” index that rated factors such as capability to earn an adequate living, to make decisions about one’s own life, to have access to quality education and health care, enjoy cultural liberty, and live free from fear and violence, Mississippi ranked lowest of 50 states. Moreover, the index was marked by significant racial disparities, with levels of education, health, and income for African-Americans well below those of white residents of the state.<sup>23</sup>

Mississippi is one of the poorest states in the nation. Median household income in Mississippi was \$36,646 in 2009, well below the national median of \$50,221.<sup>24</sup> One in five people live below the federal poverty line (\$22,000 in annual income for a family of four), the most of any state in the country.<sup>25</sup> In some economically depressed counties of the Mississippi Delta almost half of the population (48 percent) live below the federal poverty level.<sup>26</sup> In Mississippi, 28 percent of children live at or below the poverty level, compared to

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<sup>21</sup> US Census Bureau, “State and County Quick Facts, Mississippi,” 2010.

<sup>22</sup> United Health Foundation, “America’s Health Rankings,” 2009 <http://www.americahealthrankings.org/> (accessed November 15, 2010). See also: Commonwealth Fund, “Aiming Higher: State Scorecard on Health System Performance,” 2007 <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Aiming-Higher--Results-from-a-State-Scorecard-on-Health-System-Performance.aspx> (accessed November 15, 2010.)

<sup>23</sup> American Human Development Project, “A Portrait of Mississippi: Mississippi Human Development Report 2009”.

<sup>24</sup> US Census Bureau, “Household Income for States: 2008 and 2009”, [Http://www.census.gov/prod/2010pubs/acsbr09-2.pdf](http://www.census.gov/prod/2010pubs/acsbr09-2.pdf) (accessed November 18, 2010).

<sup>25</sup> US Census Bureau, “State and County QuickFacts: Mississippi,” <http://quickfacts.census.gov/qfd/states/28000.html> (accessed November 18, 2010).

<sup>26</sup> Ibid.

19 percent nationwide.<sup>27</sup> Blacks live in poverty at three times the rate of whites.<sup>28</sup> Compared to 14 percent of whites, 43 percent of black children live in poor families.<sup>29</sup>

Poverty is strongly linked with health disparities in the United States, as low-income people have less access to health coverage, less stable housing, and less healthy environments.<sup>30</sup> Poverty particularly impacts people with HIV as higher rates of homelessness, poor overall health, and drug dependence often combine with lack of access to health care to raise the risk of infection and produce significantly worse outcomes in HIV-positive persons, particularly in the South.<sup>31</sup>

The US Centers for Disease Control and Prevention (CDC) recently found that heterosexuals living in urban poverty are five times more likely to be HIV-positive than their wealthier counterparts, citing the importance of factors such as homelessness and lack of access to health care as critical obstacles to HIV prevention efforts. The CDC study recommended a similar study of HIV and poverty in rural areas, particularly in the South where rural poverty and HIV rates are high.<sup>32</sup>

The Mississippi Department of Health in the State Comprehensive HIV/AIDS Plan for 2009 recognized the impact of poverty on HIV:

The link between low economic status and HIV risk exacerbates the existing barriers of effective behavioral intervention, testing, early diagnosis and early intervention for newly infected persons.<sup>33</sup>

Mississippi has the 10<sup>th</sup> highest rate of AIDS diagnosis among US states and the 16<sup>th</sup> highest rate of diagnosis of HIV.<sup>34</sup> In 2009 the state had 9,212 people living with HIV or AIDS.<sup>35</sup>

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<sup>27</sup> National Center for Children in Poverty, "Measuring Poverty in the US," May 2009.

<sup>28</sup> 2009 American Community Survey, [http://www.census.gov/acs/www/http://factfinder.census.gov/servlet/IPGeoSearchByListServlet?ds\\_name=ACS\\_2009\\_1YR\\_Goo\\_&\\_lang=en&\\_ts=305733643704](http://www.census.gov/acs/www/http://factfinder.census.gov/servlet/IPGeoSearchByListServlet?ds_name=ACS_2009_1YR_Goo_&_lang=en&_ts=305733643704) (accessed October 21, 2010).

<sup>29</sup> "Measuring Poverty in the US," May 2009.

<sup>30</sup> CDC, Morbidity and Mortality Weekly Report, "CDC Health Disparities and Inequalities Report- United States 2011," January 14, 2011, p. 87.

<sup>31</sup> Meditz, A., et al, "Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection", *Journal of Infectious Diseases*, 2011, pp.1-10.

<sup>32</sup> Denning, P. et al, "Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States?" National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, July 2010.

<sup>33</sup> State of Mississippi Department of Health, 2009 Ryan White and HIV/AIDS Statewide Coordinated Statement of Need and Comprehensive Plan (hereinafter Statewide Comprehensive HIV/AIDS Plan), p. 6.

According to the Mississippi Department of Health, this figure underestimates the HIV/AIDS population, as 10-25 percent of people living with HIV in the state are considered to be unaware of their status.<sup>36</sup> The number of people living with HIV or AIDS in the state increased nearly 5 percent during the period 2007- 2009. The number will continue to rise as the advent of antiretroviral therapy reduces deaths from the disease, as will the need for a range of HIV-related services.

Racial and ethnic disparities in HIV/AIDS are dramatic in the state. Blacks comprise 37.5 percent of the population, but 72 percent of Mississippians living with HIV/AIDS are African-Americans. Of newly diagnosed HIV infections, 76 percent are in African-Americans. The death rate from HIV among African-Americans is 10 times that of whites. Among the Hispanic population, Hispanic males are infected at a rate four times that of whites, and Hispanic females are infected at a rate eight times that of whites.<sup>37</sup>

The largest proportion of HIV cases are diagnosed in men who have sex with men. Women having sex with men are the next largest category of infection; injection drug users are the smallest category.<sup>38</sup> Overall, the epidemic in Mississippi has remained relatively stable since 2000, with minor changes in the number of new cases diagnosed each year in the last decade. Specific populations, however, have seen variations in the rates of infection. For example, HIV cases among women, both white and African-American, have reduced in the last several years.<sup>39</sup>

However, Mississippi has seen an alarming rise in the number of HIV cases among young black men who have sex with men. Between 2005 and 2007 the cases of HIV diagnosed in black men ages 13-31 increased by 48 percent.<sup>40</sup> This prompted an investigation in 2008 by the CDC and the Mississippi Department of Health. The investigation found high rates of unprotected anal sex combined with low rates of awareness of potential risk of HIV infection.

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<sup>34</sup> Kaiser State Health Facts, “Estimated Rates (per 100,000) of AIDS Diagnosis, All Ages, 2008” and “Estimated Rates (per 100,000) of HIV Diagnosis, All Ages, 2008” <http://www.statehealthfacts.org/comparemaptable.jsp?ind=513&cat=11> (accessed January 4, 2011).

<sup>35</sup> Mississippi Department of Health, STD/HIV Office, “HIV Disease: 2009 Annual Surveillance Summary.”

<sup>36</sup> Statewide Comprehensive HIV/AIDS Plan.

<sup>37</sup> Statewide Comprehensive HIV/AIDS Plan, p. 6, 37.

<sup>38</sup> Ibid.

<sup>39</sup> Mississippi State Department of Health STD/HIV Office, “HIV Disease: 2009 Annual Surveillance Summary.”

<sup>40</sup> Mississippi Department of Health, “HIV Disease in Young African-American Men Who Have Sex with Men, Mississippi, 2008.”

The majority of HIV-infected men who participated in the study was also uninsured, had no primary health care provider, and was unlikely to have been previously tested for HIV.<sup>41</sup> Most people living with HIV in Mississippi are in the 25-44 year old age group. But Mississippi's epidemic is becoming younger, as 13-24 year olds have replaced 45-64 year olds as the state's second-largest category of both new infections and people living with HIV.<sup>42</sup>

Many Mississippians living with HIV are not receiving treatment. The US Health Research and Services Administration (HRSA) requires each state receiving federal HIV/AIDS funding to report an estimate of "unmet need" for HIV care and services. This is defined as the percentage of people who have been tested for HIV and are aware of their status but have not received basic health care services for HIV.<sup>43</sup> In Mississippi, estimates of "unmet need" are at least 50 percent, significantly higher than the national average of 33 percent.<sup>44</sup> The Director of Mississippi's STD/HIV Office said:

Save yourself a transatlantic airline fare to a developing country. Just come to Mississippi, where we have a vast underserved population.<sup>45</sup>

In Mississippi, the percentage of people with HIV not receiving care or support services is comparable to that in Botswana, Ethiopia, and Rwanda.<sup>46</sup>

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<sup>41</sup> Mississippi Department of Health, "HIV Disease in Young African-American Men Who Have Sex with Men, Mississippi, 2008." CDC, Morbidity and Mortality Weekly Report (MMWR), "HIV Infection Among Young Black Men Who Have Sex with Men, Jackson, Mississippi 2006-2008", February 6, 2009, Vol. 58, No. 4. Oster, A.M. et al., "HIV Risk Among Young African-American Men Who Have Sex with Men: A Case-Control Study in Mississippi, APHA Vol. 101, No. 1, January 2011, 137-143.

<sup>42</sup> Mississippi State Department of Health STD/HIV Office, "HIV Disease: 2009 Annual Surveillance Summary."

<sup>43</sup> Basic health services are defined as a CD4 and viral load test each quarter of the previous 12 months, HRSA, "A Practical Guide for Measuring Unmet Need for HIV-Related Primary Medical Care," <http://hab.hrsa.gov/tools/unmetneed>, (accessed January 4, 2011).

<sup>44</sup> Mississippi Comprehensive State HIV/AIDS Plan, p. 7; Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010. Mr. Thompson explained that while the Department of Health had verified and reported the 50 percent figure, a recent internal survey had placed the unmet need in the range of 70 percent, a figure which the Department was attempting to verify. Mr. Thompson resigned as Director on September 30, 2010, and was replaced by Dr. Nicholas Mosca effective November 1, 2010. According to the US National AIDS Strategy one-third of persons infected with HIV are not in care. National AIDS Strategy, p. 7.

<sup>45</sup> Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010.

<sup>46</sup> President's Emergency Plan for AIDS Relief (PEPFAR) FY 2008 Country Profiles for Botswana where 52 percent of people living with HIV are not receiving "care and support services", Ethiopia (56 percent), and Rwanda (41 percent). PEPFAR defines care and support to include not only medical treatment for HIV but a range of services that include testing but also TB screening, prevention education and other services at an identifiable clinic site. The HRSA definition of "in care" is more narrowly limited to those who have undergone a quarterly CD4 or viral load test in the past 12 months.

## V. Findings

### Living with HIV/AIDS in Mississippi

#### *Poverty*

A fundamental principle of human rights law is that everyone is entitled to a standard of living adequate for his or her health and well-being.<sup>47</sup> Throughout Mississippi, Human Rights Watch spoke with people living with HIV who were struggling with extreme poverty. In a state where the median rent is \$626 per month,<sup>48</sup> many have difficulty making ends meet, staying on medications, and maintaining their health.

Sheila R. and her husband Roy, for example, live outside of Canton, Mississippi. Both are living with HIV; Roy has AIDS and is in a wheelchair. Their only monthly income is \$694 from Roy's Social Security Disability payment; Sheila has been unable to work due to her health problems, but she is not eligible for disability as she does not have full-blown AIDS. Sheila and Roy receive primary medical care from the Ryan White clinic in Canton, but she relies on donations from pharmaceutical companies for her medications. Sheila told Human Rights Watch:

We are trying to get by on Roy's disability. We got some rent support but it ended after 21 weeks, and since then life has been a day to day struggle. We don't get help with our utilities. We survive by the grace of God but not much else.<sup>49</sup>

Tyrone L. is a 33-year-old man living with HIV in the Mississippi Delta, near the town of Clarksdale. Tyrone lives on his \$694 monthly disability check and \$62 in food stamps. When Human Rights Watch interviewed Tyrone, he was in distress because his disability check had not arrived on the first of the month. It was now near the end of the month and he had missed some of his HIV medications, a serious risk to the health of persons with HIV. Tyrone stated:

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<sup>47</sup> Universal Declaration of Human Rights, G.A. Res. 217, U.N. GAOR, 3rd Sess., pt. 1, art. 25(1), U.N. Doc A/810 (1948).

<sup>48</sup> Mississippi Development Authority, "2010-2015 Mississippi Consolidated Plan for Housing and Community Development," May 2010, p. 53.

<sup>49</sup> Human Rights Watch interview with Sheila R., Canton, Mississippi, August 27, 2010.

I don't feel so good. I've missed at least a week of medicine. There is a three dollar co-payment for the drugs but I can't afford it. I had to walk a mile to the clinic. There used to be a van but not anymore.<sup>50</sup>

The Mississippi State HIV/AIDS Plan confirms that poverty and poverty-related issues such as unstable housing and lack of transportation prevents people with HIV in Mississippi from accessing medical care and other essential services. One health clinic reported basic communication as a primary problem, stating that they cannot reach clients because their cell phones are constantly being disconnected.<sup>51</sup>

The director of the STD/HIV Office in Mississippi identified poverty as perhaps the greatest obstacle to the Department of Health's HIV efforts, stating, "People can't prioritize HIV when they are suffering from crushing poverty. Food, clothing and shelter come first."<sup>52</sup>

### *Housing*

Housing is also a fundamental human right, critical to dignity, survival, and the ability to protect one's health.<sup>53</sup> It is well established that housing is particularly important for HIV prevention and for the health of people living with HIV/AIDS.<sup>54</sup> Homeless individuals living with HIV die at a rate five times higher than those who are housed.<sup>55</sup> In addition, stable housing supports HIV prevention efforts as it reduces drug use and increases access to mental health services and other social assistance.<sup>56</sup> The federal government recognizes the crucial role of housing to people living with HIV in the National AIDS Strategy which states:

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<sup>50</sup> Human Rights Watch interview with Tyrone L., Clarksdale, Mississippi, August 24, 2010.

<sup>51</sup> Statewide Comprehensive HIV/AIDS Plan, p. 80.

<sup>52</sup> Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010.

<sup>53</sup> UDHR, G.A. Res. 217, U.N. GAOR, 3rd Sess., pt. 1, art. 25(1), U.N. Doc A/810 (1948); International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), <sup>21</sup> UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the US on October 5, 1977; Committee on Economic, Social and Cultural Rights, General Comment No. 14, Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000, para.11.

<sup>54</sup> See e.g. Columbia University Mailman School of Public Health, The CHAIN Study, 1995-2009, [http://www.nyhiv.com/data\\_chain.html#reports](http://www.nyhiv.com/data_chain.html#reports) (accessed January 25, 2010); Buchanan, D. et al., "The Health Impact of Supportive Housing for HIB-Positive Homeless Patients: A Randomized Controlled Trial," *American Journal of Public Health*, 2009, 99:3, pp.675-91.

<sup>55</sup> National AIDS Housing Coalition, "Housing is the Foundation of HIV Prevention and Treatment," 2005, <http://www.nationalaidshousing.org/PDF/Housing%20&%20HIV-AIDS%20Policy%20Paper%2005.pdf> (accessed December 14, 2010).

<sup>56</sup> Aidala, A.A., et al, "Housing need, housing assistance, and connection to medical care." *AIDS and Behavior*, 2007;11(Supp 2): S101-S115.

Individuals who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive optimal antiretroviral therapy, and are less likely to adhere to therapy.<sup>57</sup>

People living with HIV in Mississippi face severe housing problems. The Mississippi Department of Health has identified significant shortfalls in short-term, long-term, and emergency housing for the HIV/AIDS population.<sup>58</sup> The Mississippi Development Authority (MDA), the state agency responsible for housing and community development, has declared that “housing is the greatest unmet service need among people living with HIV/AIDS.”<sup>59</sup>

Mississippians living with HIV described how unstable housing affected their health. Donna M. described her fear when she was staying with relatives that they would discover her HIV medications:

First I tore the labels off [my medicines], then I ended up throwing them away. I was scared [my family] would kick me out if they found them.<sup>60</sup>

Michael J. was living on the streets before he found transitional housing at Grace House in Jackson. Michael told Human Rights Watch:

It’s tough to be homeless. I saw lots of folks in the shelters out there who are real sick with the virus, you can tell. They look grey and they’re wasting away. I would have been one of them if I hadn’t found Grace House.<sup>61</sup>

### *Lack of Access to Health Care*

The right to health requires medical care to be accessible to all, available in the community, and acceptable in quality.<sup>62</sup> Yet in Mississippi, 50-70 percent of people living with HIV and aware of their status are not receiving even a minimal level of medical care. Those that are

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<sup>57</sup> National AIDS Strategy, p. 28.

<sup>58</sup> Statewide Comprehensive HIV/AIDS Plan, pp.65-68.

<sup>59</sup> Mississippi Development Authority, “2010-2015 Mississippi Consolidated Plan for Housing and Community Development”, May 2010, p. 10.

<sup>60</sup> Human Rights Watch interview with Donna M., Jackson, Mississippi August 26, 2010.

<sup>61</sup> Human Rights Watch interview with Michael J., Jackson, Mississippi August 26, 2010.

<sup>62</sup> International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the US on October 5, 1977; Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000, para.12.

receiving treatment still face a range of barriers to adequate services that include restricted benefits, provider shortages, and significant transportation challenges.

In Mississippi, 18 percent of people are without health insurance, a figure comparable to the national average of 17 percent.<sup>63</sup> Minorities, however, are much more likely to be uninsured, as 22 percent of African-Americans and 48 percent of Hispanics are without insurance, compared to 17 percent of whites.<sup>64</sup> People living with HIV/AIDS in Mississippi without health insurance have two options: the Medicaid program or services provided under the Ryan White Act.<sup>65</sup>

Medicaid is the joint federal/state health insurance program intended to provide a “safety net” to adults and children who meet income eligibility requirements and meet other eligibility criteria such as belonging to certain groups, e.g. pregnant women, blind, aged, or disabled.<sup>66</sup> States are largely permitted to set their own income eligibility requirements resulting in significant variations among the 50 states.<sup>67</sup> Eligibility thresholds set by the state of Mississippi are among the lowest in the nation, leaving many ineligible for Medicaid.<sup>68</sup>

For people living with HIV, Medicaid is more accurately characterized as providing disability coverage rather than health insurance, as they are eligible only when their condition advances to full-blown AIDS and becomes disabling. This is a restriction set by the federal government, though states may apply for a waiver in order to provide coverage for HIV before it advances to AIDS.<sup>69</sup> Because Mississippi has not done so, many people with HIV but not AIDS are not eligible for Medicaid. For example, Roy R. was on Medicaid because he was ill

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<sup>63</sup> Kaiser State Health Facts, “Uninsured,” <http://www.statehealthfacts.org/profile.indjsp?cat=3&sub=39&rgn=26>, (accessed December 12, 2010).

<sup>64</sup> Ibid.

<sup>65</sup> Ryan White Comprehensive AIDS Resources Emergency (Care) Act of 1990, Public Law No. 101-381, 104 Stat. 576, 42 USC. 300ff-121; Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415), reauthorization extended in 2009 (P.L. 111-87).

<sup>66</sup> US Centers for Medicare and Medicaid Services (CMS), “Medicaid Program-General Information,” <http://www.cms.gov/MedicaidGenInfo/>, (accessed October 25, 2010).

<sup>67</sup> Ibid; CMS, “Medicaid Eligibility: Are You Eligible?” Kaiser Commission on the Uninsured, “Challenges of Providing Health Insurance for Parents and Children in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures and Cost-Sharing Provisions in Medicaid and SCHIP in 2009,” January 2009.

<sup>68</sup> Kaiser Family Foundation, [statehealthfacts.org](http://www.statehealthfacts.org), “Income Thresholds for Jobless and Working Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level, 2009,” <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4> (accessed October 25, 2010).

<sup>69</sup> Social Security Act, Section 1115 (a) 1 authorizes the Secretary of Health and Human Services to waive certain requirements for Medicaid when petitioned by the states. This provision has been used by two states to expand Medicaid eligibility to non-disabled people living with HIV, with state dollars matched by federal funds. See Treatment Access Expansion Project, Harvard Law School, “How to Use a 1115 Medicaid Waiver as a Bridge to 2014 for People living with HIV and AIDS,” November 2010.



enough to be in a wheelchair, but his wife Sheila, also HIV-positive and on antiretroviral medication, was not eligible.<sup>70</sup>

Those who do qualify for Medicaid face the additional challenge of restricted benefits. States have substantial discretion to set the Medicaid benefit package, and benefits in Mississippi are among the most limited in the nation for all recipients, including those with HIV/AIDS.<sup>71</sup> Mississippi Medicaid, for example, does not cover physical or occupational therapy, non-emergency dental care, psychologist services, dentures, speech therapy, prosthetic or orthotic devices, or hearing aids. Mississippi Medicaid does not cover drug dependence treatment other than short-term detoxification. This restriction has particular impact on people living with HIV, a population with a high level of substance abuse disorders and for whom injection drug use can be a primary route of HIV transmission.<sup>72</sup> As stated by Adam, a man living with HIV in the Jackson area:

You have to have money for drug treatment. There are no free beds for rehab.<sup>73</sup>

Mississippi limits people on Medicaid to five prescription drugs per month, though HIV/AIDS medication regimens often exceed this limit.<sup>74</sup> Joseph, a man living with HIV/AIDS who moved recently from Louisiana to Mississippi, told Human Rights Watch:

My doctor in Louisiana prescribed me eight drugs, but Medicaid here only covers five. I've missed two months of meds.<sup>75</sup>

Uninsured people living with HIV/AIDS who do not meet both the disability and the income requirements for Medicaid must turn to services provided by the Ryan White Act.<sup>76</sup> The Ryan White program is the country's largest federally funded initiative specifically for people living with HIV/AIDS. Ryan White provides care and services to those without other sources of

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<sup>70</sup> Human Rights Watch interview with Sheila R., Canton, Mississippi, August 27, 2010.

<sup>71</sup> Kaiser Family Foundation, Medicaid Benefits Database, <http://medicaidbenefits.kff.org/index.jsp> (accessed October 25, 2010). Public Citizen Health Research Group, "Unsettling Scores", p.82.

<sup>72</sup> Bing, EG et al, "Psychiatric Disorders and Drug Use among human immunodeficiency virus- infected adults in the United States," *Archives of General Psychiatry*, 2001, 58(8):721-728.

<sup>73</sup> Human Rights Watch interview with Adam L., Jackson, Mississippi, August 26, 2010.

<sup>74</sup> Kaiser Family Foundation, Medicaid Benefits Database, Mississippi, <http://medicaidbenefits.kff.org/state.jsp?nt=on&cat=o&yr=o&st=25> (accessed October 25, 2010).

<sup>75</sup> Human Rights Watch interview with Joseph P., Jackson Mississippi, August 26, 2010.

<sup>76</sup> Ryan White Comprehensive AIDS Resources Emergency (Care) Act of 1990, Public Law No. 101-381, 104 Stat. 576, 42 USC. 300ff-300ff-121; Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415), reauthorization extended in 2009 (P.L. 111-87).

insurance coverage or ability to pay. In Mississippi, 1,300 people living with HIV/AIDS received services through Ryan White programs in 2009.<sup>77</sup> The majority of Ryan White clinical services, however, are located in the metropolitan Jackson area, creating transportation issues for more rural residents. The state Department of Health opened several additional clinics since 2008 in an effort to address this problem, but access for many remains limited. For example, five counties in southwest Mississippi are provided no Ryan White coverage at all.<sup>78</sup>

In Mississippi, 19.6 percent of the population reports “not being able to see a doctor because of cost,” the second-highest percentage in the nation.<sup>79</sup> The scarcity of doctors in the state compounds the problem of affordability. In 2008, 31.9 percent of Mississippians were living in primary care “health professional shortage areas (HPSAs)” compared to 11.8 percent nationally. Of the 82 counties in the state, 74 are HPSAs in whole or in part.<sup>80</sup> Mississippi is one of eight states in which over 40 percent of the population is “medically disenfranchised,” meaning they have inadequate or no access to primary care physicians.<sup>81</sup>

The shortage of health care providers is particularly acute for people living with HIV, as there are fewer than 30 infectious disease specialists in the state of Mississippi and most of them practice in the Jackson area.<sup>82</sup> Lisa M. told Human Rights Watch that she travels 52 miles to her current doctor, but “the biggest problem is keeping a doctor at all. This is my fifth doctor in one year.”<sup>83</sup>

Human Rights Watch also heard numerous stories of physicians unwilling to treat people with HIV. An HIV case manager at the Crossroads Clinic in Greenville, Mississippi, stated that she had a client in need of gynecological services:

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<sup>77</sup> Statewide Comprehensive HIV/AIDS Plan, p. 82.

<sup>78</sup> Statewide Comprehensive HIV/AIDS Plan, p. 74.

<sup>79</sup> Kaiser State Health Facts, Analysis of Risk Behavior Surveillance Report, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=747&cat=8&sub=166&yr=92&typ=2&rghl=26> (accessed December 12, 2010).

<sup>80</sup> Mississippi State Department of Health, Fiscal Year 2011 State Health Plan, September 2010, p. 110.

<sup>81</sup> National Association of Community Health Centers and The Robert Graham Center, “Access Denied: A Look at America’s Medically Disenfranchised,” 2007.

<sup>82</sup> State Health Access Research Project (SHARP) of Harvard Law School, “Mississippi State Report,” 2010, p.50.

<sup>83</sup> Human Rights Watch interview with Lisa M., Olive Branch, Mississippi, August 23, 2010.

I called 20 gynecologists and all of them said flat-out no when I told them she was HIV-positive. I have also been turned down by podiatrists. A lot of stigma is coming from doctors themselves.<sup>84</sup>

A case worker at one Ryan White clinic stated that many doctors have stopped taking HIV patients. There is currently a wait of three to four months for an appointment at her clinic for someone living with HIV.<sup>85</sup>

Mississippi's predominantly rural population and a shortage of health facilities make transport a serious problem for people living with HIV. Debbie H., age 44, has HIV and lives near Olive Branch, Mississippi. Many in the Olive Branch area go to Memphis, Tennessee, for their HIV care, as it is the closest Ryan White clinic. Debbie told Human Rights Watch:

I travel 75 miles to see my doctor. Sometimes I get help from the Department of Health social worker for HIV/AIDS who will pick people up in her own car. But she has nine counties to cover all by herself.<sup>86</sup>

Latinos experience additional difficulty in accessing health care caused by language barriers and fear of immigration consequences. One case worker for HIV told Human Rights Watch:

The Hispanic community is terrified to come into care or enter the Health Department for fear of being deported. Also we can't find interpreters to help them when they do come in; we pay so little that nobody will work as an interpreter.<sup>87</sup>

### *Stigma and Discrimination*

Stigma, defined as "a mark or sign of disgrace,"<sup>88</sup> is deeply entrenched in Mississippi in relation to HIV and AIDS. People living with HIV/AIDS, medical personnel, public health officials and community activists consistently identified pervasive stigma as one of the primary barriers to prevention, care, and treatment in the state. Donna M. threw away her

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<sup>84</sup> Human Rights Watch interview with Tammie Woodall, HIV Specialist, Crossroads North Clinic, Greenville, Mississippi, August 25, 2010.

<sup>85</sup> Human Rights Watch interview with Tamara B., Olive Branch, Mississippi, August 23, 2010.

<sup>86</sup> Human Rights Watch interview with Debbie H., Olive Branch, Mississippi, August 23, 2010.

<sup>87</sup> Human Rights Watch interview with Tamara B., Olive Branch, Mississippi, August 23, 2010.

<sup>88</sup> Oxford American Dictionary, Second Edition (Oxford: Oxford University Press, 2008).

medications while staying with relatives when she was homeless for fear that they would evict her if they knew she had HIV.<sup>89</sup>

The problem of stigma is discussed extensively in the state HIV/AIDS plan prepared by the Department of Health:

Many Mississippians fear being thought to have or known to have HIV far more than they fear the disease itself. Such over-arching fear prevents effective behavioral interventions from being received and practiced, limits the number of citizens seeking HIV testing, and decreases the likelihood of remaining in care after diagnosis.<sup>90</sup>

“HIV stigma,” however, is often an overly narrow concept. Behind negative attitudes toward people with HIV is often prejudice and discrimination against groups vulnerable, or perceived to be vulnerable, to the disease, including African-Americans, gay men, prisoners, sex workers, and drug users.

June J., a 37-year-old woman living with HIV near Olive Branch, Mississippi, said, “The stigma is so bad that if you have HIV you’re either a drug user or a whore.”<sup>91</sup>

“Being gay with HIV in Mississippi is a terrible curse,” said Robert B., a 48-year old man living with HIV. “I came here from New York and it is like going back 40 years in time. Everyone treats you like dirt.”<sup>92</sup>

Joseph P., a 40-year-old man living with HIV in Jackson, Mississippi, described stigma as a fear based on ignorance. “People don’t want to touch me. They think they can get it from shaking hands.”<sup>93</sup>

Stigma exacerbates transportation problems as many people told Human Rights Watch that they were unwilling to seek health services at the facility closest to their home for fear of losing confidentiality. Tammie Woodall, an HIV nurse specialist at an HIV clinic near

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<sup>89</sup> Human Rights Watch interview with Donna M., Jackson, Mississippi August 26, 2010.

<sup>90</sup> Statewide Comprehensive HIV/AIDS Plan, p. 97.

<sup>91</sup> Human Rights Watch interview with June J., Olive Branch, Mississippi, August 23, 2010.

<sup>92</sup> Human Rights Watch interview with Robert B., Jackson, Mississippi, June 21, 2010.

<sup>93</sup> Human Rights Watch interview with Joseph P., Jackson, Mississippi, August 26, 2010.

Greenville, Mississippi, expressed surprise that half of her patients were from the local area. “That is unusual; the stigma makes people travel long distances for their care.”<sup>94</sup>

Ruby Gray, an HIV case worker in Canton, Mississippi, stated:

Stigma is the number one problem. We can’t educate the families because the clients won’t tell them they have HIV.<sup>95</sup>

Gray went on to describe a terrible irony of HIV stigma in Mississippi:

They’re isolated, depressed. Lots of times we are actually treating the family member too, but neither one knows.<sup>96</sup>

Thomas L., now living in Jackson but originally from the Mississippi Delta, said, “People in my hometown would rather die than have anybody know they have AIDS. When people do die they say it was cancer.”<sup>97</sup>

### *Lack of Affordable Legal Services*

Human Rights Watch and others have documented the importance of access to legal services to protect the rights and health of people living with HIV.<sup>98</sup> People living with HIV often face legal issues related to their HIV status including access to health benefits, discrimination, and the need for estate planning documents. For low income people with HIV, the ability to resolve legal problems related to basic necessities such as food and shelter are critical to staying healthy and maintaining adherence to medications.<sup>99</sup> A recent survey of people living with HIV/AIDS in Mississippi found that 63 percent needed legal assistance with housing issues, while another 53 percent had legal needs in the area of employment discrimination.<sup>100</sup>

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<sup>94</sup> Human Rights Watch interview with Tammie Woodall, Greenville, Mississippi, August 25, 2010.

<sup>95</sup> Human Rights Watch interview with Ruby Gray, Canton, Mississippi, August 27, 2010.

<sup>96</sup> Human Rights Watch interview with Ruby Gray, Canton, Mississippi, August 27, 2010.

<sup>97</sup> Human Rights Watch interview with Thomas L., Jackson, Mississippi, August 26, 2010.

<sup>98</sup> Human Rights Watch, “Hidden in the Mealie Meal: Gender-Based Abuses and Women’s HIV Treatment in Zambia, December 18 2007, <http://www.hrw.org/en/reports/2007/12/18/hidden-mealie-meal> January 26, 2011. Open Society Institute, “HIV/AIDS, Human Rights, and Legal Services in Uganda,” May 2008, [http://www.soros.org/initiatives/osiea/articles\\_publications/publications/aidsuganda\\_20080528](http://www.soros.org/initiatives/osiea/articles_publications/publications/aidsuganda_20080528) (accessed January 26, 2011).

<sup>99</sup> Andriote, J. and Sears, R., “The Role of Legal Services in Ensuring Access to Care for People with HIV/AIDS”, HRSA Policy Brief 4, 2000.

<sup>100</sup> Center for HIV Law and Policy, “Send Lawyers, Guides and Money: Legal Services Needs of People Living with HIV in the Southern United States,” December 2010.

Josephine B., a woman in Clarksdale, Mississippi, said that her children had been taken away by their grandmother because she “was afraid I’d give them HIV.”<sup>101</sup> Susan R. told Human Rights Watch that “I tried to get into a mental health center but they wouldn’t admit me because I’ve got HIV.”<sup>102</sup> Several others had been denied benefits, perhaps incorrectly, but had no idea how to pursue an appeal.<sup>103</sup>

Yet individuals who have suffered discrimination on the basis of HIV status or disability, sexual orientation, race, gender, or religious discrimination have limited recourse in Mississippi. There is no state anti-discrimination law; rather, individuals must attempt to enforce federal laws.<sup>104</sup> The Americans with Disabilities Act prohibits discrimination against people living with HIV,<sup>105</sup> but the ability to pursue a complaint in court is difficult. In Mississippi there is a severe shortage of legal services for those who cannot afford a private attorney. The Access to Justice Commission, a body convened by the Mississippi Supreme Court, found that Mississippi ranked 49<sup>th</sup> of 50 states in funding for civil legal services for low-income people.<sup>106</sup>

According to the Commission, Mississippi relies almost exclusively on shrinking federal funding to provide legal assistance in the state, leaving many underserved. The commission estimated that a legal services system that now serves 15,000 people per year would need to serve 200,000 people per year to meet the demand.<sup>107</sup> The commission found that state funding should be increased and the State Bar should improve and expand its pro bono services programs.<sup>108</sup> This would be particularly important for people living with HIV, many of whom are unable to pursue remedies for discrimination or claims for health insurance and other public benefits without the assistance of counsel. The necessity of legal services for people with HIV is noted in the National AIDS Strategy:

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<sup>101</sup> Human Rights Watch interview with Elaine Y., Clarksdale, Mississippi, August 24, 2010.

<sup>102</sup> Human Rights Watch interview with Maya M., Jackson, Mississippi, August 26, 2010.

<sup>103</sup> Human Rights Watch interview with Sheila R., Canton, Mississippi, August 27, 2010. Human Rights Watch interview with Lee F., Jackson, Mississippi August 26, 2010.

<sup>104</sup> For example, Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, or national origin.

<sup>105</sup> Title I and Title V of the Americans with Disabilities Act of 1990, as amended (ADA) prohibits employment discrimination against qualified individuals with disabilities in the private sector, and in state and local governments. HIV is considered a “disability” under the meaning of this section. See, ADA Amendments Act of 2008, Public Law 110-325; *Couture v. Bonfils*, USCA 10th Circuit 2005.

<sup>106</sup> Mississippi Access to Justice Commission, “Report of Public Hearings on the Unmet Civil Legal Needs of Low-Income Mississippians,” 2010, p. 5.

<sup>107</sup> Mississippi Access to Justice Report, p. 38.

<sup>108</sup> Mississippi Access to Justice Commission Report, p. 41.

People with competing demands and challenges meeting their basic needs for housing, food and child care often have problems staying in care. Access to legal services can be important to help people resolve issues with discrimination, access to public benefits including health care, and resolving problems with employment and other issues that can create serious barriers to staying in care.<sup>109</sup>

### *State Responses to the HIV Epidemic in Mississippi*

The number of new HIV infections has stabilized, but Mississippi's HIV/AIDS epidemic is not subsiding; rather, as one population stabilizes its rate of infection, infections increase among others. Every year, more people are living with HIV and AIDS in Mississippi as medications increase life expectancy. The demand for a wide range of services related to HIV continues to increase.

In Mississippi, the state continues to rely almost exclusively on limited and incomplete federal programs to address its HIV epidemic, despite clear evidence that this approach fails to meet the urgent needs of Mississippi's HIV-positive residents. It also opposes programs that would expand access to health care for people living with HIV. At the same time, the state continues to implement policies that have been proven ineffective or counterproductive for reducing HIV infection and that undermine human rights.

### **Failure to Invest in Programs for People Living with HIV/AIDS**

Mississippi received \$27 million in 2009 from the federal government for HIV prevention, care, and treatment.<sup>110</sup> These, and funds from previous years, have been utilized by the state Department of Health to support a network of medical providers, social workers, and prevention programs throughout the state.<sup>111</sup> But Mississippi's own state agencies provide ample documentation that the state's current approach fails to meet the pressing needs of a very vulnerable population. The 2009 State Comprehensive HIV/AIDS Plan finds that half of the state's HIV-positive population is not in care, and identifies access to health services, AIDS Drugs Assistance Program (ADAP) medication adherence, and medical transportation as areas of urgent unmet need.<sup>112</sup> The plan states:

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<sup>109</sup> National AIDS Strategy, p. 28.

<sup>110</sup> State Health Access Research Project (SHARP) of Harvard Law School, "Mississippi State Report," 2010, p11.

<sup>111</sup> For a detailed analysis of Mississippi's utilization of federal HIV funding see, State Health Access Research Project (SHARP) of Harvard Law School, "Mississippi State Report," 2010.

<sup>112</sup> Ibid.

Public health in Mississippi is consistently under-funded and providers in Mississippi are challenged with caring for increasing numbers of non-insured/under-insured patients in the face of shrinking budgets and increasing medical costs.<sup>113</sup>

The state housing authority has identified housing as “the greatest unmet need for persons living with HIV” in the state.<sup>114</sup> Yet in Mississippi the state HIV/AIDS allocation has remained under \$1 million since 1997, and it has never provided funds for housing or for transportation.<sup>115</sup> Reluctant to invest state funds, Mississippi depends on limited and incomplete federal government programs for prevention, care, and services for people with HIV, despite the knowledge that this approach leaves many without essential services or adequate care.

### *Housing*

In Mississippi, the state provides no funding for housing services targeted to people living with HIV/AIDS. All funding for HIV-related housing assistance comes from the federal government, primarily under the Housing Opportunities for Persons with AIDS (HOPWA) program.<sup>116</sup> HOPWA offers emergency, short-term and long-term rental assistance programs for people living with HIV/AIDS through programs administered by the states.<sup>117</sup> Mississippi’s reliance on federal funding to house people with HIV/AIDS leaves many without coverage, as federal programs are limited. Like Ryan White, HOPWA’s funding formula is based on cumulative AIDS cases rather than rates of new infections, an approach that leaves many southern states, including Mississippi, with funding levels that fail to account for high rates of new HIV and AIDS diagnosis.<sup>118</sup> In addition, HOPWA provides no services for the homeless; in order to be eligible for HOPWA assistance one must be already housed.

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<sup>113</sup> Statewide Comprehensive HIV/AIDS Plan, p. 5.

<sup>114</sup> Mississippi Development Authority, “2010-2015 Mississippi Consolidated Plan for Housing and Community Development,” May 7, 2010, p. 90.

<sup>115</sup> Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010. State of Mississippi General Fund Budget for FY 2009; State of Mississippi Budget FY 2010. State of Mississippi Executive Budget Recommendation for FY 2011.

<sup>116</sup> State Health Access Research Project (SHARP) of Harvard Law School, “Mississippi State Report,” 2010, pp. 12, 22.

<sup>117</sup> United States Department of Housing and Urban Development, “Housing Opportunities for Persons with AIDS (HOPWA) Program,” <http://www.hud.gov/offices/cpd/aidshousing/programs/> (accessed December 14, 2010).

<sup>118</sup> US Department of Housing and Urban Development, “HOPWA Funding Formula Allocations 2010,” <http://www.hud.gov/offices/cpd/aidshousing/programs/formula/grants/> (accessed December 14, 2010.) For a detailed analysis of federal funding levels for HIV in relation to the South, see, Southern AIDS Coalition, “Southern States Manifesto: Update 2008, HIV/AIDS and Sexually Transmitted Diseases in the South,” July 21, 2008.



HOPWA funding provided help to 494 individuals with HIV in Mississippi between 2008 and 2009.<sup>119</sup> Mississippi limits its HOPWA program to short-term rental assistance that supplements rental payments for only 21 weeks per calendar year. A handful of hospice residents also receive HOPWA assistance but for the majority of Mississippians with HIV, only 21 weeks of rental assistance is available.<sup>120</sup> Mississippi does not participate in HOPWA programs that provide funds for longer-term help with rent or permanent housing for people living with HIV.<sup>121</sup>

Another source of federal funding for people living with HIV is the Ryan White Act, but this statute permits states to use only 25 percent of the funds received for housing, as it is not considered a “core medical service.”<sup>122</sup> Mississippi’s reliance on federal programs that are limited, incomplete, and clearly do not meet the demand leaves many people living with HIV facing chronic housing issues. Mississippi’s failure to apply for all available federal funds compounds an already urgent problem. The Mississippi Development Authority, the state housing and community development agency, estimates that in the next five years, more than 3,500 people with HIV/AIDS, nearly 40 percent of Mississippi’s known HIV population, will have unmet housing needs. The MDA recommends increasing state participation in HOPWA to provide more medium and long-term housing options.<sup>123</sup>

Ella Tardy is Director of Grace House in Jackson, one of the state’s three transitional housing programs that together provide housing for approximately 30 people in Mississippi. According to Ms. Tardy, these small programs try to maximize federal funding sources including HOPWA, funds from the Department of Housing and Urban Development, and the Ryan White program, but she says:

The state is failing to squeeze out federal dollars and is not investing in HIV housing itself. This leaves us with a world of challenges here in Mississippi.<sup>124</sup>

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<sup>119</sup> Mississippi Development Authority, “2010-2015 Mississippi Consolidated Plan for Housing and Community Development” May 7, 2010, p. 90.

<sup>120</sup> State Health Access Research Project (SHARP) of Harvard Law School, “Mississippi State Report,” 2010, p.23.

<sup>121</sup> For a comprehensive discussion of Mississippi’s HIV housing policies see, State Health Access Research Project (SHARP) of Harvard Law School, “Mississippi State Report,” 2010, pp.12,22-24.

<sup>122</sup> Ryan White HIV/AIDS Treatment Modernization Act of 2006; US Department of Health and Human Services “Core Services Under Ryan White,” <http://hab.hrsa.gov/treatmentmodernization/core-services.htm> (accessed December 14, 2010).

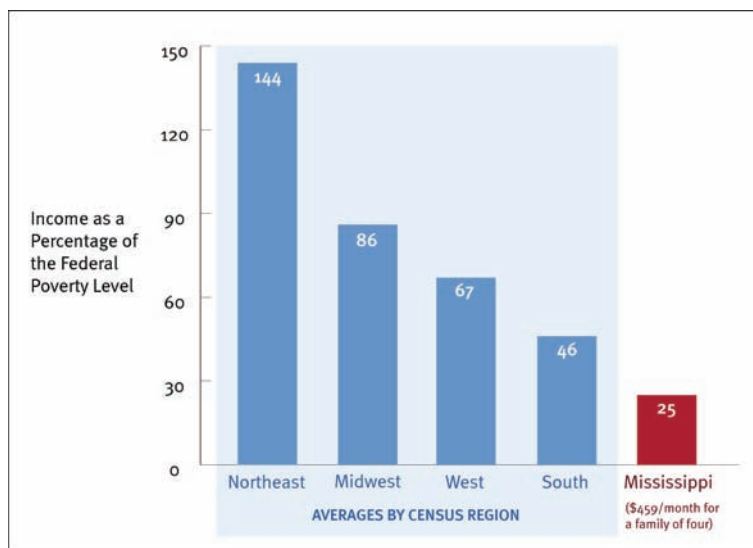
<sup>123</sup> Mississippi Development Authority, “Consolidated Plan”, p. 71.

<sup>124</sup> Human Rights Watch interview with Ella Tardy, Jackson, Mississippi, June 22, 2010.

## Health Care

Mississippi's Medicaid program could be a lifeline for many low income people living with HIV. Nationally, 36 percent of people living with HIV are on Medicaid and another 14 percent are on a combination of Medicaid and Medicare, the government insurance program for the elderly.<sup>125</sup> But Mississippi's restricted eligibility limits exclude many people with HIV from the program. The state has ranked last in national surveys of Medicaid programs for more than 20 years as a result of its low eligibility thresholds and restricted benefits.<sup>126</sup> Mississippi sets the income maximum for Medicaid eligibility at 46 percent of the Federal Poverty Level (FPL) or \$845 per month for a working family of four, significantly more restrictive than the national average of 66 percent of the FPL. For jobless parents, the maximum is even lower at 25 percent of the Federal Poverty Level or \$459 a month for a family of four.<sup>127</sup> This is significantly lower than the average for all regions of the US, even the South, as indicated in the graph below.

**Maximum Income for Medicaid Eligibility for a Jobless Family of Four<sup>128</sup>**



<sup>125</sup> Greenwald, R., "Health Care Reform: Updates to Federal Efforts to Improve Access to Care for People Living with HIV/AIDS," Treatment Access Expansion Project, Harvard Law School, April 12, 2010.

<sup>126</sup> Public Citizen Health Research Group, "Unsettling Scores: A Ranking of State Medicaid Programs" April 2007,p.82.

<sup>127</sup> Kaiser Family Foundation, statehealthfacts.org, "Income Thresholds for Jobless and Working Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level, 2009," <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4> (accessed October 25, 2010).

<sup>128</sup> Kaiser Family Foundation, "Income Thresholds for Jobless and Working Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2009", undated, <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4> (accessed November 1, 2010).

These rules put Medicaid out of reach for many people living with HIV/AIDS, as do burdensome eligibility procedures. Mississippi is the only state in the nation to require face-to-face meetings for initiating and continuing Medicaid eligibility. Recognized as a significant barrier to enrollment, these requirements have been eliminated in every other state but were praised by Governor Haley Barbour as a “key factor” in removing 100,000 people from the Medicaid rolls in the last six years.<sup>129</sup> Legislation proposed in 2010 would have eliminated the face-to-face requirement for re-enrollment, but the bill died in committee.<sup>130</sup>

As an impoverished state, Mississippi receives the nation’s highest level of federal matching funds for its Medicaid program, with the federal government contributing more than three dollars for every dollar spent by the state.<sup>131</sup> Yet Mississippi fails to maximize this favorable ratio, spending a thousand dollars less per individual on Medicaid than the national average.<sup>132</sup> The District Health Officer for the Mississippi Delta, a region with the state’s highest poverty and second-highest number of residents living with HIV/AIDS, described his state’s resistance to investment in Medicaid:

We get three dollars for every dollar we put into Medicaid, but that still means having to put a dollar in. The state doesn’t want to do it.<sup>133</sup>

There are Ryan White clinics for people living with HIV who are not eligible for Medicaid, but transportation for those living in a predominantly rural state is a major barrier. Mississippi’s public health officials identify transportation as an urgent need, but the state has never contributed to transportation for people living with HIV.<sup>134</sup> The Ryan White statute prohibits the use of more than 25 percent of grant monies for transportation,<sup>135</sup> leaving many with the burden of walking long distances, paying for gas out of tight budgets, or hoping for a ride. Reliance on limited federal funds for health care transportation leaves many without services that are critical to residents of a rural state.

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<sup>129</sup> Governor Haley Barbour, “State of the State” Address, January 13, 2009.

<http://www.governorbarbour.com/news/2009/Jan/2009StateoftheState.htm> (accessed December 14, 2010).

<sup>130</sup> HB 551, Mississippi State Legislature 2010.

<sup>131</sup> US Department of Health and Human Services, FMAP Notice, <http://aspe.hhs.gov/health/fmap11.htm> (accessed November 30, 2010).

<sup>132</sup> Kaiser Family Foundation, Mississippi Medicaid Payments Per Enrollee By Age, <http://www.statehealthfacts.org/profileind.jsp?rep=50&cat=17&rgn=26> (accessed December 14, 2010).

<sup>133</sup> Human Rights Watch interview with Dr. Al Rausa, Mississippi State District Health Officer, Greenwood, Mississippi, June 22, 2010.

<sup>134</sup> Statewide Comprehensive HIV/AIDS Plan, p. 5.

<sup>135</sup> Ryan White HIV/AIDS Treatment Modernization Act of 2006; US Department of Health and Human Services “Core Services Under Ryan White,” <http://hab.hrsa.gov/treatmentmodernization/coreservices.htm> (accessed December 14, 2010).

Access to medication is also tenuous for people with HIV in Mississippi. The Ryan White Act includes ADAP that provides antiretroviral and other essential medications for people who are uninsured or underinsured and meet income eligibility requirements.<sup>136</sup> ADAP relies on annual federal appropriations and voluntary state funding contributions. Each state administers its own ADAP and can determine, in large part, eligibility standards and benefits provided.<sup>137</sup> In Mississippi, 1,274 persons received HIV/AIDS medications through ADAP in 2007. ADAP enrollment reflects the racial disparity of HIV and AIDS, as 76 percent of Mississippi ADAP clients are African-Americans.<sup>138</sup>

Unlike the Medicaid threshold, Mississippi's ADAP eligibility standards and number of prescription drugs offered to clients are comparable to those of other states.<sup>139</sup> The current recession and resulting unemployment has increased demand for the ADAP program, and in many states waiting lists have developed due to shortages of federal and state funding.<sup>140</sup> As of December 2010 there was no ADAP waiting list in Mississippi, but the state is considering cost containment measures that may limit eligibility and benefits.<sup>141</sup> The state last made a contribution to ADAP in 1997, when there was an emergency waiting list, but has made no contribution to ADAP since.<sup>142</sup> Recently, fears have arisen among state policymakers that limited state HIV funding may have to be used for ADAP as demand for the program increases.

The current budget allocation for Fiscal Year 2011 -12 for HIV/AIDS is \$700,000 to be administered by the Department of Health and an additional \$50,000 to be divided between two AIDS service organizations. This money was appropriated from a state budget totaling \$5 billion, as part of a public health appropriation of \$31 million.<sup>143</sup> The HIV/AIDS appropriation has been \$750,000 for several years, an amount that the Department of Health STD/HIV Office has used to support salaries for its employees as well as supplemental contracts for prevention and treatment services.<sup>144</sup> According to public health officials, increased pressure

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<sup>136</sup> For comprehensive information about the ADAP program, see, National Alliance of State and Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, May 2010.

<sup>137</sup> NASTAD, "Medicaid and ADAP," October 2006.

<sup>138</sup> Statewide Comprehensive HIV/AIDS Plan, p. 64.

<sup>139</sup> NASTAD, "National ADAP Monitoring Report 2008" and "National ADAP Monitoring Report 2009."

<sup>140</sup> Kevin Sack, *Economy Hurts Government Aid for H.I.V. Drugs*, New York Times, June 30 2010.

<sup>141</sup> NASTAD, "ADAP Watch," December 10, 2010.

<sup>142</sup> Human Rights Watch telephone interview with Joy Sennett, Director of Epidemiology, State Department of Health, January 11, 2011.

<sup>143</sup> Mississippi State Legislature, House Bill 1628 (2010 session as sent to Governor).

<sup>144</sup> Human Rights Watch telephone interview with Joy Sennett, Director of Epidemiology, State Department of Health, January 11, 2011.

on ADAP would require transfer of these funds to ADAP to prevent a waiting list, an outcome that state officials are hopeful can be avoided. Under this “either/or” scenario created by scant state funding, transfer of this allocation for ADAP would leave the STD/HIV Office without its only source of state support.<sup>145</sup>

Federal health care reform legislation, enacted in March 2010,<sup>146</sup> will help to address several of the significant problems facing people living with HIV in Mississippi. Health care reform will provide additional funding for health care professionals in underserved areas and for expansion of community health centers.<sup>147</sup> Health care reform will also expand eligibility for Medicaid to all persons living at or below 133 percent of the federal poverty level whether they are “disabled” or not. This will benefit people living with HIV/AIDS, particularly in the South, the region where the highest numbers of people will become newly eligible.<sup>148</sup> These reforms do not take effect until 2014. States may apply for early expansion of Medicaid, with federal matching funds, to cover the period 2010-2014, but Mississippi has not done so.<sup>149</sup>

Indeed, whether Mississippi will take advantage of any of these opportunities is highly uncertain. As part of Governor Barbour’s commitment to “keeping government small,” the state has taken an aggressive stance in opposing health care reform, joining 17 other states in a lawsuit seeking to enjoin its implementation on constitutional grounds.<sup>150</sup> In 2009 Mississippi also rejected \$56 million in federal stimulus funds that could have provided unemployment benefits to many Mississippi residents.<sup>151</sup> Tax structures ensure that state funds remain limited; state and local tax revenues in Mississippi are the fifth-lowest in the nation, with every individual and corporation earning \$10,000 and over paying the same five percent rate of income tax.<sup>152</sup>

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<sup>145</sup> Ibid.

<sup>146</sup> Patient Protection and Affordable Care Act, signed into law March 23, 2010 (Public Law No. 111-148); Health Care and Education Reconciliation Act, signed into law March 30, 2010 (Public Law 111-152).

<sup>147</sup> Public Law No. 111-148, Sec. 10503.

<sup>148</sup> Holahan J. and Blumberg L., “How Would States Be Affected By Health Reform?” Urban Institute, January 2010; Kaiser Commission on Medicaid and the Uninsured, “Briefing on State Medicaid Programs, the Recession and Health Reform,” <http://www.kff.org/medicaid/Briefing-on-State-Medicaid-Programs-Recession-Health-Reform.cfm> (accessed November 15, 2010).

<sup>149</sup> Social Security Act, Section 1115 (a) 1 authorizes the Secretary of Health and Human Services to waive certain requirements for Medicaid when petitioned by the states. This provision has been used by two states to expand Medicaid eligibility to non-disabled people living with HIV, with state dollars matched by federal funds. See, Treatment Access Expansion Project, Harvard Law School, “How to Use a 1115 Medicaid Waiver as a Bridge to 2014 for People living with HIV and AIDS,” November 2010.

<sup>150</sup> State of Florida, et al, v. US Dept. of Health and Human Services, Case No. 3:10-CV-91-RV/EMT, US D.C., N.D. Fla (2010).

<sup>151</sup> Washington Post Profiles, “Haley Barbour,” revised September 2010, [http://www.whorungov.com/Profiles/Haley\\_Barbour](http://www.whorungov.com/Profiles/Haley_Barbour) (accessed December 15, 2010).

<sup>152</sup> Brookings Institution, Tax Policy Center, “State and Local Tax Revenue Per Capita, 1977-2008.”

A comprehensive fiscal or health policy analysis is beyond the scope of this report; however, governments have an obligation to implement health programs in a non-discriminatory manner and to use available resources to protect the right to health.<sup>153</sup> The current economic climate clearly puts additional pressures on state budgets, but Mississippi's lack of investment in HIV/AIDS services predates the recession. Funding decisions in the state deserve further scrutiny, particularly given the extremely disproportionate burden on minorities that results. The state's revenue and spending practices should prompt the question of whether Mississippi is doing everything it reasonably can to improve health care and services for people living with HIV/AIDS.

### **Denial of Comprehensive Sex and HIV/AIDS Information in Schools**

More than 47,000 young people between 13 and 24 years are currently living with HIV/AIDS in the US.<sup>154</sup> In the age group 13-19 years, 70 percent of all HIV/AIDS diagnoses in 2006 were among black youth, primarily by sexual transmission. Among black and Latino men who have sex with men, the group with the most cases of HIV/AIDS in the US, the majority of new infections are occurring in the youngest age group, ages 13-29 years.<sup>155</sup> Among women (and among black and Latina women), six of ten new infections occur among women in the youngest age group.<sup>156</sup>

Sexually transmitted diseases such as gonorrhea, chlamydia, and syphilis can double the risk of acquiring HIV infection.<sup>157</sup> In 2008, Mississippi ranked number one in both chlamydia and gonorrhea rates among the 50 states. Mississippi ranked in the top 10 in rates of syphilis, with a rate that has more than tripled since 2004.<sup>158</sup> These diseases affect African-American women and girls in Mississippi disproportionately. For example, 62 percent of women with chlamydia in Mississippi are African-Americans. Almost half are in the age group 10-19, and of these, 61 percent are African-American girls.<sup>159</sup> Sixty eight percent of girls

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<sup>153</sup> International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 UN GAOR Supp. (No. 14) at 47, UN Doc A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, ratified by the United States on November 20, 1994, article 5; International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the US on October 5, 1977, articles 2, 12.

<sup>154</sup> CDC, "HIV/AIDS Surveillance Report 2008."

<sup>155</sup> CDC, "HIV/AIDS and young men who have sex with men," May 2009.

<sup>156</sup> Kaiser Family Foundation, "HIV/AIDS Policy Fact Sheet" September 2009; Kaiser Family Foundation, "The HIV/AIDS Epidemic in the United States," September 2009.

<sup>157</sup> CDC, "Sexually Transmitted Diseases," <http://www.cdc.gov/std/hiv/STDFact-STD-HIV.htm> (accessed October 25, 2010.)

<sup>158</sup> CDC, "Sexually Transmitted Disease Surveillance," 2008

<sup>159</sup> Mississippi Department of Health, STD/HIV Office, "Reported Cases of Chlamydia: Mississippi, 2005-2009, by race/Ethnicity, Age Group and Sex".

10-19 with gonorrhea in Mississippi are African-American.<sup>160</sup> Mississippi also ranks first in the nation in rates of teen pregnancy, an indicator of high levels of unprotected sexual activity among youth.<sup>161</sup>

Lois B., a 17-year-old high school student in Jackson, Mississippi, said:

There are lots of pregnant girls in my school and kids who have STDs and HIV. They drop out.<sup>162</sup>

The promotion of abstinence-only sex education continues in many states despite little evidence that it prevents HIV/AIDS or other sexually transmitted diseases.<sup>163</sup> Education programs that emphasize abstinence while restricting discussion of condoms suppress important HIV prevention evidence and impede the right of students to potentially life-saving information.<sup>164</sup> Human Rights Watch has documented the negative consequences and human rights concerns raised by government-mandated abstinence-only programs both internationally and in the United States.<sup>165</sup> Since 1998 the federal government has distributed more than \$50 million annually to the states for abstinence-only education programs primarily through the vehicle of welfare reform legislation.<sup>166</sup> In 2010 the Obama administration and Congress eliminated two-thirds of federal funding for these programs and appropriated \$190 million for comprehensive sex education initiatives.<sup>167</sup> This approach acknowledged the findings of federal public health authorities

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<sup>160</sup> Mississippi Department of Health, STD/HIV Office, “Reported Cases of Gonorrhea: Mississippi, 2005-2009, by race/Ethnicity, Age Group and Sex”.

<sup>161</sup> National Center for Health Statistics, “State Disparities in Teenage Birth Rates in the United States”, Data Brief No. 46, October 2010.

<sup>162</sup> Human Rights Watch interview with Lois B., Jackson, Mississippi August 27, 2010.

<sup>163</sup> CDC Task Force on Community Preventive Services, “Findings on Prevention of HIV/AIDS, STIs and Pregnancy: Group-Based Intervention Programs for Adolescents” (2010); Naomi Starkman and Nicole Rajani, *The Case for Comprehensive Sex Education*, AIDS Patient Care and STDs, Vol. 16, 2002.

<sup>164</sup> The right to education, recognized in the Universal Declaration of Human Rights and other international instruments, encompasses effective health education. The Committee on Economic, Social and Cultural Rights has interpreted article 12 of the International Covenant on Economic, Social and Cultural Rights to obligate states to take steps necessary for the “prevention, treatment and control of epidemic, occupational and other diseases”, including the “establishment of prevention and education programmes for behavior-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting reproductive health.” General Comment No. 14, The Right to the Highest Attainable Standard of Health, Committee on Economic, Social and Cultural Rights, 22<sup>nd</sup> sess. 2000, para. 16.

<sup>165</sup> Human Rights Watch, *The Less They Know, the Better: Abstinence-Only HIV/AIDS Programs in Uganda*, New York, March 2005, <http://www.hrw.org/en/node/11803/section/1> (accessed October 25, 2010); Human Rights Watch, *Ignorance Only: HIV/AIDS, Human Rights and Federally Funded Abstinence-Only Programs in the United States*, New York: September 2002.

<sup>166</sup> The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Title 5, Section 510.

<sup>167</sup> SIECUS, “SIECUS State Profiles: A Portrait of Sexuality Education and Abstinence-Only-Until Marriage Programs in the States” July 2010. However, funding for abstinence-only education was attached to the health care reform legislation enacted

that abstinence-only education does not reduce sexual activity among youth.<sup>168</sup> Abstinence-only education is not recommended by the CDC Task Force on Community Preventive Services, which found “insufficient evidence of its effectiveness” in preventing pregnancy in adolescents as well as sexually transmitted diseases including HIV/AIDS. The task force recommends “comprehensive risk reduction” education that may or may not include abstinence but which directly addresses use of contraceptive devices such as condoms and may include condom distribution and demonstration.<sup>169</sup> One recent study found abstinence education to be effective in delaying sexual behavior of students in grades six to eight. However, the curriculum did not disparage condoms and did not present marriage as the only acceptable format for a sexual relationship.<sup>170</sup>

In Mississippi, rates of sexual activity among young people are significantly higher than the national average. While 46 percent of high school students nationally report having had sex at least once, 61 percent of Mississippi high school students report having done so.<sup>171</sup> Mississippi also reports the highest rates of teens having sex before the age of 13.<sup>172</sup> Yet Mississippi law does not require sex education or HIV/AIDS education to be taught in the schools. If schools choose to present such instruction, the law requires that “abstinence shall be the state standard for any sex-related education taught in the public schools.”<sup>173</sup> The law requires no discussion of condoms as a mode of protection against sexually transmitted disease or unwanted pregnancy, but if condoms are discussed, no directions can be given as to their use:

The discussion may include contraceptives but only if such discussion includes a discussion of the risks (failure rates, diseases not protected against). In no case shall there be a demonstration of how condoms or any other contraceptives are applied.<sup>174</sup>

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in March 2010. Patient Protection and Affordable Care Act, signed into law March 23, 2010 (Public Law No. 111-148); Health Care and Education Reconciliation Act, signed into law March 30, 2010 (Public Law 111-152).

<sup>168</sup> See, e.g. Mathematica Policy Research, Inc. for the US Department of Health and Human Services, *Impacts of Four Title V, Section 510 Abstinence Education Programs, Final Report*, April 2007.

<sup>169</sup> Ibid.

<sup>170</sup> Jemott, J., et al, “Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months: A Randomized Trial with Young Adolescents,” *Archives of Pediatrics and Adolescent Medicine*, Vol. 164 (2) February 2010.

<sup>171</sup> Ibid.

<sup>172</sup> CDC Youth Risk Behavior Surveillance, United States, 2009.

<sup>173</sup> Mississippi Code Annotated, 37-13-171. For a comprehensive analysis of Mississippi’s abstinence-only sex education curriculum, see SIECUS and Planned Parenthood, *Sex Education in Mississippi: Why ‘Just Wait’ Isn’t Working*, January 2010.

<sup>174</sup> Ibid.



Tanya A., 16, a high school student from Jackson, felt strongly about the need for open discussion of condoms:

These classes that talk about abstinence, they don't inform you how to protect yourself.<sup>175</sup>

HIV/AIDS may be taught in schools, but the suggested curriculum is “designed to support disease prevention and unintended pregnancy through abstinence education.”<sup>176</sup> An HIV/AIDS advocate from the Mississippi Delta, a region where sexually transmitted diseases are among the highest in the state, told Human Rights Watch:

I went to the high school to talk about HIV and the kids wanted condoms. They asked me for them but I told them I couldn't give them out. It was really a shame.<sup>177</sup>

Mississippi education law contains other provisions that might permit local school boards to adopt alternatives. If passed by majority vote, school boards may adopt a curriculum that is not abstinence-only.<sup>178</sup> However, state law also states that any alternative curriculum must not contradict any suggested component of the abstinence curriculum.<sup>179</sup> In addition, Mississippi does require general health education and the suggested materials for the health curriculum include sections on HIV, AIDS, and sexually transmitted diseases for students of appropriate age.<sup>180</sup> But this curriculum does not mention condoms or ways to prevent transmission other than abstinence.<sup>181</sup>

The numerous and often conflicting rules, guidelines, and recommendations leave sex and HIV education largely to local discretion. HIV/AIDS advocates and public health officials said that in reality, the existence and content of sex, HIV, and health education classes depends on individual principals and teachers and varies widely throughout the state.

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<sup>175</sup> Human Rights Watch interview with Tanya A., Jackson Mississippi, August 27, 2010.

<sup>176</sup> Mississippi Department of Education, “State Dropout Prevention Plan 2007-2019,” p. 47.

<sup>177</sup> Human Rights Watch interview with Marian J., Greenville, Mississippi, August 25, 2010.

<sup>178</sup> Mississippi Code Ann. 37-13-171(3).

<sup>179</sup> Mississippi Code Ann. 37-13-171 (2).

<sup>180</sup> Mississippi Office of Healthy Schools, Comprehensive Health Framework, [http://www.healthyschoolsms.org/health\\_education/curriculum\\_instruction.htm](http://www.healthyschoolsms.org/health_education/curriculum_instruction.htm) (accessed December 1, 2010).

<sup>181</sup> Mississippi Office of Academic Education, “Comprehensive Health: Quality Education for Every Child,” 2006 <http://www.mde.k12.ms.us/acad/id/curriculum/physed/healthfi.htm> (accessed December 8, 2010).

Nsombi Lambright, Executive Director of the American Civil Liberties Union (ACLU) of Mississippi, described the pressure on school personnel who believe in providing more comprehensive sex education:

In Mississippi sex education is determined school by school, principal by principal, with progressive teachers willing to put their jobs on the line.<sup>182</sup>

Juanita Davis, Director of HIV/STD Prevention and Education at the Mississippi Department of Health, stated:

What we can say is a matter for each principal and local school. Some invite us to talk and we can be free about what we tell the kids. Others are non-cooperative. There is a need for more AIDS education in the schools, there is a lot of misinformation, like you can get it from a mosquito.<sup>183</sup>

Mary L., age 16 and a high school student told Human Rights Watch:

Kids need information about HIV; they don't know how you can and can't get it.<sup>184</sup>

Human Rights Watch interviews with students from four public high schools in Jackson revealed that there was no sex education at all in two of the schools, while students in the other two received sex education that talked about abstinence with no discussion of condoms.<sup>185</sup> One student at a school where sex education was not part of the standard curriculum stated that she received an hour of HIV education in a childhood development course. However, many students “opted out” of the class on that day, utilizing an option provided to parents for all sex education classes in the state.<sup>186</sup>

The mixed messages will continue in 2011. The Mississippi Department of Health applied for and received federal dollars for 2011 to implement a teen pregnancy program that

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<sup>182</sup> Human Rights Watch interview with Nsombi Lambright, Jackson, Mississippi November 9, 2010.

<sup>183</sup> Human Rights Watch interview with Juanita Davis, Jackson, Mississippi June 22, 2010.

<sup>184</sup> Human Rights Watch interview with Mary L., Jackson, Mississippi August 27, 2010.

<sup>185</sup> Human Rights Watch interview with Tanya A., Keneesha R., Jasmine J., and Mary L., Jackson, Mississippi August 27, 2010.

<sup>186</sup> Human Rights Watch interview with Lois B., Jackson, Mississippi August 27, 2010; The opt-out provision is set forth in Miss. Code Ann. 37-13-173.

incorporates comprehensive sex education rather than emphasizing only abstinence.<sup>187</sup> This is a positive step, but until the state repeals laws that require the promotion of abstinence and restrict discussion of condoms, the lack of comprehensive sex education will continue to endanger the health of a young, sexually-active population.

The state's commitment to abstinence education is particularly dangerous for young men who have sex with men, the highest risk group for HIV infection in Mississippi. The alarming increase in HIV infection among young African-American men who have sex with men prompted an investigation and a formal study in 2008 by the Centers for Disease Control and Preventions and the Mississippi Department of Health. Recommendations from the study emphasized the need for early intervention during adolescence with information stressing the importance of condom use for preventing transmission, recommendations that have been utterly ignored by the public schools.<sup>188</sup>

The sex education policies also carry, and in some cases mandate, negative messages about homosexuality that harm lesbian, gay, bisexual and transgender youth. Mississippi law requires discussions of sex education to teach “that a mutually faithful, monogamous relationship in the context of marriage is the only appropriate setting for sexual intercourse.”<sup>189</sup> The law further states that such discussions must teach “current state law re: rape, statutory rape, paternity, establishment of child support and homosexual activity.”<sup>190</sup> The state law regarding “homosexual activity” is the anti-sodomy law that remains on the books despite the ruling of the US Supreme Court in 2003 declaring such laws to be unconstitutional.<sup>191</sup> Mississippi criminal law section 97-29-59 declares it a crime punishable by one to ten years in prison to engage in a “detestable and abominable crime against nature,” interpreted to include the crime of sodomy.<sup>192</sup>

Teaching that positive, healthy sexuality only occurs in heterosexual marriage renders alternative sexuality invisible and fails to protect the right of LGBT youth to relevant and

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<sup>187</sup> Human Rights Watch telephone interview with Dr. Mary Currier, State Health Officer, Jackson, Mississippi September 1, 2010.

<sup>188</sup> Mississippi Department of Health, “HIV Disease in Young African-American Men Who Have Sex with Men, Mississippi, 2008”; CDC, Morbidity and Mortality Weekly Report (MMWR), “HIV Infection Among Young Black Men Who Have Sex with Men, Jackson, Mississippi 2006-2008”, February 6, 2009, Vol. 58, No. 4; Oster, A.M. et al., “HIV Risk Among Young African-American Men Who Have Sex with Men: A Case-Control Study in Mississippi, APHA Vol. 101, No. 1, January 2011, 137-143.

<sup>189</sup> Miss. Code Ann. 37-13-171.

<sup>190</sup> Miss. Code Ann. 37-13-171.

<sup>191</sup> *Lawrence v. Texas*, 539 US 558 (2003); Code of Alabama 13A-6-60.

<sup>192</sup> Miss. Code Annotated 97-29-59 and case law cited therein.

necessary health information. Mandating anti-homosexual messages in the schools discriminates against LGBT youth and creates a hostile school environment that conflicts with their right to an education free of discrimination.<sup>193</sup> Research by the Gay, Lesbian and Straight Education Network has found that in schools that promote abstinence-only sex education, LGBT youth experience higher levels of victimization and lack of physical safety than in school than in schools where sex education is not abstinence-only.<sup>194</sup> Though there is no evidence of a directly causal effect, this association is a matter of concern. Mississippi's education laws are part of a larger government-sponsored abstinence campaign that has been fueled by federal dollars in the last decade, most recently \$4.7 million between 2008 and 2009.<sup>195</sup> The Mississippi Department of Human Services describes its "Just Wait" abstinence campaign:

Mississippi has one of the highest percentages of births to teens in the nation. Although the teen pregnancy rate is decreasing in Mississippi, it is still a significant problem—one which has a definite impact on the state's welfare rolls. In an effort to assist with this serious problem, the Mississippi Department of Human Services (MDHS) established the "Just Wait" Abstinence Unit within the Division of Economic Assistance. The sole purpose of the unit is to address the issue of out-of-wedlock births, teen pregnancy and other "at risk" behavior of Mississippi's young people.<sup>196</sup>

The "Just Wait" program is problematic from the perspectives of both health and human rights. Although the program description mentions "at-risk" sexual behaviors, it makes no mention of HIV or other sexually transmitted diseases. There is an online link to one "fact sheet" that warns of HIV and STDs, but nowhere on the "Just Wait" program website are condoms referenced, nor is there a reference or link to the Department of Health or its HIV/STD unit. Rather, the program goals are to involve churches, government, and the media in encouraging abstinence outside of marriage and helping young people "discover that the only safe answer is abstinence."<sup>197</sup>

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<sup>193</sup> International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc.A/6316 (1966), 999 UNTS 171, entered into force March 23, 1976, ratified by the US on June 8, 1992, article 26 (right to equal protection under the law); Yogyakarta Principles, Principle 16.

<sup>194</sup> Gay, Lesbian and Straight Education Network, "The 2007 National School Climate Survey," p. 133.

<sup>195</sup> SIECUS, "Federal Abstinence-Until-Marriage Funding By State FY 2009" <http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1260> (accessed December 1, 2010).

<sup>196</sup> Mississippi Department of Human Services, "Just Wait" Abstinence Program, [http://www.mdhs.state.ms.us/ea\\_justwait.html](http://www.mdhs.state.ms.us/ea_justwait.html) (accessed December 1, 2010).

<sup>197</sup> Ibid.

Given that the overwhelming majority of people on Mississippi's "welfare rolls," officially known as the Temporary Assistance for Needy Families (TANF) program, are African-American women,<sup>198</sup> targeting this group for state-sponsored abstinence messages raises concerns of interference with the right to reproductive freedom.<sup>199</sup> The involvement of religious institutions in the campaign raised civil rights concerns among US legal advocates as well. In 2009 the "Just Wait" program used federal funding to hold a public rally for abstinence led by religious leaders in Jackson, Mississippi, that was challenged by the ACLU on US constitutional grounds as a failure to separate church and state.<sup>200</sup> Most disturbing is the denial of information relating to HIV and other sexually transmitted diseases to African-American women, a group so heavily impacted by these infections in Mississippi.

## State-Sponsored Homophobia

Nationally, gay and bisexual men comprise two percent of the US population yet account for 53 percent of new HIV infections each year.<sup>201</sup> Gay, bisexual, and other men who have sex with men are the group "most severely affected" by the HIV epidemic and the only group in which infections have been rising steadily since the 1990s.<sup>202</sup> The Mississippi State HIV/AIDS Plan reports that men who have sex with men are the leading exposure category for rates of new infection and for individuals living with HIV/AIDS.<sup>203</sup>

In relation to HIV and AIDS, homophobia can be dangerous to one's health. Public health officials in Mississippi cite the extreme stigma surrounding homosexuality as a primary factor in avoidance of testing and care among men who have sex with men, the group with the highest infection rates in the state.<sup>204</sup> "Men who have sex with men are an extremely

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<sup>198</sup> US Dept HHS, Administration for Children and Families, TANF Statistics 2009, <http://www.acf.hhs.gov/programs/ofa/character/FY2008/tab20.htm> (accessed December 1, 2010).

<sup>199</sup> CERD 2(c); ICESCR, articles 2(2) and 3 (racial and gender equality under the law) and article 12 (right to health.); Committee on Economic, Social and Cultural Rights, Gen Comment 14, para 8 (reproductive freedom. For comprehensive discussions of state attempts to limit the reproductive freedom of African-American women through promotion of the myth of the 'welfare queen', see, Dorothy Roberts, *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (New York: Random House, 1997) and Anna Marie Smith, *Welfare Reform and Sexual Regulation* (New York: Cambridge University Press, 2007).

<sup>200</sup> *Robinson et al, v. Thompson*, Civil Action No. 3:09-cv-537-WHB-LRA (USD.C., S.D. Miss.), Motion to Dismiss Granted September 30, 2010.

<sup>201</sup> National AIDS Strategy, p. 14.

<sup>202</sup> US Centers for Disease Control, "HIV Among Gay, Bisexual, and Other Men Who Have Sex With Men", <http://www.cdc.gov/hiv/topics/msm/index.htm> (accessed December 12, 2010).

<sup>203</sup> Statewide Comprehensive HIV/AIDS Plan, p. 33.

<sup>204</sup> Statewide Comprehensive HIV/AIDS Plan p 84.

hard to reach population,” said Juanita Davis of the Department of Health. “There is so much stigma that they do not want to come forward.”<sup>205</sup>

The State Comprehensive HIV/AIDS Plan addresses the impact of homophobia on HIV prevention and treatment:

Stigma connected to sexual orientation may lead men who have sex with men to be secretive about their sexual behaviors and less likely to practice risk reduction. Due to pervasive social mores many MSM also engage in sex with women in addition to sex with their male partners.<sup>206</sup>

In 2008 local HIV advocates challenged the Mississippi Department of Health’s failure to apply for federal funds available from the US Centers for Disease Control and Prevention that would permit them to target the MSM population for testing and prevention programs.<sup>207</sup> Since then, the Department of Health has shown an improved response to the needs of this population by allocating 41 percent of community-based prevention funds in 2009 to groups that are targeting men who have sex with men.<sup>208</sup>

Prevention funding alone, however, is not an adequate response. The state of Mississippi contributes to stigma and homophobia with discriminatory criminal and family law. Criminal laws that call sodomy “a detestable and abominable crime against nature” are not enforceable under federal law yet they remain in the criminal code and continue to be referenced in the state education code as mandatory subject matter for Mississippi youth. Mississippi is the only state in the union that expressly bars gay people from adopting children.<sup>209</sup>

In 2004 Mississippi amended its Constitution in order to invalidate any attempt by lesbians or gay men to marry.<sup>210</sup> The legislative sponsor of the amendment, Representative Alan Nunnelee, called for voters to approve the measure as gay marriage “goes against everything society has

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<sup>205</sup> Human Rights Watch interview with Juanita Davis, Jackson, Mississippi June 22, 2010.

<sup>206</sup> Statewide Comprehensive HIV/AIDS Plan, p. 84.

<sup>207</sup> Housing Works, “Advocates Address Health Department’s Failure to Apply for Necessary HIV Prevention Funding, Press Release, November 6, 2008.

<sup>208</sup> Human Rights Watch email communication with Joy Sennett, Mississippi STD/HIV Office, December 30, 2010.

<sup>209</sup> MSNBC.com, “Florida Gay Adoption Ban Ends,” October 22, 2010, [http://www.msnbc.msn.com/id/39803884/ns/us\\_news-life](http://www.msnbc.msn.com/id/39803884/ns/us_news-life) (accessed December 15, 2010).

<sup>210</sup> Miss. Const. Ann. Article 14 (263A).

ever stood for.”<sup>211</sup> Nunnelee also opposed developing a school curriculum that addressed homosexuality, calling the materials proposed for combating homophobia “trash.”<sup>212</sup> Nunnelee was recently elected to the US House of Representatives from Mississippi.

State Representative John Hines of the 50<sup>th</sup> District, a strong advocate for the HIV/AIDS community, said homophobia was a major barrier to improving state support for people with HIV and AIDS. Hines told Human Rights Watch:

Legislators in Mississippi don’t see it as a public health crisis; they see it as punishment for an unhealthy lifestyle.<sup>213</sup>

Alonzo Dukes, Executive Director of the Southern AIDS Commission in Greenville, Mississippi, told Human Rights Watch:

I’ve been called a nigger and a faggot by state legislators right in the Capitol.<sup>214</sup>

Public health officials rightly express concern about the willingness of gay and bisexual men to come forward to access health services. But this public health problem is part of a larger political context. As long as the state government continues to promote negative and discriminatory policies that create a hostile environment for LGBT people, men who have sex with men will continue to be what the Department of Health calls a “hard to reach population” at significant risk to their health.<sup>215</sup>

## Use of the Criminal Law to Address HIV

Mississippi is one of 34 states that criminalize behavior related to HIV exposure or transmission.<sup>216</sup> The majority of these statutes impose liability on persons who are aware of their HIV status and fail to disclose it to their sexual partner. In many states transmission is not required for conviction, and, in the majority of cases prosecuted under these laws,

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<sup>211</sup> Washington Post Profiles, “Alan Nunnelee: Why He Matters” November 3, 2010, [http://www.whorun.gov.com/Profiles/Alan\\_Nunnelee](http://www.whorun.gov.com/Profiles/Alan_Nunnelee) (accessed December 8, 2010).

<sup>212</sup> Ibid.

<sup>213</sup> Human Rights Watch interview with State Rep. John Hines, Greenville, Mississippi, June 23, 2010.

<sup>214</sup> Human Rights Watch interview with Alonzo Dukes, Executive Director of Southern AIDS Commission, Greenville, Mississippi June 23, 2010.

<sup>215</sup> Human Rights Watch interview with Juanita Davis, Jackson, Mississippi June 22, 2010.

<sup>216</sup> Center for HIV Law and policy, Positive Justice Project, Ending and Defending Against HIV Criminalization: A Manual for Advocates, State and Federal Laws and Prosecutions, First Edition, Fall 2010.

transmission has not occurred.<sup>217</sup> Under Mississippi criminal law, the “knowing exposure” of another to HIV is a felony punishable by 3-10 years in prison.<sup>218</sup> Neither intent to transmit HIV nor actual transmission is required. In 2008 a woman was prosecuted under this provision and subjected to house arrest for one year for failure to inform her husband of her HIV-positive status. No transmission of HIV occurred in this case.<sup>219</sup>

In addition, willful violation of an order issued by the local public health officer while “afflicted with a life-threatening communicable disease” is a felony punishable by five years in prison and a \$5,000 fine.<sup>220</sup> In 1998 a man received positive HIV test results and was instructed by a Disease Intervention Specialist at the Department of Public Health to refrain from activity that might transmit HIV. He signed a “quarantine order” to this effect. His sexual partners were notified of his status and, months later, one partner came forward to accuse him of engaging in sex without informing the partner of his HIV status. The man was sentenced to five years in prison for violating the quarantine order.<sup>221</sup>

Targeting people with HIV for penalties related to their sexual behavior is problematic for both health and human rights. Because other criminal laws prohibit acting against another person with intentional harm,<sup>222</sup> laws that single out people with HIV are unnecessary and discriminatory. These laws may have been expected to increase communication between sexual partners thereby reducing transmission but there is no evidence to support this. Imposing harsher penalties on those who are aware of their HIV status may discourage HIV testing and diminish an individual’s willingness to seek care and services.<sup>223</sup> In addition, studies conducted in the United Kingdom have found that some gay men are less likely to insist on condom use with a partner whom they perceive as being under a legal duty to disclose his HIV status, as they assume he will comply with the law.<sup>224</sup>

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<sup>217</sup> Ibid.

<sup>218</sup> Mississippi Code Annotated 97-27-14.

<sup>219</sup> Nicklaus Lovelady, “Women Gets House Arrest in HIV Case,” Clarion-Ledger, October 7, 2008; Center for HIV Law and policy, Positive Justice Project, *Ending and Defending Against HIV Criminalization: A Manual for Advocates, State and Federal Laws and Prosecutions*, First Edition, Fall 2010, p. 96.

<sup>220</sup> Mississippi Code Annotated 41-23-2.

<sup>221</sup> *Carter v. State*, 803 So. 2d 1191 (Miss. 1999).

<sup>222</sup> See, e.g., Miss. Code Ann. 97-3-7 (crimes against the person, assault, intent to cause bodily harm).

<sup>223</sup> UNAIDS Policy Brief: Criminalization of HIV Transmission (Geneva) August 2008, p. 3. See also, Burris, S. and Cameron, E. “The Case Against Criminalization of HIV transmission,” *JAMA* 2008; 300 (5): 578-81.

<sup>224</sup> Dodds, C., et al., “Homosexually active men’s views on criminal prosecutions for HIV transmission are related to HIV prevention need,” *AIDS Care* 2008; 20 (5) pp. 509-14.



Criminal HIV laws have been criticized by international and domestic public health authorities. The joint United Nations Programme on HIV/AIDS (UNAIDS) found little evidence that criminal statutes promote either criminal justice or prevention of HIV transmission.<sup>225</sup> The US National AIDS Strategy cited a recent study indicating that people with HIV do not change their behavior in states with HIV-specific criminal laws,<sup>226</sup> stating:

The continued existence and enforcement of these laws may run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment.<sup>227</sup>

The Department of Justice has agreed to report on the implications of HIV-specific criminal laws for people living with HIV and to work with states considering changes to criminal statutes in order to “align laws and policies with public health principles.”<sup>228</sup>

In the midst of an HIV/AIDS epidemic, Mississippi cannot afford policies that have the potential to drive persons with HIV away from testing and treatment. The Department of Health estimates that at least one-quarter of HIV cases are undiagnosed,<sup>229</sup> and 50-70 percent of people who are aware that they have HIV are not in care.<sup>230</sup> Criminal laws represent a punitive approach to HIV on the part of the state that threatens to deepen fear, stigma, and exclusion for individuals with HIV.

## **Public Health Practices That Undermine Human Rights**

Under Mississippi law, individuals testing positive for HIV shall be reported by name to the Department of Health.<sup>231</sup> Individuals testing positive may also be subject to quarantine if such action is deemed necessary. Those reasonably suspected of having HIV may be required to submit to testing or quarantine and those who refuse may be prosecuted.<sup>232</sup> Post-test counseling must be provided by law and other parties who may have been exposed

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<sup>225</sup> UNAIDS Policy Brief: Criminalization of HIV Transmission (Geneva) August 2008.

<sup>226</sup> Horvath, KJ et al, “An examination of attitudes among US men who have sex with men and the impact of state law,” *AIDS Care*, 2010 Oct; 22 (10), 1221-8.

<sup>227</sup> National AIDS Strategy, p. 37.

<sup>228</sup> National HIV/AIDS Strategy Federal Implementation Plan, July 2010, p. 26.

<sup>229</sup> Statewide Comprehensive HIV/AIDS Plan, p. 6.

<sup>230</sup> Ibid.

<sup>231</sup> Mississippi Code Ann.41-23-1.

<sup>232</sup> Ibid.

to HIV or other communicable diseases must be notified.<sup>233</sup> For these purposes, the Mississippi Department of Health employs a team of Disease Intervention Specialists. There have been objections from the HIV/AIDS community to the practices of some DIS workers.

Human Rights Watch heard complaints ranging from disrespectful treatment to breaches of confidentiality about the practices of some DIS workers who were conducting follow up to positive HIV tests. According to the Department of Health, the role of DIS workers is to explain positive test results, inquire about sexual or drug-sharing partners who may be at risk, and connect people to medical care and services.<sup>234</sup> Some people, however, experienced the contact with DIS as threatening:

They came to my house and banged on the door, told me I would be prosecuted if I didn't show up for my interview. They scared me to death.<sup>235</sup>

Others discovered their confidentiality had been breached:

One DIS guy came to find me at my job, and told my employer why he was there. I was never able to go back there again, I never felt comfortable. I gave up the job.<sup>236</sup>

Providers and case workers confirmed that complaints about DIS workers were widespread:

The DIS experience can be a nightmare. I have four clients who had terrible experiences where the DIS worker came to their house and treated them very badly.<sup>237</sup>

A recent report found after extensive interviews of people living with HIV in Mississippi that DIS employees frequently had been disrespectful, harassing, and had sometimes threatened people newly diagnosed with HIV and that such practices had turned people away from

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<sup>233</sup> Ibid.

<sup>234</sup> State Health Access Research Project (SHARP) of Harvard Law School, "Mississippi State Report," 2010, p.38.

<sup>235</sup> Human Rights Watch interview with Sheila R., Canton, Mississippi, August 27, 2010.

<sup>236</sup> Human Rights Watch interview with Thomas H., Canton, Mississippi, August 27, 2010.

<sup>237</sup> Human Rights Watch interview with Latonia Johnson, Outreach Coordinator, G.A. Carmichael Family Health Center, Canton, Mississippi, August 27, 2010; Human Rights Watch interview with Tammie Woodall, HIV Specialist, Crossroads North Clinic, Greenville, Mississippi, August 25, 2010.

essential services.<sup>238</sup> The report, conducted by the State Health Access Research Project at Harvard Law School, recommended additional training on federal confidentiality requirements under the Health Insurance Portability and Accountability Act (HIPAA).<sup>239</sup> The report also recommended the establishment of a consumer advisory board to the Department of Health that would serve as a liaison between the department and the community of people living with HIV/AIDS in Mississippi.<sup>240</sup> Department of Health officials acknowledged to Human Rights Watch that the actions of some DIS workers may have been problematic and have agreed to develop a Patient's Bill of Rights as well as to review training materials for the DIS employees.<sup>241</sup>

Human Rights Watch also received complaints about the form used by DIS when interviewing people who had recently tested positive for HIV. This form asks questions about previous HIV tests, number of sex partners, and other topics reasonably related to public health surveillance. However, the form also contains a checklist where the individual must indicate that he or she has been counseled as to a number of "requirements" that include "the necessity of not causing pregnancy or becoming pregnant."<sup>242</sup>

The provision was interpreted by some people living with HIV as a legal prohibition on pregnancy, as stated by Ruth T. in Olive Branch, Mississippi:

I'm too old to worry about it, but after I signed the form I called my friend and told her she couldn't get pregnant. I wasn't even sure she could date.<sup>243</sup>

The ACLU of Mississippi has challenged this provision as unlawful interference with the right to reproductive health and is currently negotiating with the Department of Health for revisions to the form.<sup>244</sup> The State Health Officer at the Department of Health Dr. Mary Carrier assured Human Rights Watch that the checklist has been recently removed from use and will be revised to correct the impression that it is illegal to become pregnant in Mississippi if you are HIV-positive.<sup>245</sup>

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<sup>238</sup> State Health Access Research Project (SHARP) of Harvard Law School, "Mississippi State Report," 2010, p.38.

<sup>239</sup> Public Law 104-191 (1996).

<sup>240</sup> State Health Access Research Project of Harvard Law School, "Mississippi State Report," 2010, p.62.

<sup>241</sup> Human Rights Watch telephone interview with Dr. Mary Carrier, State Health Officer, Jackson, Mississippi September 1, 2010; Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010.

<sup>242</sup> A copy of this form is included in this report at Appendix A.

<sup>243</sup> Human Rights Watch interview with Lena S., Olive Branch, Mississippi, August 23, 2010.

<sup>244</sup> Human Rights Watch interview with Nsombi Lambright, Executive Director of the ACLU of Mississippi, November 9, 2010.

<sup>245</sup> Human Rights Watch telephone interview with Dr. Mary Carrier, State Health Officer, Jackson, Mississippi September 1, 2010.

## VI. Human Rights Obligations

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.<sup>246</sup> These principles from the Universal Declaration of Human Rights establish that medical care, necessary social services, and housing are integral components of human dignity, and are part of the claims all people have to their right to an adequate standard of living. Housing has been recognized as key to the realization of the right to health for all people,<sup>247</sup> and protection of this right is particularly urgent for people living with HIV, a fact acknowledged by both the US government and the State of Mississippi.<sup>248</sup> Medical care should be accessible, available, and of adequate quality,<sup>249</sup> a goal that remains out of reach for more than half of the people living with HIV in Mississippi.

Moreover, the United States is obligated to address the racial disparities that characterize the domestic HIV epidemic, a duty that is fundamental to international and domestic human rights law, including the International Convention on the Elimination of all forms of Racial Discrimination (ICERD) to which the United States is a party.<sup>250</sup> ICERD requires states parties, when the circumstances so warrant, to take “special and concrete measures” to ensure the development and protection of racial groups “for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms.”<sup>251</sup> Moreover, under Article 5(e)(iv) of ICERD, the US is to eliminate racial discrimination and guarantee to everyone, without distinction, the right to public health.<sup>252</sup> The treaty requires state parties to

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<sup>246</sup> Universal Declaration of Human Rights, G.A. Res. 217, U.N. GAOR, 3rd Sess., pt. 1, art. 25(1), U.N. Doc A/810 (1948).

<sup>247</sup> International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), <sup>21</sup> UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the US on October 5, 1977; Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000, para. 11.

<sup>248</sup> National AIDS Strategy, p.28; Mississippi Development Authority, “2010-2015 Mississippi Consolidated Plan for Housing and Community Development”, May 2010, p. 10.

<sup>249</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000, para.12.

<sup>250</sup> International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 UN GAOR Supp. (No. 14) at 47, UN Doc A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, ratified by the United States on November 20, 1994, article 5.

<sup>251</sup> ICERD, Article 2.2.

<sup>252</sup> ICERD, Article 5( e)( 4).

address not only intentional racial discrimination but laws, policies, and practices that result in disparate racial impact.<sup>253</sup>

In February 2008 the United States presented its periodic report to the Committee for the Elimination of Racial Discrimination as required under the treaty. Human Rights Watch and other NGOs submitted reports to the Committee highlighting the health disparities based on race that have worsened in the US over the last decade.<sup>254</sup> Human Rights Watch specifically addressed the failure of the US government to adequately address HIV/ AIDS, stating:

As HIV/AIDS rages through African-American communities, the response of the US government ranges from neglect to undermining potential solutions. There is no national HIV/AIDS plan and no comprehensive plan to address the epidemic in minority communities. Medicaid, which offers health insurance to low-income persons, denies eligibility until applicants are disabled from full-blown AIDS. The Ryan White CARE Act and the AIDS Drug Assistance Program (ADAP), designed to be "safety nets" for HIV/AIDS patients denied Medicaid eligibility, are chronically under-funded. This gap leaves many without access to medical care or life-saving medications. One in five new HIV infections among African-Americans is a result of injection drug use, yet the US government prohibits the use of federal funds for proven harm reduction programs such as needle exchanges.<sup>255</sup>

In response to information provided by civil society as well as by the United States, the committee issued concluding observations that expressed concern about persistent racial disparities in health outcomes, access to health care, and access to health insurance in the US.<sup>256</sup> Moreover, the committee noted its continuing concern that the US lacks sufficient mechanisms to ensure and coordinate implementation of the treaty at the state and local levels.<sup>257</sup> Mississippi has proven to be a case in point as the state's failure to adequately address HIV has placed an unacceptably high burden on the state's African-American population. Federal leadership is needed to ensure that state policies that conflict with

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<sup>253</sup> ICERD, Article 1.1.

<sup>254</sup> Human Rights Watch, Submission to the Committee on the Elimination of Racial Discrimination, During its Consideration of the Fourth, Fifth, and Sixth Periodic Reports of the United States of America, CERD 72nd Session, vol. 20, no. 2(G), February 2008, <http://hrw.org/reports/2008/uso2008/>.

<sup>255</sup> Human Rights Watch, Submission to the Committee on the Elimination of Racial Discrimination, p. 40.

<sup>256</sup> Committee on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination, Geneva, May 8, 2008, UN Doc. CERD/C/USA/CO/6, paras. 16, 32.

<sup>257</sup> Committee on the Elimination of Racial Discrimination, Concluding Observations, para. 13.

evidence-based national and international standards for managing HIV are replaced with those that are compatible with human rights.

The Committee on Economic, Social and Cultural Rights has interpreted article 12 of the International Covenant on Economic, Social and Cultural Rights, to which the United States is not yet party, to obligate states to take steps necessary for the “prevention, treatment and control of epidemic, occupational and other diseases,” including the “establishment of prevention and education programmes for behavior-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting reproductive health.”<sup>258</sup> Mississippi’s state-wide abstinence campaign ignores the evidence that such approaches have little effect on reducing HIV or STD transmission. Suppression of information about condom use and effectiveness impedes the right of students to accurate and relevant health information that is an essential component of the right to health.<sup>259</sup>

Given the severe impact of sexually transmitted diseases, including HIV, on African-American youth, Mississippi’s continued refusal to endorse methods proven to reduce disease transmission conflicts with obligations to address racially-based disparities in health. Promoting abstinence-only messages to African-American women while failing to address HIV/AIDS and other sexually transmitted infections is problematic in a population heavily impacted by these infections.<sup>260</sup>

The sex education curricula in Mississippi that renders the sexuality of LGBT youth invisible and mandates negative messages about “homosexual activities,” interferes with the right to health of LGBT youth, and creates school environments that are discriminatory and may be unsafe. Combined with other laws and policies that discriminate against homosexuals, Mississippi is responsible for state-sponsored homophobia that, according to state public health officials, endangers the health and lives of men who have sex with men by keeping them away from testing and treatment services. These policies conflict with fundamental principles of human rights including the right to health and the right to be free from discrimination on the basis of sexual orientation.<sup>261</sup>

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<sup>258</sup> International Covenant on Economic, Social and Cultural Rights (ICESCR), , article 12; General Comment No. 14, The Right to the Highest Attainable Standard of Health, Committee on Economic, Social and Cultural Rights, 22<sup>nd</sup> sess. 2000, para. 16.

<sup>259</sup> ICESCR, para. 11. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000, para.11.

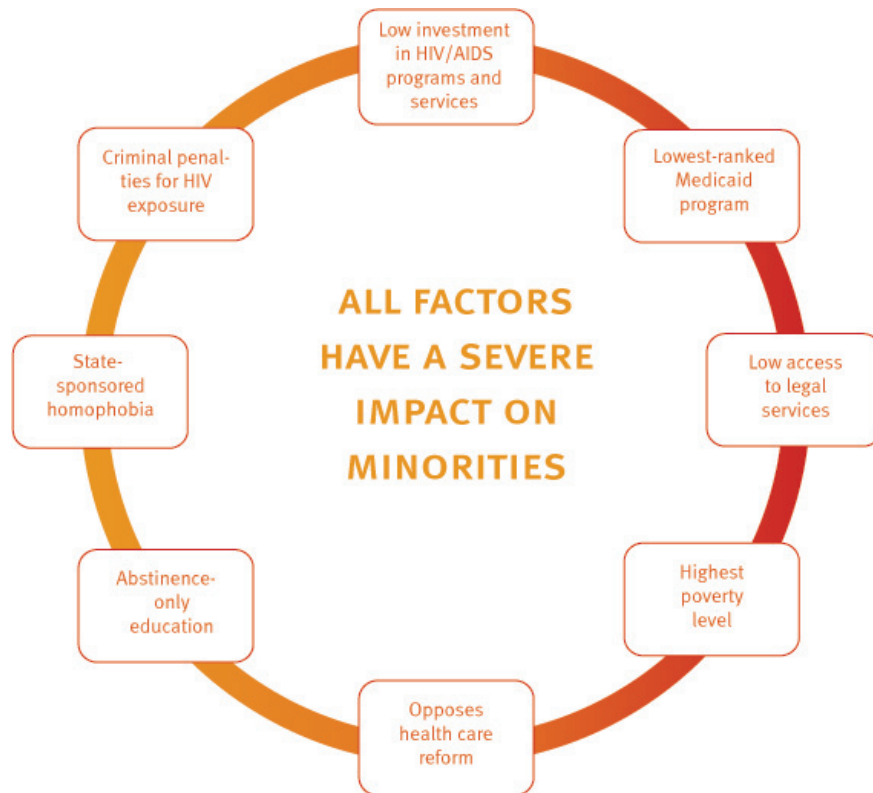
<sup>260</sup> CERD 2(c); ICESCR, articles 2(2) and 3 (racial and gender equality under the law) and article 12 (right to health).

<sup>261</sup> ICCPR, article 26 (right to equal protection under the law); Yogyakarta Principles, Principle 16; UNAIDS, International Guidelines on HIV/AIDS and Human Rights (2006).

Laws that single out HIV exposure for criminal penalties are unnecessary, discriminatory, and are considered by public health authorities as likely to undermine, rather than promote, the public health. To their credit, Mississippi public health officials have promised to revise practices that convey the impression that the law prohibits people with HIV from causing pregnancy or becoming pregnant. Development of a Patient's Bill of Rights and improved training for state employees would improve protection against breach of confidentiality laws for people living with HIV.

## VII. Conclusion

### HIV and Human Rights in Mississippi: An Environment of Risk



Factors that contribute to HIV risk in Mississippi. © 2011 Human Rights Watch

In Mississippi, harsh socio-economic conditions place people at high risk of acquiring HIV and make it difficult to access adequate treatment and support. Yet instead of promoting policies that might ameliorate these conditions, Mississippi's response ranges from inadequate support to actively opposing interventions that could make a difference to the health and lives of its residents. Mississippi relies almost exclusively on limited federal programs to provide HIV prevention, medical care, housing, and transportation, but even with this approach the state fails to maximize federal dollars that are available for these services. Federal health care reform would expand access to health care for many Mississippians living with HIV, but the state has joined a lawsuit to block its implementation.



At the same time, Mississippi continues to ignore evidence-based recommendations for comprehensive sex education, requiring abstinence before marriage to be the primary message delivered to a student population that is reporting the highest rates of sexually transmitted disease and teen pregnancy in the country. The state criminalizes failure to disclose HIV status despite recommendations to the contrary from national and international health and HIV experts. HIV Infection among young black men who have sex with men is increasing at an alarming rate, yet efforts to reach out to this population are undermined by anti-gay laws and policies that keep them underground and away from public health services.

The severe and disproportionate impact of these failed laws and policies on African-Americans in Mississippi is highly problematic from a human rights perspective. The US is obligated to address health disparities based on race, an obligation that includes the duty to end ostensibly neutral policies that nevertheless have a discriminatory impact on racial groups and to ensure compliance at the state and local levels. Mississippi's current approach to HIV is inconsistent with both public health and human rights imperatives.

The federal government bears the ultimate responsibility to protect the right to health, ensure access to health services free from discrimination, and to address racially-based health inequities. The goals of the National AIDS Strategy will not be realized without improved federal oversight of state approaches. Strong leadership, both federal and state, will be needed to eliminate ineffective, stigmatizing, and discriminatory policies that are placing health and life at risk in Mississippi.

## **VIII. Acknowledgements**

This report was researched and written by Megan McLemore, senior researcher with the Health and Human Rights Division. The report was reviewed at Human Rights Watch by Joseph Amon, Director of the Health and Human Rights Division, Rebecca Schleifer, Director of Advocacy for the Health and Human Rights Division, Alison Parker, Director of the US Program, Dinah Pokempner, General Counsel, and Babatunde Olugboji, Deputy Program Director at the Program Office. Production assistance was provided by Alex Gertner, Associate to the Health and Human Rights Division, Grace Choi, Kathy Mills and Fitzroy Hepkins.

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Most of all, Human Rights Watch thanks the courageous men and women living with HIV in Mississippi who shared their experiences for this report.

## Appendix

DIS Number   **HIV INTERVIEW RECORD** Case ID  

| Testing and Treatment History  |  |
|--|--|
| Date Survey Completed: <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (mm/dd/yy)  | Name: <span style="border: 1px solid black; padding: 0 20px;"> </span> |
| 1. When was the FIRST time you ever tested POSITIVE for HIV? <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (mm/yy)<br>Date of Positive (DOP)   |  |
| 2. When was the FIRST time you EVER got an HIV test?<br>(whether positive or negative) <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span>   |  |
| 3. Have you EVER had a test that was NEGATIVE? <span style="border: 1px solid black; padding: 0 10px;"> </span> Y/N/R/D<br>If yes, when did you get your LAST NEGATIVE? <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span>  |  |
| 4. Was your VISIT from your first positive test on <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (DOP): Circle one<br><b>Inpatient:</b><br>Hospital, Drug Treatment, Hospice, Other: <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span><br><b>Outpatient:</b><br>Private Doctor, Community Health Clinic, Health Dept, Blood Donation, Other: <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span>   |  |
| 5. What was your REASON for getting the test on <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (DOP) - Check one:<br><div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> Patient has symptoms, recent illness, wt loss, OI<br/> <input type="checkbox"/> Current STD and/or STD screening<br/> <input type="checkbox"/> Blood/plasma donation or referred by blood bank<br/> <input type="checkbox"/> Hospitalization, pre-op test, other procedure<br/> <input type="checkbox"/> Needed to initiate care<br/> <input type="checkbox"/> Required by Military, Insurance or other agency<br/> <input type="checkbox"/> Community screening /free test /test offered                 </div> <div style="width: 48%;"> <input type="checkbox"/> Named as contact to a partner/ex who is HIV+<br/> <input type="checkbox"/> MD recommendation / rule out HIV diagnosis<br/> <input type="checkbox"/> Incarceration<br/> <input type="checkbox"/> Prenatal screening or pregnancy<br/> <input type="checkbox"/> Entry to drug/alcohol treatment<br/> <input type="checkbox"/> Because you regularly test (i.e. every 6 months)<br/> <input type="checkbox"/> Other: <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span> </div> </div> |  |
| 6. In the 2 YEARS before <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (DOP), how many times did you have an HIV test? <span style="border: 1px solid black; padding: 0 5px;">1+</span> Tests?   |  |
| 7. In the 6 MONTHS before <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (DOP), were you taking any of these HIV Medications? <span style="border: 1px solid black; padding: 0 10px;"> </span> Y/N/R/D<br>If yes, which medications did you take: <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span><br>Are you taking any of these medications now?<br>When was the first <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> and last <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> day you took these medications?   |  |
| HIV and TB   |  |
| 8. Has the patient been medically evaluated for HIV infection by a physician? <span style="border: 1px solid black; padding: 0 10px;"> </span> Y/N/R/D<br>If yes, the Physician's name: <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span> Phone: <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span><br>If no, has the patient's been referred for HIV disease case management?<br>Case manager's name: <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span> Date: <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span>   |  |

Y – Yes   N – No   R – Refused to Answer   D – Did not ask

Form 917

Revised 8-13-09

9. Is the patient a blood product donor?

☐ Y/N/R/DIf yes, dates:     -     /     -        Facility Name: 10. Date of HIV test from FIELD RECORD:     -     -     Site :  Result: Date of Repeat Test:     -     -     State Site:  Result: Refused? : 11. Date of TB Skin Test:     -     -     State Site:  Refused? : Has the patient been diagnosed with **pulmonary TB**?☐ Y/N/R/DHas the patient been diagnosed with **extra-pulmonary TB**?☐ Y/N/R/D

Has the patient been referred in-house for TB skin test, flu pneumonia immunizations?

☐ Y/N/R/D**Sexually Active Females**

12. Has the patient been referred to a family planning clinic?

☐ Y/N/R/D

13. Has the patient ever delivered a live-born infant?

☐ Y/N/R/DIf yes, when was the most recent birth?     -     -    

14. Is the patient Pregnant?

☐ Y/N/R/DIf yes, has she been referred for prenatal care? Due Date     -     -    **Risk Factors**

15. Has the patient had more than one sex partner during his/her lifetime?

☐ Y/N/R/D

16. Has the patient received a blood transfusion?

☐ Y/N/R/DIf yes, Date:     -     -     Facility: 

17. Is the patient hemophiliac?

☐ Y/N/R/DIf yes, what type: 

18. If patient is less than 13, is the mother infected with HIV/AIDS?

☐ Y/N/R/D

19. Is the patient Health Care Worker with history of blood/body fluid exposure?

☐ Y/N/R/D

20. Did the patient know that they were at risk?

☐ Y/N/R/D

21. Does the patient currently attend any type of school?

☐ Y/N/R/DIf yes, Name: 

Y – Yes N – No R – Refused to Answer D – Did not ask

Form 917

Revised 8-13-09

Case ID

Below is an official Mississippi State Department of Health document and is considered a legal document.



## MISSISSIPPI STATE DEPARTMENT OF HEALTH

| I acknowledge that the six following requirements have been explained to me:   | Initial: |
|--|----------|
| <i><b>Safer sex practices</b> (condoms, limiting the number of sexual partners, etc.)</i>  |          |
| <i>Necessity of <b>informing future contacts</b> of HIV positive status before sex or needle sharing activities (even if condoms are used)</i> |          |
| <i>Necessity of <b>not donating</b> and/or <b>selling blood</b> or blood products</i>  |          |
| <i>Necessity of not causing <b>pregnancy</b> or becoming pregnant</i>  |          |
| <i>Necessity of <b>informing all health care providers</b> of HIV positive status when seeking health care</i>                                 |          |
| <i><b>Quarantine Order</b></i>   |          |

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MSDH SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**NOTES:**

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Form 917

Revised 8-13-09



**HIV INTERVIEW  
FORM No. 917**

**PURPOSE**

This form is to be completed by the Disease Intervention Specialist (DIS) or Health Protection Nurse (HPN) upon notification of positive HIV status. It will also assure appropriate care process and related documentation needed for surveillance.

NOTE: THIS DOCUMENT CONTAINS VERY SENSITIVE AND PRIVATE INFORMATION ABOUT THE ORIGINAL PATIENT. IT SHALL BE HANDLED IN A CONFIDENTIAL MANNER AT ALL TIMES.

**INSTRUCTIONS**

- ✦ Last First - Enter the patient's last name in the first field labeled "Last" and the patient's first name in the field labeled "First".
  - ✦ Date Survey Completed - Enter the date of the interview. If the patient is deceased, enter the date the interview was attempted and deceased status was obtained.
  - ✦ HARS Number - Enter the HIV/AIDS Reporting System Number.
  - ✦ DIS Number - Enter the Disease Intervention Specialist identification number. Leave blank if the HPN is completing the form.
1. When was the FIRST time you ever tested POSITIVE for HIV? This date will be referred to as the Date of Positive.
  2. When was the very FIRST time you EVER had an HIV test? (Whether test was Positive or Negative)
  3. Have you EVER had an HIV test that was NEGATIVE? (If no skip 3a)
    - ✦ If the patient indicates that he/she has had a Negative HIV test, Check "Y" for yes. If the patient has never had a negative test, check "N" for no and skip question 3a.
    - ✦ If the patient refuses to answer the question check "R" for refused and if the patient does not know if they ever had a negative test, check "D" for don't know.
    - ✦ If yes, when did you get your LAST NEGATIVE test?
    - ✦ Indicate Month and Year for the patient's last negative HIV test.
  4. Was your VISIT from your first positive test on / / (DOP): circle one INPATIENT/ OUTPATIENT?
    - a. Ask the patient what type of visit prompted their first HIV positive test:
      1. INPATIENT (Hospital, ER, Hospice, and etc)
      2. OUTPATIENT (Community Clinic, Doctor's office, Health Dept STD Clinic)
    - b. What was the REASON for taking an HIV test on the Date of Positive?
    - c. Ask and record the reason given for taking the test that had the first positive result.
  5. In the two years before / / (DOP), how many times did you have an HIV test?

The first box has entered "1" to account for the first positive. In the empty box, indicate the number of tests taken in the 2 years previous to the first positive. This also refers to cases where the Date of Positive is from years previous.
  6. In the six months before / / (DOP), were you taking any HIV MEDICATIONS? (If no, skip to # 7).

The question is meant to determine if the blood sample collected for ST ARHS analysis has been somehow altered due to the use of un-prescribed HIV medication (i.e., HIV medications given to the patient by a sexual partner or friend).

If the patient did not use HIV medications before receiving their first positive test, check N for no and proceed to question # 7.

If the patient did use HIV medications before receiving their first positive test, check Y for yes and proceed to the following four questions.

Note: Show the updated HIV Medication chart when asking this question to assist the patient in identification of any drugs they may have taken.

- a. Which HIV Medications did you take? List the drugs by the name that appears in the HIV Medication Chart.
- b. What was the first day you took these HIV medications? Record the first day of HIV medication use (should be previous to the Date of Positive).
- c. Are you taking any of the HIV Medications now? Check Y for yes, N for no, R for refused or D for don't know.
- d. When was the last day that you took these medications? Record the last day of HIV Medication use.

#### **HIV and TB**

7. Has the patient been medically evaluated for HIV infection by a physician? Check the appropriate box for answer.
  - a. If yes, the physician's name/phone. If the answer to question 9 is yes, indicate the physician's name and phone number, if available, in the space provided.
  - b. If no, has the patient been referred for HIV disease case management? Check the appropriate box for answer.
  - c. To whom have you referred the patient for case management. (Case manager's name/phone). If the patient has been referred, indicate the case manager's name and date of referral in the space provided.
8. Is the patient a blood product donor? (includes plasma). Check the appropriate box for answer. If yes, enter the date and medical facility of any/all blood donations made by the original patient.
9. Date of HIV test from field record/Site name/Result.  
Enter the date, location of test and result of test in the space provided.
10. Date of repeat test (document refusal date, name of County Health Dept., and results). Check the appropriate box. Enter the date, county and results of the HIV repeat test.
11. Date of TB skin test (document refusal date and name of County Health Dept).  
Enter the date and county where the TB test was performed
  - a. Has the patient been diagnosed with pulmonary TB? Check the appropriate box.
  - b. Has the patient been diagnosed with extra-pulmonary TB? Check the appropriate box.
  - c. Has the patient been referred in house for TB skin test, flu and pneumonia immunizations? Check the appropriate box.

#### **Sexually Active Females**

12. Has the patient been referred to a family planning clinic? Check the appropriate box.

13. Has the patient ever delivered a live-born infant? Check the appropriate box. a. If yes, when was the most recent birth? Enter the most recent date.
14. Is the patient pregnant? Check the appropriate box.
  - a. If yes, has she been referred for prenatal care? Check the appropriate box
  - b) Enter the due date and risk factors
15. Has the patient had more than one sex partner during his/her lifetime? Check the appropriate box.
16. Has the patient received a blood transfusion? Check the appropriate box. If yes, in the "Date" – "Facility" box enter the date(s) of transfusion and the medical facility on the space provided.
17. Is the patient a hemophiliac? Check the appropriate box. If yes, what type? Enter the type of hemophilia on the space provided.
18. If the patient is less than 13, is the mother infected with HIV/AIDS? Check the appropriate box if the patient's mother is infected with HIV/AIDS.
19. Is the patient a Health Care Worker with a history of blood/body fluid exposure?
20. Did the patient know that they were at risk? Check the appropriate box.
21. Does the patient currently attend any type of school? If yes, enter name of school.

#### **Discussion**

Items 1-6 should be discussed with patient and discussion indicated by entering initials. After discussion of items 1-6, ask the patient to sign in the space provided to verify that the above six issues were read and explained to them. If patient refuses to sign form, the DIS or Epi Nurse conducting the interview should document this in the "Notes".

#### **Signature of the Interviewer**

Enter the complete and legible signature of MSDH employee and date in the space provided.

#### **Notes:**

Any additional information that may be pertinent to that case should be recorded in the note. Attach additional sheets if necessary.

#### **OFFICE MECHANICS AND FILING**

The field DIS/PHN conducts the HIV interview and completes the HIV Interview form. The completed form will be sent along with CDC's Interview Record #73.54 to the appropriate DIS Supervisor or Epi Nurse to be checked for completeness and correctness of information and then be initialed. The original or other legible copy is forwarded to the STD/HIV Bureau's Surveillance Branch for data entry. The Interview Record is to be copied and stored in a secure cabinet by the DIS Supervisor or Epi Nurse. The STD/HIV Office Surveillance Branch staff stores the original or other legible copy with the CDC Interview Record #150 and retain indefinitely.

Revised 8/13/09



## Rights at Risk

### State Response to HIV in Mississippi

In Mississippi, harsh socio-economic conditions place people at high risk of acquiring HIV and make it difficult to access adequate treatment and support. Yet instead of promoting policies that might ameliorate these conditions, the state provides inadequate support and even actively opposes interventions that could make a difference to the health and lives of people living with HIV and AIDS. Mississippi's current approach to HIV is inconsistent with both public health and human rights imperatives.

Mississippi continues to ignore evidence-based recommendations for comprehensive sex education, requiring abstinence before marriage to be the primary message delivered to a student population that is reporting the highest rates of sexually transmitted disease and teen pregnancy in the country. The state criminalizes failure to disclose HIV status despite recommendations to the contrary from national and international health and HIV experts. HIV Infection among young black men who have sex with men is increasing at an alarming rate, yet efforts to reach out to this population are undermined by anti-gay laws and policies that keep them underground and away from public health services.

These failed laws and policies have a severe and disproportionate impact on African-Americans in Mississippi. The federal government bears the ultimate responsibility to protect the right to health, ensure access to health services free from discrimination, and to address racially-based health inequities. Strong leadership, both federal and state, will be needed to eliminate ineffective, stigmatizing and discriminatory policies that are placing health and life at risk in Mississippi.

*Couple living with HIV in Greenwood, Mississippi. In Mississippi, African-Americans are 37 percent of the population but 76 percent of new HIV cases.*

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