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Women and HIV/AIDS: Toward a Jurisprudence of Social and Economic Rights

Anna Carpenter

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"You talk about 'Can we decrease the HIV burden in the United States?' I would say, 'What can we do to decrease poverty in the United States?'"[1]

– Carlos del Rio, chair of global health at Emory University's Rollins School of Public Health

For twenty years, rates of HIV infection among women in the United States, particularly low-income women and women of color, have been increasing while the overall rate of new HIV infections has held steady. According to recent studies from the public health field, socioeconomic factors, particularly poverty, are to blame.[2] To date, the preventative response to the HIV epidemic has focused on reducing the risk of infection by discouraging individual

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IMPOWR (the International Models Project for Women's Rights), established by the American Bar Association, is an innovative initiative to harness the information sharing power of the internet to empower advocates and defenders of gender equality under the law around the world. The project is focused on the establishment of a global, collaborative, online database of information on gender-equality laws, law reform efforts and law enforcement strategies. More information on IMPOWR can be found online: www.impowr.org.

[1] Del Rio, *quoted in* Mike Stobbe, *Study: Poverty, more than race, tied to HIV*, THE WASHINGTON TIMES, July 19, 2010, available at http://p.washingtontimes.com/news/2010/jul/19/study-poverty-more-than-race-tied-tohiv/?page=all (last visited July 26, 2012).

[2] *See* Sally L. Hodder et al., *Challenges of a Hidden Epidemic: HIV Prevention Among Women in the United States*, 55 J. ACQUIR. IMMUNE DEFIC. SYNDR. S69, S70 (Supp. 2 2010), available at http://www.pwn-usa.org/wp-content/uploads/2011/03/HiddenEpidemic.pdf (noting higher rates of HIV for women living in areas of concentrated poverty and naming poverty as a risk factor for HIV among women); Sally Hodder et al., *The HPTN 064 (ISIS Study)—HIV Incidence in Women at Risk for HIV: US*, HIV Prevention Trials Network (HPTN) (forthcoming), abstract available at http://www.retroconference.org/2012b/Abstracts/43702.htm, cited in Mikaela Conley, *Shocking HIV Rates Among Black Women: Study*, ABCnews.com (March 9, 2012) (noting that poverty is a "confounding factor" in HIV risk for women and high rates of HIV for women are most prevalent in areas of concentrated poverty), available at http://abcnews.go.com/Health/AIDS/hivrates-black-urban-women-times-higher-previously/story?id=15878578 - .T-3sa3DOTqs (last visited July 26, 2012); Press release, HIV Prevention Trials Network, *HIV Rates for Black Women in Parts of the US Much Higher than Previously Estimated* (March 8, 2012) (announcing results of study which found disproportionately higher rates of HIV infection among women living in poverty and in communities hardest-hit by the HIV epidemic), available at http://tinyurl.com/cmpwces (last visited July 28, 2012); *See also* Press Release, Ctrs. for Disease Control & Prevention, *New CDC Analysis Reveals Strong Link Between Poverty and HIV Infection* (July 19, 2010) (announcing study showing strong link between poverty and HIV risk), available at http://www.cdc.gov/nchhstp/newsroom/povertyandhivpressrelease.html (last visited July 26, 2012).

behaviors that create a high risk of infection, such as unprotected sex and intravenous drug use.[3] These efforts have been successful in stabilizing the overall HIV infection rate, but the scale of the epidemic among low-income women and women of color has grown.

This article will first argue that traditional prevention efforts focused on addressing individual risk factors are not sufficient to end the spread of HIV/AIDS among women.[4] Rather, systemic factors rooted in economic and gender inequality are the primary drivers of the HIV epidemic among women. As a result, the U.S. response to HIV/AIDS must address the specific social and economic factors that drive infection rates: poverty and violence. The article then will argue for a commitment to a social and economic rights framework as a key part of efforts to end the HIV epidemic. The social and economic rights critical to ending the HIV epidemic are those that would lift women and their families out of poverty, help them secure stable housing, give them the economic means to leave violent relationships, and give them access to health care. These rights include a right to a minimum level of economic support, a right to housing, and a right to health. A commitment to this rights-based framework would offer descriptive, practical, and aspirational benefits necessary to eradicate the HIV epidemic among U.S. women.

Women and HIV/AIDS: Socioeconomic Factors Drive the Epidemic

During the past two decades, the rate of new HIV infections in the general population has remained steady at about 56,000 new infections each year.[5] But in that same period, the rate of new HIV/AIDS cases among women has climbed.[6] Even more troubling, the burden of HIV infection in the United States falls squarely on the shoulders of poor women, women of color, and women who have experienced intimate partner violence.[7] While HIV is well known to be a risk for men who have sex with men and intravenous drug users—which is reflected in the traditional focus on these populations in prevention and treatment campaigns—policy makers, advocates, and public health researchers in the United States have only recently begun to take note of, and respond to, the growing epidemic among women.[8] Examining HIV's impact on women is critical, because women are uniquely vulnerable to HIV infection. The factors that place women at risk are deeply connected to social and economic inequality rather than the individual behavioral risk factors that have been the focus of traditional prevention efforts.

When HIV/AIDS was first identified in the United States more than twenty-five years ago, few women were infected with the virus. However, the rate of HIV infection among women has more than tripled since 1985, when women made up just 8 percent of new diagnoses.[9] By the early '90s, that number had grown to 14 percent;[10] in 2011, women made up 24 percent of new HIV diagnoses.[11] The most recent public health research points to socioeconomic factors—principally poverty and violence—as the primary drivers of HIV risk for women. As a

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[3] Hazel D. Dean & Kevin A. Fenton, *Addressing Social Determinants of Health in the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections, and Tuberculosis*, 125 PUB. HEALTH REP. 1, 1 (Supp. 4 2010), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2882967/.

[4] *See generally* Daniel Whelan, *Human Rights Approaches to an Expanded Responseto Address Women's Vulnerability to HIV/AIDS*, 3 HEALTH AND HUMAN RIGHTS 20, 22 (1998), available at http://www.ncbi.nlm.nih.gov/pubmed/10347373; Carolynne Shinn, *The Right to the Highest Attainable Standard of Health: Public Health's Opportunity to Reframe a Human Rights Debate in the United States*, 4 HEALTH AND HUMAN RIGHTS 114, 129 (1999), available at http://www.ncbi.nlm.nih.gov/pubmed/10438557.

[5] H. Irene Hall et al., *Estimation of HIV Incidence in the United States*, 300 JAMA 520, 525 (2008), available at http://www.ncbi.nlm.nih.gov/pubmed/18677024.

[6] *See* Hodder et al., *Challenges of a Hidden Epidemic, supra* note 3.

[7] *See id.*

[8] *See, e.g.*, Dean & Fenton, *supra* note 4; Amie L. Meditz et al., *Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection*, 203 J. INFECT. DIS. 442 (2011), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071223/.

[9] E.L. Machtinger et al., Recent Trauma is Associated with Antiretroviral Failure and HIV Transmission Risk Behavior Among HIV-Positive Women and Female-Identified Transgenders, 2012 AIDS BEHAV 1, 1 (March 17, 2012), available at http://www.springerlink.com/content/n164716853x285h7/fulltext.pdf.

[10] *Id.*

[11] Ctrs. for Disease Control & Prevention, *HIV Among Women*, 1, available at http://www.cdc.gov/hiv/topics/women/pdf/women.pdf.

result, researchers now insist that any response to the epidemic must include structural changes that reduce poverty and improve the status of low-income women.[12]

The Role of Poverty

Groundbreaking new studies have confirmed what public health experts and those at the front lines of the HIV epidemic have long suspected: there is a direct correlation between living in poverty and being at high risk for HIV infection, particularly for women.[13] The demographic impact of HIV/AIDS illustrates the role economics plays in driving infection rates. In America, women, particularly women of color, are disproportionately poor. Black and Latina women, who are only 25 percent of the population, make up nearly 80 percent of all new HIV/AIDS diagnoses among women in the United States today.[14] Put another way, one in every 526 white women will be diagnosed with HIV in her lifetime; for Latinas, the rate is one in 106, and for black women, the rate is one in 32.[15]

The most recent research on HIV prevalence in areas of concentrated poverty makes clear that nothing about race or ethnicity drives the differences in infection rates. Infection rates for poor whites, blacks, and Latinos are essentially the same—the controlling factor in HIV infection among women is poverty.[16] In one study of high-poverty communities, more than 40 percent of women in the study did not know the HIV status of their last sexual partner.[17] The complex set of factors that combine to increase HIV risk for poor women is not well understood, as researchers are still in the early stages of work on this issue in the United States. However, a few elements of the problem are apparent: Low-income women and their partners are less likely to have access to health care and thus much less likely to be tested, diagnosed, and treated for HIV.[18] As a result, even women whose partners would use condoms may not be aware of the need for them. In addition, a lack of testing inevitably leads to later diagnoses of HIV, a factor that further increases the likelihood that an infected partner will transmit the virus because HIV transmission risk increases as the disease advances.[19]

Once diagnosed, low-income individuals are less likely than their wealthier counterparts to have access to health care at all, let alone quality health care and anti-retroviral treatment.[20] This, in turn, further increases infection rates, as recent research shows that individuals who receive treatment are drastically less likely to infect a sexual partner. Researchers have found that HIV-positive individuals who maintain consistent treatment are far less likely to transmit the infection during intercourse.[21] When poor Americans, women and men, are denied access to

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[12] *See* Hodder et al., *Challenges of a Hidden Epidemic*, *supra* note 3.

[13] *See id. See also* Press Release, Ctrs. for Disease Control & Prevention, *supra* note 3.

[14] Machtinger et al., *Recent Trauma*, *supra* note 10, at 2. In this study, white and Asian women were included in the same category.

[15] *HIV Among Women*, *supra* note 12.

[16] Paul Denning & Elizabeth DiNenno, *Communities in crisis: is there a generalized HIV epidemic in impoverished urban areas of the United States?* XVIII International AIDS Conference, 2 (July 18-23, 2010), available at http://www.cdc.gov/hiv/topics/surveillance/resources/other/pdf/poverty_poster.pdf.

[17] *See* Hodder et al., *ISIS Study*, *supra* note 3.

[18] Ctrs. for Disease Control and Prevention, *Risk, Prevention, and Testing Behaviors Related to HIV and Hepatitis*, May 2005–February 2006, 29, available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/pdf/hiv_surveillance_special_report_7.pdf.

[19] Earlier diagnosis decreases likelihood of transmission not only by allowing HIV-positive individuals to become abstinent, but also by beginning treatment that can reduce risk of transmission even if individuals remain sexually active after notification. *See* discussion of viral load, antiretroviral treatments and effects on transmission, *infra* note 22.

[20] *See* Marcie S. Rubin et al., *Examination of Inequalities in HIV/AIDS Mortality in the United States from a Fundamental Cause Perspective*, 100 AM. J. PUB. HEALTH 1053, 1057 (June 2009), available at http://www.ncbi.nlm.nih.gov/pubmed/20403885.

[21] Treatment reduces the risk of sexual transmission in a variety of ways, but most prominently through pharmaceuticals that reduce patient's 'viral load,' or concentration of the virus in the blood and tissue. *See* Thomas C. Quinn et al., *Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1*, 342 NEW ENG. J. MED. 921, 923 (2000), available at http://www.ncbi.nlm.nih.gov/pubmed/10738050. Viral load is the best predictor of the risk of heterosexual transmission, and modern antiretroviral therapy can greatly reduce viral load for HIV positive individuals. *See, e.g.*, Massimo Musico et al., *Antiretroviral Treatment of Men Infected With Human*

effective treatment, the emerging scientific consensus suggests that they are also losing access to one of the most effective means of preventing new HIV infections.[22]

The consensus emerging from the field of public health is clear: given the relationship between poverty and HIV/AIDS, prevention efforts must include a response that improves economic conditions for women.[23] Unfortunately, the insight that poverty is a primary driver of HIV infection comes at a time when the social safety net in the United States does not provide the support low-income women need to lift themselves and their families out of poverty.[24] The kind of systemic change required to end the epidemic will be realized only through legal and public policy reforms. Such reforms include expanding and improving social welfare programs such as direct cash payments, food stamps, housing assistance, health care, and child care, as well as expanding women's access to job training and education.

The Role of Violence

In addition to poverty, intimate partner violence is a systemic problem that is an established risk factor for HIV infection among women. Two recent studies–the first to compare rates of intimate partner violence for women with and without HIV—show highly disproportionate rates of recent trauma and post-traumatic stress disorder among HIV-positive women as compared to the general population of women.[25] In fact, the rate of intimate partner violence among women with HIV is 55 percent, more than twice the national rate.[26]

Three major aspects of intimate partner violence lead to increased risk of HIV infection. First, women who are in violent or coercive relationships are less likely to be able to negotiate safe sex practices or encourage a sexual partner to be tested for HIV.[27] While traditional prevention strategies focus on condom use as an effective means of preventing the transmission, this method has little viability for women who are victims of abuse. Some abusive men may refuse to wear condoms at all, while women who are victims may fear the violence will increase if they ask their partner to use a condom.[28] In addition, rape and sexual assault are common in violent relationships.

Immunodeficiency Virus Type 1 Reduces the Incidence of Heterosexual Transmission, 154 ARCH. INTERN. MED. 1971, 1971 (1994), available at http://www.ncbi.nlm.nih.gov/pubmed/8074601; Chi-Tai Fang et al., *Decreased HIV Transmission after a Policy of Providing Free Access to Highly Active Antiretroviral Therapy in Taiwan*, 190 J. Infect. Dis. 879, 881-82 (2004), available at http://www.ncbi.nlm.nih.gov/pubmed/15295691.

[22] "Treatment as prevention" is controversial among people living with HIV/AIDS and their advocates because it raises the possibility that some governments may choose to make testing and treatment mandatory. *See, e.g.*, Dale O'Leary, *How Not to Prevent AIDS*, CRISIS MAGAZINE, Apr. 20, 2012, available at http://www.crisismagazine.com/2012/how-not-to-prevent-aids (criticizing the opposition to an HIV policy that more closely resembles the public health measures enacted to combat SARS or tuberculosis, involving mandatory notification and testing). For a discussion of the relevant social constructs at work in disease prevention policy, *see* Wendy E. Parmet, *Dangerous Perspectives: the Perils of Individualizing Public Health Problems*, 30 J. LEG. MED. 83, 108 (2009), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1361704.

[23] *See generally, supra* note 3 and accompanying text.

[24] *See, e.g.*, Steven Devereux, *Can Social Safety Nets Reduce Chronic Poverty?*, 20 DEV. POL. REV. 657, 672 (2002), available at www.africacsp.org/wahenga/.../devereux02_dpr_v20n5.pdf (finding that well-implemented social safety nets worked to significantly reduce poverty in vulnerable populations).

[25] E.L. Machtinger et al., *Psychological Trauma and PTSD in HIV-Positive Women: A Meta-Analysis*, 2012 AIDS BEHAV 1, 6. (Jan. 17, 2012), available at www.natap.org/2012/HIV/psychologicaltraumawomenhiv.pdf.

[26] *Id.*, at 1; Machtinger et al., *Recent Trauma*, *supra* note 10, at 7-8. In addition, the overall health outcomes for women who are in violent relationships are much poorer than for women who are not victims of violence, mainly because women who are victims of violence find it much more difficult to access medical care and fully utilize their treatment options.

[27] *See* Jacquelyn C. Campbell, *Health consequences of intimate partner violence*, 359 LANCET 1331, 1332 (2002), available at www.nnvawi.org/pdfs/alo/campbell_1.pdf (describing the various mechanisms through which gynecological problems, including transmission of HIV, are "the most consistent, longest lasting, and largest physical health difference between battered and non-battered women").

[28] Gina M. Wingood & Ralph J. DiClemente, *The Effects of an Abusive Primary Partner on the Condom Use and Sexual Negotiation Practices of African-American Women*, 87 AM. J. PUB. HEALTH 1016, 1017, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380941/.

Second, women are at greater biological risk for HIV transmission during heterosexual intercourse.[29] This means that, as a matter of physiology, women are more than twice as likely as men to be infected through unprotected heterosexual intercourse.[30] In fact, 85 percent of all American women who contract the disease are infected through heterosexual intercourse.[31] Tragically, this risk increases in violent or coercive relationships not only because abusive partners are less likely to use condoms,[32] but because the biological risk of vaginal or anal tearing, and thus the exchange of bodily fluids that may transmit HIV infection, is much higher during a violent or coercive sexual encounter.[33]

Third, and perhaps most critically, intimate partner violence interacts with poverty to further increase women's risk of infection and complicate women's efforts to protect themselves. While women of all socioeconomic groups may be victims of intimate partner violence, women living in extreme poverty are more likely to be violently attacked by intimate partners than women with higher incomes, and low-income women face serious economic barriers to leaving a violent relationship.[34] A victim of abuse may be dependent on her abusive partner for housing, transportation, or childcare. The isolation and control a violent partner may exert over her may leave her with no economic means to escape.[35] Poverty and violence have a powerful reflexive relationship that increases women's risk of HIV exposure. It is widely accepted by experts that intimate partner violence makes women poor and keeps them poor, making it that much more difficult for women to access HIV testing or treatment.[36]

Living in concentrated poverty exposes women to sexual partners who are more likely to be living undiagnosed with HIV, while poor women are more likely to be trapped in violent relationships where they cannot negotiate safe sex practices. The complex interaction of poverty and violence creates massive barriers to stability, good health, and upward mobility, effectively blocking women's access to fundamental social goods, including health care, stable housing, employment opportunities, and supportive social networks. The dynamics that interact to increase HIV risk for low-income women are complex but clearly driven by systemic factors. As a result, HIV prevention for women at risk must take into account the social, economic, political, and legal forces that shape the lives of low-income women.

Toward a Social and Economic Rights Framework

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[29] Nancy S. Padian et al., *Female-to-Male Transmission of Human Immunodeficiency Virus*, 266 JAMA 1664 (September 25, 1991), available at http://www.ncbi.nlm.nih.gov/pubmed/1886189.

[30] *Id.* at 1664; European Study Group on Heterosexual Transmission of HIV, *Comparison of female to male and male to female transmission of HIV in 563 stable couples*, 304 BRIT. MED. J. 809, 811 (March 28, 1992).

[31] Joseph Prejean et al., *Estimated HIV Incidence in the United States, 2006–2009*, 6 PLOS ONE 7 (2011), available at http://www.plosone.org/article/fetchObjectAttachment.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0017502&representation=PDF.

[32] Donna A. Champeau & Susan M. Shaw, *Teaching About interlocking Oppressions: The Case of HIV and Women*, 14 FEMINIST TEACHER 208, 211 (2008), available at http://www.jstor.org/stable/10.2307/40545892; Melissa Moore, *Reproductive Health and Intimate Partner Violence*, 31 FAMILY PLANNING PERSPECTIVES 302, 304 (1999), available at http://www.guttmacher.org/pubs/journals/3130299.html (last visited July 26, 2012).

[33] Lawrence O. Gostin et al., *HIV Testing, Counseling, and Prophylaxis After Sexual Assault*, 271 JAMA 1436, 1437 (1994), available at http://www.ncbi.nlm.nih.gov/pubmed/8176804; Heidi Resnick et al., *Rape-Related HIV Risk Concerns Among Recent Rape Victims*, 17 J. INTERPERSONAL VIOLENCE 746 (July 2002), available at http://jiv.sagepub.com/content/17/7/746.full.pdf.

[34] Lisa A. Goodman & Deborah Epstein, LISTENING TO BATTERED WOMEN: A SURVIVORCENTERED APPROACH TO ADVOCACY, MENTAL HEALTH, AND JUSTICE 15, 22 (2008) *citing* J. Raphael, *Rethinking criminal justice responses to intimate partner violence*, 10 VIOLENCE AGAINST WOMEN 1352, 1357-58 (2004), available at www.biscmi.org/aquila/Mills_Bk_reviewed--Rapheal.pdf.

[35] Moore, supra note 32, at 304; Richard L. North et al., Sounding Board: Partner Notification and the Threat of Domestic Violence Against Women with HIV Infection, 329 NEW ENG. J. MED. 1194 (1993).

[36] *See, e.g.*, Geeta Rao Gupta, *How men's power over women fuels the HIV epidemic*, 324 BRIT. MED. J. 183 (2002), available at http://www.ncbi.nlm.nih.gov/pubmed/11809629; Goodman & Epstein, *supra* note 34, at 105-09 (discussing how poverty is not only a key predictor of the likelihood of partner violence but also how "battering increases women's risk of poverty" and "pushes many women into homelessness").

Following the announcement of the Obama Administration's "National HIV/AIDS Strategy"[37] and the publication of new research on the link between poverty and HIV, leading HIV/AIDS researchers are calling for a response to HIV/AIDS that addresses socioeconomic and structural factors that drive infection rates.[38] Public health experts have published study after study outlining the complex factors that drive the disease—namely poverty, lack of access to health care, lack of stable housing, and violence—and have argued that these factors are particularly powerful for women.[39] To end HIV among women, this consensus tells us, we must create meaningful structural change that would raise women's economic status, and we must increase access to stable housing and provide access to quality health care.

Given the goal of creating meaningful structural change, it is time to integrate a framework of social and economic rights into existing efforts to stop the epidemic.[40] This framework would serve three purposes, descriptive, pragmatic and aspirational, as discussed in greater detail below. First, it is necessary to provide background on the history of social and economic rights in American legal thought and constitutional doctrine.

Social and economic rights are acknowledged in international legal discourse as a key part of the basic package of fundamental human rights.[41] These include, but are not limited to, rights to shelter, health care, economic support, work, and nutrition, all of which require governments to take some affirmative action to effectuate them. These rights, also known as positive rights, are commonly contrasted with negative rights, which include rights to be free from government interference. Negative rights include the civil and political rights familiar to all Americans, such as the rights to freedom of speech and property.

Most modern democratic constitutions and many international instruments include explicit guarantees of social and economic rights, in stark contrast to the U.S. Constitution. In many Western industrialized nations, including Canada and much of Europe, the rights to health, health care, education, and income are constitutionally

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[37] The White House Office of National AIDS Policy, NATIONAL HIV/AIDS STRATEGY, available at http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf. The strategy acknowledges that the HIV/AIDS epidemic has continued to center on certain high-risk populations. It celebrates some important breakthroughs, such as the development of retroviral drugs, but notes that limited access to healthcare in the US has made such treatments unavailable to many of the populations most at risk to be infected with HIV. Two of the strategy's three primary goals directly address this issue: "1) Reducing the number of people who become infected with HIV; *2) increasing access to care and improving health outcomes for people living with HIV; and, 3) reducing HIV-related health disparities*." (emphasis added).

[38] Z. Gant, *A County-Level Examination of the Relationship Between HIV and Social Determinants of Health: 40 States, 2006-2008*, 6 OPEN AIDS J 1 (2012), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3286852/; Dean & Fenton, *supra* note 4.

[39] Hodder et al., supra note 3; Whelan supra note 5, at 22; Elise D. Riley et al., Basic Subsistence Needs and Overall Health Among Human Immunodeficiency Virus-infected Homeless and Unstably Housed Women, 174 AM. J. EPIDEMIOL. 515, 520-21 (2011), available at http://aje.oxfordjournals.org/content/early/2011/07/11/aje.kwr209.abstract.

[40] 41Among the key issues raised by any conversation about rights is the fundamental question of the practical and analytic usefulness of the positive/negative rights distinction. A full engagement with this conversation is beyond the scope of this paper. Many scholars have effectively attacked the dichotomy and exposed its fundamental flaws. This author believes that there is no compelling analytic difference, only political and historically contingent differences, between what American legal discourse commonly understands as positive and negative rights. For example, a common distinction between positive and negative rights is that the former requires government action but the latter only restricts government from acting. However, the classic negative rights, such as the right to property, all require some form of government action, and often, extensive administration, to protect the right. For ease of categorization, this article will use the terms insofar as they are useful in reflecting the common understanding in American legal thought and rights jurisprudence.

[41] *See generally* Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948); International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (Dec. 16, 1966).

recognized, enforced by courts, and realized through a range of social welfare programs.[42] In developing nations, legislatures and courts are struggling to define, develop, and enforce social and economic rights guarantees in the face of powerful economic and infrastructure limitations.[43]

In contrast, when other nations amended existing constitutions or drafted new ones during the 20th century to affirm the importance of social and economic rights, the United States remained steadfastly committed to a negative rights framework. Despite a series of cases in the 1960s suggesting that the Supreme Court might begin to locate social and economic rights in the U.S. Constitution,[44] beginning in the 1970s the Court explicitly and repeatedly held that the Constitution only protects the right to be free from government interference with certain liberties, but no rights to affirmative government action.[45] In this way, the United States is out of step with modern understandings of the role of government in recognizing and realizing basic human rights.

This resistance to social and economic rights has led to a decline in the United States' standing as a model for emerging democracies. Recent data indicates that the U.S. Constitution has in fact become the "anti-model" of constitutionalism and an example of mistakes to avoid in constitutional drafting, in structure as well as the substance of enumerated rights.[46] U.S. Supreme Court Justice Ruth Bader Ginsburg recently noted that if she were to recommend a model for drafting a modern constitution, she would not look to her country's 18th-century natural rights-based constitution but to modern constitutions that recognize a broad commitment to human rights, such as the Canadian Charter of Rights and Freedoms and the South African Constitution.[47]

Why Rights?

In the context of responding to the HIV epidemic, the United States is a clear outlier on social and economic rights.[48] In the international community, there is a consensus that HIV/AIDS implicates such rights and that the epidemic cannot be stopped without systemic changes that attack economic and gender inequality.[49] For those who advocate incorporating a social and economic rights framework into U.S.-based HIV prevention efforts, the ultimate goal is the recognition and enforcement of legal claims to social and economic rights, particularly rights to a minimum level of economic support, health, and housing. The short-term goal is to integrate a vision of social justice and systemic change into the conversation about the HIV epidemic, which in turn may build support for efforts to enact legislative and policy changes that begin to address the interrelated problems of poverty, violence, and gender inequality. Such reforms would include economic support, housing, and health care access for low-

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[42] *See generally* Mary Ann Glendon, *Rights in Twentieth-Century Constitutions*, 59 U. CHI. L. REV. 519 (1992), available at http://www.jstor.org/stable/10.2307/1599944; Puneet K. Sandhu, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151 (2007), available at http://www.jstor.org/stable/20439121; Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?*, 56 SYRACUSE L. REV. 1 (2005), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=375622.

[43] *See* Gov't of S. Afr. v. Grootboom 2000 (11) BCLR 1169 (CC) (S. Afr.), available at http://www.constitutionalcourt.org.za/uhtbin/cgisirsi/HTiGeqUSoP/MAIN/101130006/9#top (claiming a constitutional right to shelter after petitioners became homeless and were evicted from private land); David S. Law & Mila Versteeg, *The Declining Influence of the United States Constitution*, 87 N.Y.U. L. REV. 762, 830 (2012).

[44] CASS R. SUNSTEIN, THE SECOND BILL OF RIGHTS 23 (2004).

[45] *Id.* at 90.

[46] Law & Versteeg, *supra* note 43, at 773; *see also* Heinz Klug, *Model and Anti-Model: The United States Constitution and the "Rise of World Constitutionalism"*, 2000 WIS. L. REV. 597 (2000), available at http://www.law.wisc.edu/profiles/pubs.php?iEmployeeID=155.

[47] Adam Liptak, *'We the People' Loses Appeal With People Around the World*, N.Y. TIMES, Feb. 6, 2012, available at http://www.nytimes.com/2012/02/07/us/we-the-people-loses-appeal-withpeople-around-the-world.html?_r=1.

[48] The logical coherence and the historical and practical impact of making of rights claims is the subject of a vast body of scholarly literature, with the critique of the indeterminacy of rights of notable importance. A discussion of this literature is beyond the scope of this paper, but a development of key concepts may be found in Mark Tushnet, *An Essay On Rights*, 62 TEX. L. REV. 1363 (1984); Robin West, RE-IMAGINING JUSTICE (2003).

[49] Office of the U.N. High Comm'r for Human Rights & UNAIDS, *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version 85* (2006), available at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.

income women, their families, and their communities. However, as discussed below, a commitment to social and economic rights offers three key benefits. These benefits are descriptive, pragmatic and aspirational.[50]

The Descriptive Purpose

While HIV/AIDS is clearly a public health problem that requires traditional public health responses, it is also a problem driven by systemic forces and thus by political power. A major benefit of a rights-based framework is that it accurately identifies the epidemic as a problem with legal and political dimensions and one that implicates the fundamental interests of those affected.[51] The language of rights is inevitably the language of entitlements and of power. As a historical matter, rights claims implicate the political power of the group claiming the right, the role of the legal system in assessing and enforcing the right, and, insofar as social and economic rights describe the basic social goods that all people need to thrive, fundamental human needs.

HIV/AIDS is a disease that has its most devastating impact on and poses the highest risk to the least politically and economically powerful groups in America. It is a disease perpetuated by poverty and inequality and thus requires systemic responses that necessitate state action. The HIV epidemic has clear political dimensions in that the greatest impact of the disease is felt among those groups who have the least and most diffuse political power. Women at risk for HIV represent some of the most marginalized segments of our society in terms of economic strength, political force, social status, and access to the legal system.[52] To state that the rights of women are violated when they are placed at risk for HIV for reasons beyond their control is to recognize the broad and severe impact of the problem, to identify the complex structural forces at play, and, perhaps most critically for the purposes of this discussion, to call for legal justice remedies.

In legal discourse, a rights-based claim serves to describe a problem as an injustice that requires a remedy. Two of the leading indicators of HIV risk for women—poverty and violence—are themselves problems with legal dimensions. The entrenched nature of poverty among women can be traced to a legal system that makes some women poor and keeps them poor, and recognizes a limited role for the state in remedying poverty. Lack of access to health care for low-income women is directly traceable to a legal system that does not recognize health as a fundamental human right. The widespread role of violence in relationships reflects a legal system that implicitly, and often explicitly, condones such violence. Employing a rights-based framework in the context of HIV prevention describes the powerful injustices at work, namely the lack of government accountability for the social forces that place women at risk for HIV, which is directly due to the lack of political power of the women most affected by the epidemic, while at the same time pointing to the importance of developing legal tools to remedy the structural failings that drive the epidemic.

The Pragmatic Purpose

Given the powerful resistance to social and economic rights in Supreme Court jurisprudence over the past thirty years, it is unlikely that the Court will locate such rights in the federal constitution at any point in the near future.

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[50] This argument is not meant to suggest that the incorporation of a social and economic rights framework as a response to HIV/AIDS is the only way or the inevitable way to end the HIV epidemic or force systemic change that reduces poverty and violence, but to suggest one possible path towards reform.

[51] For a critique of this view, which asserts that rights do not reflect the value of our lived experiences, see generally Tushnet, *supra* note 48, at 1382-84.

[52] Low-income women are commonly demonized in popular media and political discourse and blamed for a host of social ills, from higher crime rates to failing schools to changes in the institution of marriage. Over the past two decades in America, a period that coincides with the increasing rates of HIV infection among this population, the formerly spare social safety net that once provided at least a measure of support for low-income families has been cut back to essentially nothing. Today, a woman struggling to raise her family has no hope of subsidized child care, faces a five-year lifetime limit on cash assistance, and has little hope of receiving health care if she works even a low-wage job.

However, in the U.S. system, there is another source of constitutional support: the constitution of every state in the nation contains at least some commitment to social and economic rights.[53]

Historically, state courts have been reluctant to enforce social and economic rights guarantees due to concerns about institutional competence and a view that within our federal system the Supreme Court sets the outer limit on what may be recognized as constitutional rights.[54] However, in recent years, a small but growing movement of advocates and legal scholars has begun developing a jurisprudence of social and economic rights through state constitutional law.[55]

This project has been injected with a sense of possibility given the comparative example set by the South African Constitutional Court, which recently recognized a right to housing.[56] Many scholars have lauded the South African court's decision for its balance between the realities of limited government resources and the responsibility of government to meet the minimal needs of citizens.[57] The court declared the government had a duty to provide housing, then instructed the legislature to "devise and implement within its available resources a comprehensive and coordinated programme progressively to realize the right of access to adequate housing."[58] Thus, the court recognized a right to housing while also recognizing that a full realization of the right would take time and deferring to the legislature, alleviating some concerns about the court's competence to adjudicate rights claims.[59]

In the context of HIV prevention in the United States, there are three ideal structural reforms based on social and economic rights claims: poverty reduction through the provision of a minimum level of income support for women at risk; subsidized safe and affordable housing for those who cannot afford it; and a guarantee of health care.

Taking one example, poverty reduction, twenty-three state constitutions contain explicit language in support of claims that the state has a duty to provide for the needs of poor residents.[60] Following the South African model, securing a right to a minimum level of income support through state constitutional law might involve litigation in a state court seeking a declaratory judgment on the question of whether the legislature failed to sufficiently fund and implement the state's cash assistance program. A potential remedy might consist of a declaratory judgment finding that the legislature violated the state constitution's minimum guarantee of economic support and an order that the legislature develop policy responses within a reasonable period of time. The court might then retain jurisdiction to assess the legislative response as it develops.

Despite historical resistance in this country to social and economic rights claims, state constitutional law provides one pragmatic path toward promoting systemic reform for women at risk for HIV through such rights claims. While the path toward full realization of rights in this context will inevitably be long and complex, comparative

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[53] See Rava, Protections for the Poor, and Pascal, Welfare Rights, infra note 60; see also Jeffrey Omar Usman, Good Enough for Government Work: The Interpretation of Positive Constitutional Rights in State Constitutions, 73 ALB. L. REV. 1459 (2010).

[54] *See generally* Helen Hershkoff & Stephen Loffredo, *State Courts and Constitutional Socio-Economic Rights: Exploring the Underutilization Thesis*, 115 PENN ST. L. REV. 923 (2011), for a discussion of the role of the federal government in influencing state enforcement of socioeconomic rights. The adjudication of positive rights claims raises questions about the institutional role of the judiciary and the separation of powers, the institutional competence of the judiciary, and the practical limits of judicial involvement in the administrative and policymaking work of the legislature.

[55] A full treatment of the possibilities for advocacy at the state level is beyond the scope of this paper. For a discussion of existing efforts and analysis, *see id*. *See also* Burt Neuborne, *Foreword: State Constitutions and the Evolution of Positive Rights*, 20 RUTGERS L.J. 881, 893-901 (1989); Norma Rotunno*, State Constitutional Social Welfare Provisions and the Right to Housing,* 1 HOFSTRA L. & POL'Y SYMP. 111, 128-33 (1996); Usman, *supra* note 53.

[56] *Grootboom*, (11) BCLR 1169 (CC).

[57] *See e.g.,* Sunstein, *supra* note 44, at 209-230.

[58] *Grootboom*, (11) BCLR 1169 (CC) at 67 para. 99.

[59] This is often characterized as a "weak" form of judicial review.

[60] William C. Rava, *State Constitutional Protections for the Poor*, 71 TEMP. L. REV. 543, 551 (1998); *see also* Elizabeth Pascal, *Welfare Rights in State Constitutions*, 39 RUTGERS L.J. 863, 864 (2008).

examples, such as the South African experience, offer hope that social and economic rights are justiciable, even in the U.S. legal system.

The Aspirational Purpose

The language of social and economic rights is aspirational in that it invokes an ideal vision of what might be possible when a government makes a real commitment to protecting the basic human rights of its people. All rights claims, whether regarding positive or negative rights, begin as mere ideas, as ideals, and as expressions of fundamental values. Rights claims implicate our shared notions of justice and fundamental fairness and define the possible contours of the relationship between the state and the individual. Even where a particular articulated right is not yet justiciable or enforceable against the government, making the claim to that right stakes out a moral and political position that articulates an affirmative role for the state in protecting that right. To invoke the language of rights in the context of protecting women at risk for HIV is to describe an ideal that may not ever be fully realized, but which sets the highest possible achievable standard and thus shapes judicial interpretation, legislative actions, and advocacy conversations. Rights claims broaden our collective vision about what law and, by definition, government can achieve.[61] To claim a violation of fundamental rights where the government fails to protect or respond to the needs of women at risk for HIV is to offer hope for what is possible rather than a story about what is impossible.

Conclusion

Given the emerging consensus in the field of public health that the HIV epidemic among American women can be directly traced to the impact of economic and social inequality and cannot be stopped without structural interventions, ending the epidemic will require lifting women and their families out of poverty, offering women the economic means to leave violent relationships, providing secure stable housing, and securing access to health care. Integrating a framework of social and economic rights into HIV prevention efforts is essential to the success of any such efforts. And by doing so, those who seek to eradicate HIV among American women would achieve the descriptive goal of naming the powerful injustices that underlie the epidemic and revealing the importance of developing legal tools to remedy them; the pragmatic goal of forging new paths toward developing those legal tools; and the aspirational purpose of providing hope that such an outwardly daunting goal can in fact be achieved.

[61] For a notable rebuttal to this claim, see generally Tushnet, *supra* note 49.