A Capitol Offense:

The Gender Dimensions of Washington D.C.'s HIV/AIDS Crisis

A HUMAN RIGHTS REPORT
BY THE WOMEN'S COLLECTIVE
&
THE INTERNATIONAL WOMEN'S HUMAN RIGHTS CLINIC AT
GEORGETOWN UNIVERSITY LAW CENTER

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EXECUTIVE SUMMARY

Washington, D.C. is facing a modern epidemic, with the highest HIV/AIDS rate in the United States. In its response to this crisis, the D.C. government has failed to recognize the way policies and structural factors have interacted to increase women's vulnerability to HIV/AIDS. As a result, women have one of the fastest growing rates of HIV infections in D.C. Yet, the District has no integrated and multi-sectoral HIV policy, and its care and prevention plans lack a concerted government strategy to address the HIV/AID crisis for women.

This human rights report was written with the goal of beginning a dialogue in the District about women's unique needs in the HIV/AIDS epidemic and the way in which a human rights framework can best address the current gender gaps in the District's approach to HIV/AIDS. The report is the result of a partnership between The Women's Collective – an organization run by and for HIV-positive women in the District – working on the front lines of the HIV/AIDS crisis, and the International Women's Human Rights Clinic at Georgetown University Law Center.

Working together, the partners have highlighted and reported on key areas in which government programs, or the lack thereof, compromise women's health and rights and contribute to their greater exposure to HIV, or fail to serve the needs of women already living with the virus in the District. The report will focus on 1) the increasing and disproportionate impact of HIV/AIDS on women, and black women in particular; 2) barriers to accessing preventive health services, particularly mental health and substance abuse resources; 3) lack of affordable housing options placing women at risk of HIV transmission and creating barriers to care; and 4) failure to link HIV/AIDS prevention and treatment efforts to address pervasive rates of gender-based violence in the District.

To its credit, Washington, D.C. has proactively developed or implemented federal laws and policies to address issues of discrimination, health care, prevention, and housing as they relate to HIV. These laws and policies, however, do not go far enough and lack the cohesion and necessary integration to effectively stem the tide of the modern epidemic in Washington, D.C. To tackle the HIV/AIDS epidemic by achieving sustainable and long-tern results, the District must adopt a comprehensive HIV/AIDS policy guided by a human rights framework that addresses the prevention, care, and treatment needs of women. The D.C. government cannot continue to haphazardly plug holes in the dam rather than examine and strengthen the system as a whole.

The District, as in other parts of the United States, reflects a history of neglect and discrimination evidenced by extreme disparities in the rates of HIV/AIDS and other health outcomes among racial minorities and in particular minority women. These disparities must be addressed by incorporating a gender analysis into all polices related to HIV/AIDS in the District, making adjustments to current policies accordingly, and by the meaningful involvement of HIV-positive women in all levels of policy making.

As evidenced by the District's extremely high HIV rates, the government fails to provide adequate preventive care, testing, and treatment for HIV/AIDS to its residents, and, as a result, D.C. residents cannot enjoy their right to health. Mental healthcare and substance abuse treatment programs are insufficient, and this shortage undermines existing HIV/AIDS prevention and

treatment efforts. At the same time, HIV/AIDS testing and counseling are not provided consistently as a part of routine medical care, in both primary and emergency medical care. This oversight contributes to D.C.'s high rate of late testers – those who are diagnosed with AIDS within one year of first testing positive for HIV – and missed opportunities for prevention, early diagnosis, and treatment.

D.C. residents face a variety of barriers to accessing healthcare and effective treatment, hindering the success of existing HIV/AIDS testing, treatment, and prevention efforts. Insufficient transportation and child care resources, coupled with inflexible work schedules for the District's most vulnerable, impede prevention efforts by making preventive care nearly impossible to access. Patients lack basic health literacy and healthcare providers are not culturally competent, resulting in a breakdown of doctor-patient trust and communication that the District must address in the fight against HIV.

Existing laws to address homelessness in D.C. fall short of fulfilling the human right to housing and thereby increase vulnerability to HIV. D.C. faces an affordable housing crisis that increases the spread of HIV and limits the effectiveness of HIV treatment efforts, particularly for women. Families with children are one of the fastest-growing segments of the homeless population, and as many as 80% of homeless families are headed by women. Unstable housing diminishes the ability of these women to enjoy the right to health by interfering with their adherence to HIV treatment and putting them into situations where they must take risks to provide shelter for their families. To succeed in fighting the HIV epidemic, the D.C. government must recognize housing as a human right and take the necessary steps to ensure that it is fulfilled for D.C. residents.

Currently, the D.C. government has failed to acknowledge and address the intersection of two major threats plaguing the District—gender-based violence and HIV/AIDS. Failure to address this link leaves residents, many of them women, at a higher-risk for exposure to both HIV/AIDS and gender-based violence. HIV vulnerability may intersect with gender-based violence in four key ways: women in violent relationships may be infected by their abusers; childhood and past abuse are linked to increased likelihood of exposure to HIV/AIDS; survivors of gender-based violence may forego HIV testing or treatment for fear of violent retribution when their status becomes known; and many HIV-positive women suffer from abuse as a direct result of their HIV status. Current programs and policies in the District fail to meet the needs of individuals affected by both gender-based violence and HIV/AIDS. As a result, their rights to physical integrity, dignity, freedom from violence and degrading treatment, information, healthcare, and life are violated.

D.C. is experiencing a modern epidemic of HIV/AIDS. The statistics are shocking. At least 3% of District residents are living with the infection, giving D.C. the highest rate of any city in the country. Some estimates indicate that as many as one in twenty people in the District are living with HIV/AIDS. While the District has programs to prevent and treat HIV/AIDS, D.C. falls short in many ways, violating numerous human rights of District residents. The District's HIV/AIDS programs fail to serve the needs of women living with HIV/AIDS through systemic discrimination, inadequate access to healthcare, the insufficient provision of mental health and substance abuse programs, the absence of affordable housing options, and the alarming and pervasive rates of gender-based violence directed at women. In order to protect the human rights of women living in D.C. and to ensure effective prevention and treatment of HIV/AIDS, the D.C. government must take action to correct these shortcomings.

I. METHODOLOGY

This report was researched, and written through a partnership with The Women's Collective (TWC)[1] and the International Women's Human Rights Clinic at Georgetown University Law Center.[2] Between February and April 2009, teams of students and supervisors conducted 86 in-depth interviews, including three focus groups with HIV-positive women in Washington, D.C. Interviewees included women living with HIV /AIDS, providers of healthcare, social service and legal providers, local government employees and officials, and advocacy and non-governmental organizations (NGOs). Interviews ranged from one hour to two hours in length and were conducted on a completely voluntary and consensual basis. Interviewee ages ranged from 19 to 56 with education level ranging from high school to advanced public health, medical and legal degrees. In addition, interview teams conducted on-site observations of various medical and service delivery facilities, including hospitals and a mobile HIV-testing unit.

The in-depth interviews and focus groups aimed to give a voice to the many experiences shared by individuals affected by HIV/AIDS. This report intends to fill a gap in existing studies and reports on HIV in the District by bringing the human dimension of the HIV epidemic to the forefront. The report is also based on an extensive review of secondary sources, a survey of relevant local laws and policies, and an analysis of domestic, comparative, and international human rights instruments. The field and legal research identified patterns of shared experiences and trends relevant to policymakers in addressing the HIV/AIDS crisis in the District.

The investigation assessed D.C. and federal government compliance with local and international human rights standards that facilitate gender-responsive prevention, treatment, and care of HIV/AIDS. Based on the identified violations, the report is accompanied by proposed policy reforms to facilitate better compliance with women's human rights, especially in the context of HIV/AIDS in the District. Due to time and resource constraints, this report focuses on the intersection between HIV/AIDS and discrimination, healthcare and prevention services, housing, and gender-based violence. These topics were selected according to the pronounced needs of The Women's Collective's clients, and on trends that emerged through the investigation and research. While this report seeks to provide a thorough analysis of the issues selected, it should not be considered a comprehensive report but an introduction to several complex issues that must be further researched and addressed.

II. INCREASINGLY HIGHER HIV RATES AMONG WOMEN IN WASHINGTON, D.C. REMAIN UNADDRESSED

In D.C., women are more rapidly becoming infected with the virus than men. Between 2003 and 2007, the number of women living with AIDS increased at a rate of 27.2 percent compared with an increase of 22.1 percent for men. The District has more newly reported HIV cases among females than any other jurisdiction in the United States.

D.C. Department of Health, HIV/AIDS Epidemiology Update 2008

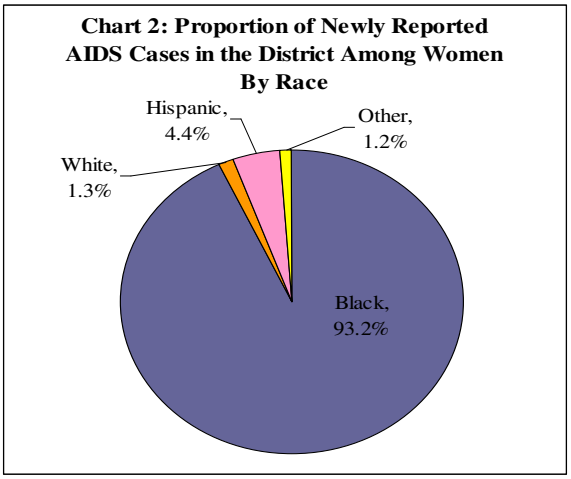
A. The Nation's Capitol Leads the Nation with the Most Severe and Diverse HIV/AIDS Epidemic in the Country

Washington, D.C. has the highest HIV/AIDS prevalence rate in the country with 3% of District residents known to be living with the virus.3 D.C.'s known prevalence rate is triple the "generalized and severe" epidemic level established by the Centers for Disease Control and Prevention (CDC).[4] Actual HIV/AIDS prevalence rates are likely even higher because, as Tiffany West-Ojo, Chief of the Bureau of Strategic Information in D.C.'s HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) has emphasized, these figures do not include "people infected who aren't yet diagnosed."[5] Nearly twenty-five years ago D.C. was "a pioneer" in its response to HIV/AIDS;[6] it was one of the first cities in the U.S. to appoint an AIDS Director and establish a dedicated office to monitor the AIDS epidemic. [7] Over the years, however, the District's response has fallen far short of what was necessary to adequately care for the diverse population of people living with HIV and prevent further infection, thus leading to the modern HIV/AIDS epidemic in the nation's capital.

As D.C.'s Department of Health (DOH) Director, Pierre Vigilance stressed in his introduction to the latest report on HIV/AIDS figures, the District has "the most diverse epidemic affecting every population group and neighborhood."[8] The dozens of HIV-positive women interviewed for this report echoed the sentiment expressed by a HIV Tester and Counselor and Field Supervisor for The Women's Collective: "HIV is hitting home. Relatives, friends, a partner – if you're not infected, you're affected. Almost everyone knows someone who has HIV."[9]

<u>D.C. has more newly reported case of HIV-positive women than anywhere in the U.S.</u>

Blanket statements about the high HIV/AIDS rates in D.C. veil the fact that increasingly more women, and in particular Black and Latina women bear the brunt of the epidemic. The epidemic has become increasingly feminized, both globally[10] and in D.C., yet public perceptions, including those of many policymakers and providers, continue to mischaracterize HIV/AIDS as a disease of homosexual men and injecting drug users. In D.C., women are more rapidly becoming infected with the virus than men. Between 2003 and 2007, the number of women living with AIDS increased at a rate of 27.2% compared with an increase of 22.1% for men.[11] The District has more newly reported HIV cases among females than any other jurisdiction in the U.S.[12] The impact has been especially devastating for Black women. Nationally, HIV/AIDS is now the leading cause of death for Black women ages 25-34[13] and one of the four leading causes of death for Black women regardless of age.[14] Black women are diagnosed with HIV/AIDS at a rate 23 times that of white women.[15] In Washington, D.C., Black women comprise more than half of all women living with HIV/AIDS and 25.8% of all persons living with the disease.[16] In 2007, Black and Hispanic women combined constituted 97.6% of all newly reported AIDS cases among women in the District.[17]



<u>Heterosexual sex emerging as leading mode of HIV transmission</u>

D.C.'s DOH updated HIV/AIDS figures suggest that "heterosexual contact is slowly emerging as the leading mode of transmission in recent years."[18] Women constitute 58% of heterosexuals living with HIV/AIDS in the District. The DOH report cautioned that given that D.C. has a "severe epidemic, persons engaging in any type of unprotected sex are at risk for becoming infected."[19] Amongst Blacks and Hispanics in D.C. the shift from men having sex with men (MSM) to heterosexual sex as the leading mode of transmission is most pronounced.[20] The top three leading modes of transmission reported among living HIV/AIDS cases are: MSM sexual contact (37%), heterosexual sex (28%), and injecting drug use (18%).[21] Blacks and females constitute the greatest number of HIV infections through heterosexual contact, with the majority of cases between the ages of 20 and 49.[22] Almost 60% of Black women living with HIV/AIDS attribute it to heterosexual sex. In contrast, only 20% of Black men, 28.3% of Hispanic men, and 6.7% of white men attribute this infection to heterosexual sex.

In locations like Washington D.C. where HIV rates are at epidemic levels, all unprotected sex, including sex with partners traditionally considered "low-risk" is high-risk sex. There is often a focus on changing individual behaviors as a means to stemming D.C.'s epidemic. Anecdotally, many attribute the high rates of HIV/AIDS among women to men who sleep with both men and women but fail to disclose their sexual behaviors or use protection with their partners. While this phenomenon may be one explanation for the high rates of transmission in heterosexual relationships, what is more significant is the extremely high viral load in the community, which makes all unprotected sex "risky." Regardless of a partner's status disclosure, failure to use protection in any sexual relationship opens both partners to the possible transmission of the HIV virus. Continued focus on the phenomenon of men on "the down low," or "DL," as the vector of HIV/AIDS in the heterosexual community[23] is likely to lead to further homophobia and misinformation about the nature of the modern HIV/AIDS epidemic and may even play a strong role in male partners' failure to disclose their status, or get tested in the first place. In 2006-2007, the DOH conducted its first HIV behavior study focusing on heterosexual relationships and HIV in Washington, D.C., finding very low rates of condom use and high rates of concurrent sexual relationships within the studied population.[24]

This report, however, is focused primarily on the structural challenges facing the residents of the District that lead to increased HIV/AIDS incidence. For example, HIV/AIDS transmission is complicated by the effects of disproportionate rates and the unique system of incarceration on communities in the District. Since 2001, D.C. inmates are held in two D.C. jail facilities[25] or, for felony convictions, in federal prisons across the country. In D.C., about "21,000 people pass through local correctional facilities each year," and "over 2,500 former prisoners return… from [federal] facilities outside of the area."[26] Whereas inmates in D.C. receive HIV testing and treatment, condoms are distributed, and ad hoc re-entry programs are run by local organizations, advocates are concerned about continuity of treatment once released. Concern is greater for people incarcerated in federal facilities where condom distribution is illegal, and health care is known to be inconsistent and at times negligible.

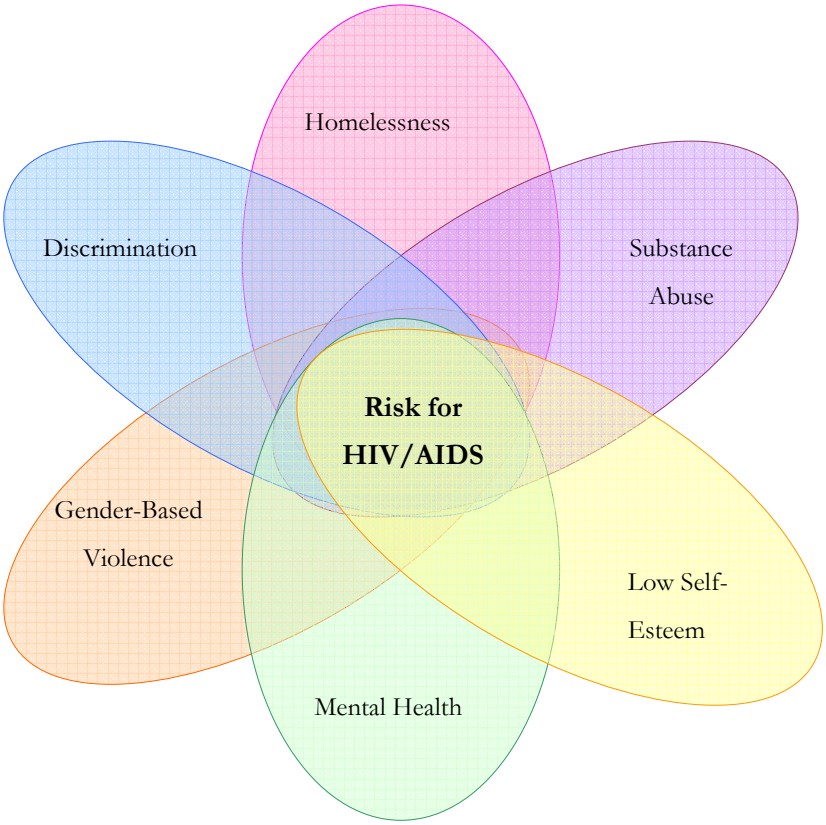
In 2008, almost 68% of incarcerated persons were late-testers, compared with 60.5% in the non-incarcerated population,[27] suggesting that both populations lack access to HIV testing. Several HIV-positive women interviewed have either found out their HIV status while incarcerated or suspect getting the virus from sexual relations with a formerly incarcerated man. According to the Deputy Director of Our Place, an organization that has served more than 5,000 incarcerated D.C. women since 1999, the vast majority of the women they service were nonviolent drug offenders, and "close to 95% of [these] women are survivors of domestic violence. Whether heterosexual or same sex domestic violence survivors."[28] No study has yet to be

conducted on the complex impact of incarceration on HIV in the District for the incarcerated person, the people left behind, and the community upon reentry.

B. The D.C. Government Failed to Anticipate and Address Women's Unique Vulnerabilities to HIV/AIDS

The economic and social conditions and human rights violations that place women at increased risk for HIV/AIDS intersect in complex ways. Women are increasingly and disproportionately affected by the virus because "biologically, socially, and economically [they are] more vulnerable to HIV infection."[29] The most vulnerable women find themselves at the center of overlapping policies, programs, and social dynamics that leave them ill-equipped to protect themselves from the disease and to achieve healthy outcomes once they have acquired the virus. (See Figure 1) For example, a Women's Collective case manager working with HIV-positive women estimated that 60 to 70% of the women she serves suffer from mental health issues, and 95% of her female clients have experienced sexual or other abuse.[30] In focus groups conducted for this report, several HIV-positive women related that drug addiction resulted in risk-taking behaviors: "You will do anything and everything that you thought you'd never do in order to get the drugs. If a man offers you some crack or some money and … he doesn't want to use a condom. Guess what? You're not going to use a condom."[31]

Figure 1



Likewise, women described trading sex for shelter to avoid sleeping on the streets or in a shelter: "If you don't have a place to stay, you're out on the street. A man is going to offer you a place to stay. But what you've got to do is sleep with that man to stay some place warm and sheltered in."

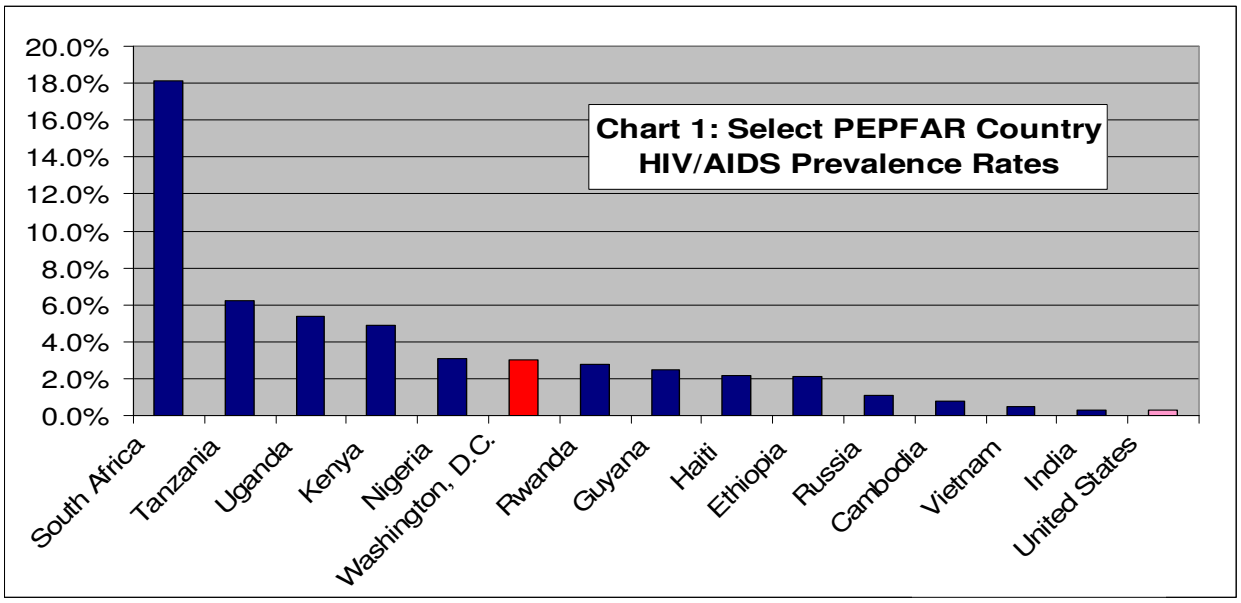
The intersecting effects of these conditions and violations demand a strategic and comprehensive response from the D.C. government that goes far beyond the much needed universal testing proposed by the HIV/AIDS Administration. A piecemeal approach will continue to fail because many women are at risk of infection as a result of multiple dynamics. Eliminating or ameliorating a single factor, therefore, does little to eliminate their overall risk. For women already living with the disease, addressing one factor alone still leaves multiple barriers to achieving positive and sustainable health outcomes. Moreover, the current lack of a comprehensive HIV policy in D.C. that directly addresses the gender aspects of the epidemic violates D.C. women's rights articulated in international human rights treaties and declarations. Both the federal and the D.C. government have failed to comply with the U.N. General Assembly consensus Declaration of Commitment on HIV/AIDS which obliged nations to "[b]y 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework."[32]

D.C. falls behind the majority of the world in addressing women and HIV

HIV/AIDS is so widespread in the District that the city's known prevalence rate is higher than the rates in Haiti, Rwanda, and six other countries that receive foreign aid funding to combat their epidemics through the President's Emergency Plan for AIDS Relief (PEPFAR).[33] Unlike D.C., the 20 countries designated for this HIV/AIDS assistance funding have national HIV policies and holistic, multi-sector plans to combat the epidemic. The District lacks an integrated HIV policy and its care and prevention plans lack a concerted government strategy to address the HIV/AIDS crisis for women. Notably, both PEPFAR and D.C. have focused on medical treatment, often at the expense of funding holistic and integrated programs that address the multiple needs of HIV-positive women, including protection of their civil and human rights, support with familial responsibilities, mental health, housing, and employment. These gaps illustrate the need for an integrated human-rights-based approach to the drivers of the HIV/AIDS epidemic.

Because D.C. lacks an HIV policy or plan which addresses the particular drivers and effects of HIV on women, it falls behind the majority of the world, including countries which have lower HIV rates, lower-incomes, and far less resources. In adopting the 2001 Declaration of Commitment on HIV/AIDS, U.N. Member States including the United States, committed to regularly report on their progress in responding to HIV. Based on these reports in 2008, in contrast to the U.S. and D.C., "a total of 80% of countries specifically address women as a component of their national HIV strategy… [and] about half (53%) of countries report budget allocations specifically devoted to HIV-related programmes for women and girls."34 Countries with specific women-focused programs and HIV policies, which employ a women's rights terminology include Cambodia, India, Papua New Guinea, South Africa and Zimbabwe.[35]

Global experts and national governments advocate for the "Three Ones"—one national HIV/AIDS action framework, one national HIV/AIDS coordinating authority, and one system for monitoring and evaluation— that draw upon fundamental principles of human rights and gender equality.[36] Both the federal and D.C. governments lack such a structure, which the U.S. typically requires from other countries – even those with lower HIV rates than in D.C.- before qualifying for HIV/AIDS funding.



Source: PEPFAR, Country Profiles at http://www.pepfar.gov/countries/nigeria/index.htm

C. The District Must Act Now To Prevent A Catastrophic Tipping Point

It is critical to act now before – as in many other regions of the world – D.C. reaches a tipping point where women's HIV rates far outstrip that of men. At the outset of the epidemic nearly three decades ago, women comprised a small ratio of people living with HIV/AIDS. Today, they account for half of the people living with HIV worldwide. Many of them are married or in what they perceive as monogamous relationships, where HIV is transmitted through heterosexual conjugal contact. Women "increasingly make up the majority in sub-Saharan Africa (61% of all adults living with HIV), and the proportion of women living with HIV is steadily growing in other regions…. In parts of Africa and the Caribbean, young women aged 15-24 are up to six times more likely to be HIV-positive than young men of the same age."[37] In the U.S., AIDS is the leading cause of death for African-American women ages 25–34 years,[38] and as detailed above, women in D.C. are more rapidly becoming infected with the virus than men and make up the lion's share of newly reported HIV cases.

Dr. Shannon Hader, Senior Deputy Director of HAHSTA in D.C., emphasized that historic models which presume that only individuals engaged in "high-risk behavior" are at risk for HIV are no longer appropriate because "a lot of the women who are getting infected have no idea they are at risk, because they have one partner. They don't necessarily have what you think of as high-level individual risk factors."[39] Dr. Hader underscores that even "normal behaviors and normal relationships" in a severe and generalized epidemic environment like the District put women at substantial risk for HIV/AIDS.[40] Dr. Peter Piot, retired UNAIDS Executive Director, offered a similar warning saying, "[w]e've seen it in every society. When you go beyond . . . 1 or 2 or 3 percent of infection in society, suddenly you get a logarithmic growth. You go outside classic groups that are at high-risk such as sex workers, truck drivers, injecting drug users and there is more heterosexual transmission."[41] Data from D.C.'s Bureau of Strategic Information suggests that D.C. is on the verge of such "logarithmic growth" since "heterosexual sexual contact is quickly becoming the leading mode of transmission among all HIV/AIDS cases."[42]

The U.N. Development Fund for Women (UNIFEM) explains that discrimination against women and imposed gender roles put women at greater risk for HIV both here and around the world:

Women's lower social, economic and political status hinders their human rights in ways that deprive them of protection from HIV. Even women with steady partners often cannot abstain from sex, insist that their partner use a condom or demand fidelity. Pervasive forms of violence against women - from rape to domestic abuse… - increase their chance of exposure. Once women have HIV, evidence suggests that gender discrimination poses obstacles to treatment.[43]

Without tackling these intersecting vulnerabilities, women in D.C. will continue to bear a disproportionate brunt of the HIV burden.

III. EXTENSIVE EXISTING HIV LAWS AND POLICIES LACK THE COHESION, OVERSIGHT, AND NAVIGABILITY NEEDED TO STEM A MODERN EPIDEMIC

Washington D.C. has proactively developed or implemented federal and local laws and policies to address issues of discrimination, health care, prevention, and housing as they relate to HIV. These laws and policies, however, do not go far enough and lack the cohesion and necessary integration to effectively stem the tide of the modern HIV epidemic in D.C. Enforcement mechanisms are not well developed – HIV-positive people are routinely discriminated against in housing, homeless shelters, and employment; agencies that facilitate provision of services to the community – e.g., Housing Opportunities for Persons with AIDS (HOPWA), Ryan White supportive services, domestic violence shelters, legal services, mental health services – are not sufficiently integrated; many government funded programs are not accessible to those who need them most because they are run in a culturally or medically inappropriate manner – many interviewees reported stigma and discrimination when seeking supportive services; programs suffer from chronic underfunding and lack of resources – currently hundreds of people are on waiting lists for permanent and temporary housing through federally- and locally-funded housing programs; and beyond the Ryan White Planning Council, the District has no formalized, meaningful inclusion of people living with HIV/AIDS in policy-making decisions.

A. The Robust D.C. Human Rights Act Still Lacks Enforcement and Its Insufficient Focus on Communities Most Affected by HIV has Lead to Discriminatory Outcomes for Women

The D.C. Human Rights Act, first passed in 1977, was "intended to end discrimination in the District of Columbia based on race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, disability, source of income, and place of residence or business."[44] The robust Act requires the District government to ensure that "individual[s] shall have an equal opportunity to participate fully in the economic, cultural and intellectual life of the District and to have an equal opportunity to participate in all aspects of life, including, but not limited to, in employment, in places of public accommodation, resort or amusement, in educational institutions, in public service, and in housing and commercial space accommodations."[45] This promise of equal human rights

has not come to fruition for many of the District's residents and this inequality is evidenced in the disparate rates of HIV/AIDS and other health outcomes among racial minorities and in particular, minority women. The district has an explicit responsibility to adequately address many of the structural and social drivers of the epidemic, such as, gender inequality and economic, educational and housing disparities. Failure to address the epidemic in the District from a gendered lens has lead to fatally discriminatory results for women.

The D.C. government has an obligation not only under domestic law but also under international law to rectify racial and gender disparities and discrimination in all aspects of society. By ratifying the International Convention to Eliminate all Forms of Racial Discrimination[46] (ICERD) in 1994, the U.S. Senate committed federal, state, and local government to "take effective measures to review governmental, national, and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists."[47] The International Covenant on Civil and Political Rights[48] (ICCPR), ratified by the U.S. in 1992, reinforces state guarantees of "equal and effective protection against discrimination" on the basis of race, color, or sex.[49] The U.S. Constitution guarantees all citizens equal protection under the law.[50] D.C.'s Human Rights Act protects individuals' "equal opportunity to participate in all aspects of life" in places of "public accommodation" which is defined to include clinics, hospitals, and housing units.[51] In passing the Human Rights Act, the D.C. City Council explicitly intended to end "discrimination for any reason other than that of individual merit, including, but not limited to, discrimination by reason of race, color, national origin or sex…."[52]

Under article 2 of ICERD, federal and local governments have a duty to "review … amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists."[53] Indeed, when the U.S. Senate ratified ICERD, it adopted a clarification acknowledging that "practices that have discriminatory effects are prohibited by certain federal civil rights statutes [including Title VI of the Civil Rights Act], even in the absence of any discriminatory intent underlying those practices."[54] In its 2007 report to the UN on compliance with ICERD, the U.S. cited a comprehensive government study that concluded that "U.S. laws, policies, and government institutions are fully consistent" with ICERD provisions prohibiting discrimination in effect.[55] While some U.S. case law favors prohibiting only intentional, direct discrimination, and not discrimination that in fact results in disparate impact,[56] the U.S. and D.C. governments must act consistently with their obligations under ICCPR and ICERD.

The 2007 U.S. report on implementing ICERD acknowledges that "a number of disparities in the prevalence of certain diseases and conditions among racial and ethnic groups . . . continue to exist."[57] After reviewing U.S. government compliance with ICERD in 2001 and again in 2008, the Committee on the Elimination of Racial Discrimination (CERD) specifically noted its concern over "growing disparities in HIV infection rates for minority women" across the U.S. and in the District.[58] The CERD Committee lamented that "despite the efforts of the State party, wide racial disparities continue to exist in the field of sexual and reproductive health… among women …belonging to racial, ethnic and national minorities, especially African Americans…."[59]

Disparities in health outcomes – in particular high rates of a preventable terminal infection, such as HIV – contravene article 5(e)(iv) of ICERD which requires that "States Parties undertake to prohibit and to eliminate racial discrimination in all its forms

and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: … (iv) The right to public health, medical care, … and social services" (emphasis added). While the U.S. has yet to explicitly recognize certain social and economic rights, such as right to healthcare and social services, the U.S. government clarified in its 2007 report on its compliance with ICERD, that Article 5 of CERD requires that it takes immediate action to "prohibit discrimination in the enjoyment of those rights to the extent they are provided in domestic law."[60] In line with this interpretation, the U.S. Commission on Civil Rights, an independent bipartisan federal commission charged with investigating, reporting, and making recommendations on civil rights concerns, has highlighted the discriminatory nature of gender and racial disparities in relation to state run programs and has emphasized states' duties to establish "quality assurance measures to ensure that minorities and women benefit equally" from any state sponsored programs.[61]

Persistent disparities in health outcomes reveal systemic discrimination in healthcare access and treatment for racial minorities.[62] Domestic and international laws prohibit both direct and indirect discrimination. Indirect discrimination "occurs when a practice, rule, requirement or condition is neutral on its face but impacts disproportionately upon particular groups." [63] ICERD in article 1 defines discrimination as "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life"[64] (emphasis added). The ICCPR, as interpreted by the Human Rights Committee in General Comment 18, echoes ICERD's definition of discrimination to encompass indirect discrimination "based on any ground such as race, colour, sex, … and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms."[65] While signed but not yet ratified by the U.S., the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)[66] reiterates this definition of discrimination in the specific context of sex-based discrimination.[67]

To bring the U.S. into compliance with its obligations under the ICERD, the CERD Committee has requested that the U.S. collect statistical data on health disaggregated by age, gender, race, and ethnic or national origin.[68] International HIV/AIDS experts, including the UN Agency on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), have emphasized that such "baseline data provides a common starting point for a situation analysis and for developing strategic interventions."[69] With the publication of epidemiological data in 2007 and 2009, the District has begun the task of painting an accurate picture of who is affected by HIV. This data, however, has not to this point been used by the District to identify and address the structural barriers women face[70] in order to craft effective HIV prevention, care, and treatment strategies that adequately address women's biological, social, and economic vulnerability to HIV. The UNAIDS Interagency Task Team on Gender and HIV/AIDS emphasizes that the realities of women and girls must be a central component of any successful HIV/AIDS strategic intervention.[71] D.C. officials likewise recognize their obligation to do more than sentinel surveillance, or to merely collect, monitor, and report HIV/AIDS health data. Tiffany West-Ojo, Chief of D.C.'s Bureau of Strategic Information, stated that, "Speaking on behalf of myself and my experiences, you have to use data to inform policies and programs…. You have to look at data as far as measuring the effectiveness of your programs."[72]

Yet, despite recently released disaggregated data that demonstrates increasingly disparate impact on women, particularly minority women, the District – apart from a testing and access to HIV medicine campaign - has yet to develop targeted intervention strategies that serve the needs of women infected and affected by HIV/AIDS.[73] The current D.C. Prevention Plan references women-centered, or gender role-focused interventions in the description of several "best-evidence and promising-evidence interventions" utilized around the country.[74] Notably, no training or replication/ intervention packets are available for virtually any of these programs.[75] Only one program cited addresses "Female- & Culturally-Specific Negotiation" with a focus "on the social context of women's daily lives. The intervention explores the meaning of gender-specific behaviors and social interactions, norms and values, and power and control."[76] Developed by the School of Public Health at Emory University in Atlanta, no training or interventions packets are available for its replication in the District.[77]

Rather than regarding "gender issues as special interests," D.C. must "treat gender as a critical consideration in policy formulation, planning, evaluation, and decision-making procedures."[78] Also known as gender mainstreaming,[79] this approach emphasizes that occasional or haphazard attention to the rights of women violates their right to equal protection and threatens the full realization of their human rights.[80] Rather than an "add-on or appendage," gender is understood as "a core element to be addressed in order to maximize the effectiveness" of every government policy or program.[81] Gender mainstreaming is premised "on the view that because gender matters, its differential effects must be analyzed in the context of all human rights activities."[82]

B. The Existing Health Care System Attempts to Address the Needs of People Living with HIV but Often Falls Short

While the District has several federally- and locally -funded programs in place to address HIV/AIDS and healthcare for low-income residents, gaps in healthcare provision related to the prevention and treatment of HIV/AIDS exist and the District lacks a comprehensive HIV policy that connects such programs cohesively. The primary agency responsible for the administration of the District's HIV/AIDS prevention and care activities is HAHSTA in the D.C. Department of Health.[83] HAHSTA receives D.C. government funds, as well as federal funding from the CDC, the Department of Health and Human Services (HHS) via the Ryan White Care Act program, and the Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HOPWA) program. HAHSTA then distributes some of these funds to community-based organizations working on prevention and care programs in D.C.[84] Funding from the federal government composes almost 90% of HAHSTA's budget, which has raised concerns about the extent of HAHSTA's ability to set prevention and care priorities that are specifically tailored to the needs of D.C.'s residents[85].

The federally-funded Ryan White program is the largest funder of HIV/AIDS-related programs in the District.[86] The District draws on the federal Ryan White Care Act to fund HIV medications through the AIDS Drug Assistance Program (ADAP). D.C. residents who earn up to 500% of the federal poverty line, or about $52,000 a year for a single person, can qualify for the program.[87] Insurance coverage does not disqualify residents from receiving assistance through ADAP.[88] The District has some discretion over Ryan White funding use. About 75% of these funds must be used for "core medical services" including outpatient and ambulatory health services, ADAP, early intervention services, health insurance premium and cost-sharing assistance, home healthcare, and medical nutrition therapy.[89] The remaining 25% of funds cover support services for people

living with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for healthcare and support services.[90]

Local and federal funding is also used to provide healthcare coverage to otherwise uninsured residents of the District. Medical care for uninsured D.C. residents is covered by one of three sources. The federally funded Medicaid program is one source of healthcare coverage for many District residents. Eligibility for Medicaid is determined by the D.C. Income Maintenance Agency.[91] Residents who are over 65 years of age, disabled, or have children under age 19 and meet the income guidelines may be eligible for Medicaid. For low-income residents that do not qualify for Medicaid, D.C. offers health insurance programs. The primary health insurance program for low-income residents, D.C. Alliance, was created in 2002 to provide health insurance for low-income District residents and to ensure low-income city residents can access preventive and primary care outside of emergency rooms.[92] D.C. Alliance coverage is available to District residents who do not qualify for Medicaid, do not have health insurance, and whose income is at or below 200 percent of the federal poverty line, or $20,800 a year for a single individual.[93] The D.C. Alliance's providers include many area hospitals, as well as private primary care and specialty care providers. In addition, the District offers the D.C. Healthy Families program to uninsured children under the age of 19 and their parents or guardians, and to pregnant women.[94]

The District recently increased its health insurance programs by creating Healthy D.C.[95] This program aims to cover uninsured District residents who do not meet the Medicaid or D.C. Healthcare Alliance income guidelines.[96] District residents who earn between 200 and 400 percent of the federal poverty level, or between $20,800 and $41,600 a year for a single individual, will be eligible.[97] Passed by the D.C. City Council, the program was originally scheduled to begin by July 1, 2009, but due to budget constraints it will likely be delayed.[98] In addition, federal Ryan White funding is used as a "last resort" to cover treatment and care costs for people living with HIV/AIDS who are not otherwise covered by federal or local insurance funds.[99]

Despite an impressive array of healthcare programs, D.C. fails to provide adequate prevention, testing, and treatment of HIV/AIDS. At least 3% of District residents have HIV or AIDS, surpassing the 1% threshold that signifies a generalized and severe epidemic.[100] Health experts consider a high HIV rate as an indicator of inadequacy in a healthcare system. As Carter Hewgley, Program Manager for Health and Human Services in the Office of the City Administrator, noted the city has "excellent health coverage, we almost have universal health coverage. We have terrible health outcomes for a lot of things, so we have a lot of evidence that the quality of healthcare is not adequate."[101]

HIV prevention, treatment, and care are severely curtailed by lingering barriers to accessing healthcare, the lack of mental healthcare and substance abuse treatment programs, and inconsistent and discretionary provider-initiated testing. Women face particular barriers to accessing HIV-related care, such as need for transportation and childcare to enable attending appointments, health literacy, and gender-specific cultural competency of healthcare providers.

C. Existing Laws Recognize the Importance of Housing and Acknowledge Its Role in HIV Treatment but Fail to Fulfill the Human Right to Housing

Federal housing assistance programs attempt to provide a safety net for homeless persons throughout the United States, but in D.C. they fall well short of the need. Through a variety of programs, the U.S. Department of Housing and Urban Development (HUD) provides funding for local housing assistance programs in the form of grants to individual jurisdictions and in some cases, directly to non-profit organizations which administer particular housing programs or facilities. Three major programs form the basic housing assistance framework in Washington, D.C.: the Housing Choice Voucher Program, more commonly known as Section 8 housing, the McKinney-Vento Homeless Assistance Act programs, and Housing Opportunities for Persons with AIDS (HOPWA).

The Section 8 program came into existence with the Housing and Community Development Act of 1974.[102] Section 8's major program is the provision of vouchers to eligible individuals and families to offset part of the rental cost of a housing unit. Eligibility for Section 8 vouchers is primarily income-based (with consideration of assets): recipients obtain a voucher and lease a housing unit, generally paying 30% of their income directly to the landlord as rent.[103] The public housing agency responsible for implementing Section 8 in a given jurisdiction pays the remainder of the rent directly to the landlord, up to the fair market rent – a HUD estimate of housing costs in the particular geographic area. Section 8 vouchers may be tenant-based, which permits the voucher holder to find a suitable unit, or project-based, where the voucher is restricted to a particular housing complex.[104]

Whereas Section 8 housing vouchers responded to the high cost of permanent housing relative to income, the McKinney-Vento Homeless Assistance Act of 1986[105] aimed to address the growing problem of homelessness by providing funding for shelter programs. Through formula grants, McKinney-Vento funding supports the operation and development of emergency shelters. The McKinney-Vento program also offers competitive grants to organizations in communities that have developed a "Continuum of Care,"[106] including supportive housing (e.g., transitional housing); the Shelter Care Plus program, which provides rental assistance to homeless individuals with disabilities; and single-room occupancy programs in rehabilitated dwellings.

The definition and interpretation of "homelessness" under the McKinney-Vento Homeless Assistance Act have impacted the availability of housing assistance for women in D.C., as this federal definition of homelessness has been incorporated into state and local policies.[107] Although the McKinney-Vento Act defines homelessness more broadly in its provisions for education of homeless children and youth,[108] the statute defines a homeless person generally as:

1) An individual who lacks a fixed, regular, and adequate nighttime residence; and
2) An individual who has a primary nighttime residence that is—
    a. A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
    b. An institution that provides a temporary residence for individuals intended to be institutionalized; or
    c. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.[109]

Based on extensive interviews in D.C., many HIV-positive women and providers highlighted the persistent problems facing women who have housing only through tenuous or volatile relationships. The current legal system leaves these women in an extremely vulnerable position because they are not eligible for housing assistance despite living in unstable, insecure housing. These are women who may be sleeping on a sofa at the home of a friend or distant relative (e.g. "couch surfing") or who enter into sex-for-a-place-to-sleep arrangements. They are not counted among D.C.'s homeless and cannot reliably access the resources available to combat homelessness. HUD's own interpretation of the McKinney-Vento definition considers a person homeless only when he or she resides in one of the following places: a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings or on the street; an emergency shelter; or transitional housing or supportive housing for homeless persons who originally came from the streets or emergency shelters."[110] This definition excludes many women at high-risk for HIV because many women in the District, in order to avoid shelters and street living, and protect their families at all costs may stay in an unhealthy or abusive relationship or trade sex for a roof over their heads.

The final federal program in place in D.C. is HOPWA. HOPWA was developed by HUD to respond specifically to the housing needs of people living with HIV/AIDS (PLHA) and their families.[111] HOPWA provides formula grants to states and metropolitan areas and competitive grants for programming and technical assistance to governments and non-profit service providers. The HOPWA program has been very successful at housing PLHA while receiving high ratings for cost-effectiveness and goal attainment.[112] The Office of Management and Budget's review gave HOPWA the highest program success rating possible.[113] HOPWA is less expensive than some other housing assistance programs; it provides more short term housing relief during housing crises rather than month-to-month support through a Section 8 voucher.[114] HOPWA may have less expensive vouchers as it has served more single member households, a local priority determination.[115] A soon-to-be published study from the Chicago Housing for Health Partnership noted that placing people in housing as they come out of hospitals "was significant in reducing overall public costs."[116] In D.C., HOPWA funds pay for housing information services, facility maintenance, project and tenant-based rental assistance vouchers, short-term rent and mortgage payments to keep residents in housing, supportive services for PLHA in HOPWA housing, and permanent housing placement.[117] The current waiting list for HOPWA housing, however, is in the hundreds, thereby leaving a huge portion of PLHA in the district to fend for themselves.

D. Current Programs and Policies in the District Fail to Meet the Needs of Individuals Affected by Both Gender-Based Violence and HIV/AIDS

Without updating and revising the D.C. AIDS Healthcare Act to mandate integrated services for HIV/AIDS and gender-based violence, women's rights to health, information, and life continue to be violated. The D.C. AIDS Health Care Act fails to provide explicit mandates or policies for developing and coordinating HIV/AIDS services through appropriate agencies, community groups or other organizations in the District like those working with survivors of gender-based violence.[118] The provisions in the Act, such as § 7-1604 on the role of the AIDS Program Coordination Officer ,[119] do not specify whether information, outreach, and education programs should be related to the prevention and treatment of HIV/AIDS or simply a scientific explanation of the disease. Further, any assistance for coordination of HIV/AIDS plans, programs, and services fails to mention reaching more vulnerable populations like women experiencing gender-based violence.

Even more recent attempts by the government, such as D.C. Department of Health's March 2009 report titled, "Heterosexual Relationships and HIV in Washington, D.C.," neglected to investigate fully the intersection of gender-based or intimate partner violence and HIV. Under "Other Factors" in the very last section of the report, the study merely indicates that one-third of the participants reported ever having been emotionally or physically abused, but fails to acknowledge that this abuse acts as a significant barrier to seeking HIV treatment or disclosing HIV status, and thus increases the need for integrated services, training and education. Nor does it mention that intimate partner violence or gender-based violence require further study in future reports.[120] In order for District residents and medical and other service providers to fully understand the interwoven relationship between HIV/AIDS and gender-based violence and protect the rights of those affected by both epidemics, the D.C. government must take significant steps, including 1) thoroughly investigate this intersection, 2) develop training modules for service providers in both fields, 3) mandate screening for both HIV/AIDS and gender-based violence by service providers working with the affected population, and 4) implement a monitoring system to ensure these screenings are routinely taking place.[121]

In addition to the behavioral studies conducted by D.C.'s DOH, the District's Comprehensive Plan on HIV Care for 2009-2011 also fails to investigate or acknowledge the link between HIV and gender-based violence. The only mention of "violence" or "rape" contributing to HIV infection in the entire 2009-2011 Washington, D.C. Comprehensive HIV Care Plan is in relation to the refugee immigrant population: "Immigrants who come to the US via refugee camps may experience overcrowding, violence, rape, and the need to sell or exchange sex to survive."[122] While the immigrant population in Washington is recognizably underserved and has also been identified to have a growing rate of individuals affected by HIV/AIDS, it is a serious oversight that the D.C. HIV Comprehensive Care Plan does not recognize violence against women in the greater population as a driver of the epidemic .

In addition to the publications prepared by DOH, HAHSTA has also prepared a comprehensive and easy-to-read directory of all D.C. HIV/AIDS services. The directory contains information ranging from HIV testing locations to medical care, medications, and support services, including nutrition services and housing.[123] The directory, however, does not include any specific gender-based violence services or references. The page on "Personal and Family Services" directs residents to services related to child placement or child care, but fails to mention any services related to intra-family violence or abuse.[124] Although the planned distribution of 30,000 copies of the directory to residents and providers is greatly needed, the failure to include gender-based violence services in the 2009 edition perpetuates the D.C. government's inaction towards the links between gender-based violence and the spread of HIV/AIDS.

While the District has made a serious commitment to provide services for victims of domestic and gender-based violence, the rising levels of HIV in the district, especially among women, make it imperative to integrate those services with HIV/AIDS testing, counseling, and treatment. The D.C. government provides services to survivors of gender-based violence through the Domestic Violence Intake Center (DVIC) project. DVIC is a collaborative project of governmental and non-governmental agencies and service organizations[125] working to provide coordinated services to survivors of gender-based violence in the District. The project aims to provide "a single access point for victims of gender-based violence by conducting intake evaluations, providing counseling, safety planning, assisting victims in drafting pleadings and other documents necessary for

acquisition of protective orders and free legal representation."[126] Currently, this single access point does not provide access to health services like HIV screening, creating another missed opportunity and a barrier to accessing services for women affected by both issues.

The federal Violence Against Women Act (VAWA) likewise neglects the need for integrated HIV and gender-based violence services, though it provides for a myriad of other programs and services for target groups, such as youth. Although VAWA's findings report that "women who have been abused are much more likely to suffer from…sexually transmitted infections, including HIV/AIDS,"[127] subsequent provisions only mention HIV in relation to "develop[ing] HIV testing programs for sexual assault perpetrators and notification and counseling protocols,"[128] allocating funds for HIV testing for victims of sexual assault[129] and for youth education programs focused on HIV and other STDs.[130] For VAWA to provide a model for other jurisdictions to follow, it should include provisions that address the need to train providers and designate services for women affected by HIV/AIDS and gender-based violence. In Section 204, VAWA addresses the need for education, training, and enhanced services to end violence against women with disabilities.[131] Here, the term "disabilities" is defined as in Section 3 of the Americans with Disabilities Act of 1990, which includes persons living with HIV, even if they are asymptomatic.[132] Therefore, in order to address the needs of women affected by both HIV/AIDS and gender-based violence, VAWA could address the need for education, training, and enhanced services for women living with HIV/AIDS under this sub-section which contains examples of successful integration models of domestic violence and other services.

Currently, the District has no systematic, integrated screening policy for both gender-based violence and HIV/AIDS that would provide women, who are already seeking one form of services, a single-entry point to access assistance for both. Given the increased risk of HIV among women who experience gender-based violence, compared to those who have not, violence-related service providers serve as a vital entry point to connecting women to prevention and treatment services for HIV/AIDS.[133] Similarly, given this intersection, medical providers and HIV testing and counseling staff must be trained to identify, counsel, and refer women experiencing violence to the appropriate services.[134] In order for this training and integration to occur, the D.C. government needs a policy that coordinates with all levels of government and associated community organizations. A report on violence against women from the U.N. Secretary-General recommended such an approach:

The implementation of international norms and standards on violence against women requires comprehensive legal policy and other measures at the national level, with the involvement of many stakeholders. These include all levels of the State at federal, state, provincial and local levels, as well as all branches of Government…. Collaboration and coordination between all stakeholders, including Governments, NGOs and civil society organizations are vital for an effective approach to redressing such violence.[135]

While the District should be recognized for its early response to the epidemic and more recent efforts in the right direction, years of neglect, lack of enforcement of existing laws, and poorly integrated policies have lead to a serious modern epidemic that is severely affecting women. To better address the needs and rights of women in the District, it is necessary to use a human rights framework premised on the right of all people to equality, non-discrimination, health, housing, and to live a life free from violence.

IV. A COMPREHENSIVE, HUMAN RIGHTS-BASED HIV/AIDS POLICY WOULD EFFECTIVELY TACKLE D.C.'S HIV CRISIS

"It is time to take a fresh look at what [the District HIV/AIDS policies] need to achieve and that includes bold vision, bold goals, innovation and accountability."

Dr. Shannon Hader, Senior Deputy Director, HIV/AIDS, Hepatitis, STD, and TB Administration, D.C. Department of Health[136]

When asked about obstacles to improving HIV/AIDS prevention, care, and treatment outcomes in the District, D.C. Congresswoman Eleanor Holmes Norton responded: "I don't see any obstacles…. If we lived in a third world country there would be obstacles. The leadership is the obstacle."[137] On Feb. 3, 2009, D.C. City Council Members Marion Barry and Michael A. Brown introduced a "Comprehensive HIV Prevention Plan Act of 2009;" the short 4-section bill calls on the Mayor to develop a 5-year "Comprehensive Plan to reduce and prevent the incidence of HIV in the District of Columbia" which will include public education through the media and culturally-competent training for healthcare personnel. As of late 2009, minimal to no action has been taken on this bill since its public introduction.[138]

Once a pioneer in its response to HIV/AIDS, the District currently lacks a comprehensive, inter-agency strategy to stem the rising tide of infection among women. While the D.C. government distributed nearly $500 million in HIV/AIDS funding to community-based organizations (CBOs) between 1998 and 2006,[139] it has never developed a holistic policy that addresses the social and economic factors that contribute to the spread of the virus among women.

To tackle the HIV/AIDS epidemic by achieving sustainable and long-tern results, the District must adopt a comprehensive HIV/AIDS policy guided by a human rights framework that addresses the prevention, care, and treatment needs of women. The D.C. government cannot continue to haphazardly plug holes in the dam rather than examine and strengthen the system as a whole.[140] Meredith Owensby, Social Services Manager at Miriam's House, a residential facility for HIV-positive women, characterizes current efforts as falling short because "There doesn't seem to be a big picture view that we need 'A' but we also need 'B'."[141] She echoes frustrations of other social service providers about the lack of guiding principles, strategy, and coordination across governmental entities: "[At the monthly meetings for government-funded HIV organizations] there's always new plans or new acronyms or new reporting requirements. There's lots of paper and lots of words. But I don't get the sense anyone knows where we're going….The right hand isn't quite sure what the left hand is doing."[142]

Women in Washington, D.C. are experiencing epidemic rates of infection because the government has failed to address the intersecting dynamics influencing the spread of the epidemic among women. For years, domestic and international experts have emphasized governments' obligation to focus on the "multi-dimensional and cross-cutting nature of HIV/AIDS." International experts emphasize that response efforts will not be successful unless the "human rights, economic, social, development and security dimensions" of the disease are acknowledged.[143] With respect to HIV/AIDS specifically, the UN General Assembly found "gender equality and the empowerment of women" to be "fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS."[144]

Not only does D.C. lack an HIV policy, neither its Comprehensive Care Plan nor the Prevention Plan cite, much less rely on human rights principles in outlining their respective goals. The Comprehensive HIV Care Plan, 2009-2011, substantially drafted to account for the Ryan White Treatment Act funds in D.C., makes no mention of human rights. The HIV Care Plan – which forms the closest document to an HIV policy for the District – addresses the epidemic in terms of "health and quality of life," but stops short of adopting a human-rights based approach. Its only mention of women is restricted to brief paragraphs of statistics. It outlines that women now make up about 33% of all new HIV cases and of those already living with HIV/AIDS, and recognizes that "[t]he impact on Black women is even more striking," as "African American women constitute 58% of the female population, but accounted for 90% of all new female HIV cases."[145] The D.C. HIV Prevention Plan for 2006-2009 makes no mention of human rights, with the minute exception of a footnote to a Human Rights Watch report on Race and Incarceration in the United States in the section on "Inmates and Ex-Offenders."[146]

Promoting and protecting human rights are necessary to both the protection of "the inherent dignity of persons affected by HIV and to the achievement of the public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV and AIDS on those affected and empowering individuals and communities to respond to HIV."[147] By tailoring programs to better serve the needs of women, the government will yield "more sustainable long term results in terms of lowering the incidence of infection and mitigating the negative consequences of AIDS."[148]

V. INTERNATIONAL HUMAN RIGHTS BIND AND MUST GUIDE D.C.'S PREVENTION AND TREATMENT EFFORTS

"Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any map of the world … where every man, woman, and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere."

Eleanor Roosevelt, first U.S. delegate to the United Nations General Assembly and co-drafter of the Universal Declaration of Human Rights[149]

When the capital of the United States – one of the wealthiest countries in the world – suffers from the nation's highest rate of a deadly, yet preventable epidemic, policymakers must swiftly adopt a comprehensive framework to address the prevention, treatment, and care of HIV/AIDS. A human-rights based approach is needed as it provides governments with a binding and normative framework to address the crosscutting dimensions of HIV/AIDS with particular recognition of the importance of gender equality. International human rights standards outline HIV/AIDS prevention, care, and treatment strategies that are both legally required and grounded in sound public health policy. International human rights standards demand that governments "respect" human rights and "exercise due diligence to prevent, punish, investigate or redress" violations of the rights of every individual.[150] Analyzing the current HIV epidemic in D.C. through a human rights lens highlights the ways in which state actions- and inactions - fail to fully protect the rights and respond to the fundamental needs of its residents.

When a group of HIV-positive women at a focus group at The Women Collective was asked whether HIV was a human rights issue, many looked puzzled and were quick to say "no." Yet, they then elaborated that all they want is to be "treated with

dignity," to be "respected," "not to be discriminated against," and to "be treated like any other person." That is, they wanted their fundamental human rights to be respected. [151] It is time these basic protections are enshrined in an HIV/AIDS policy premised on the very rights expressed in these sentiments.

A. Human Rights Are Essential To An Effective HIV/AIDS Response

While all human rights apply to all human beings, certain core rights, derived from core international human rights treaties and documents, have particular relevance both to addressing the HIV/AIDS pandemic and to treating people living with HIV/AIDS. The following key rights drawn from the Joint United Nations Programme on HIV/AIDS, while not exhaustive, are meant to highlight the minimal guarantees that must guide Washington D.C.'s local approach to HIV: [152]

Non-discrimination and Equality Before the Law:[153] protection against discrimination when seeking help, services, benefits, or housing; equal access to services; right not to be mistreated on the basis of health status, including HIV status, in employment, benefits, and immigration contexts.

Right to Privacy and Physical Integrity:[154] protection against mandatory, or coercive testing; the right to confidentiality in testing and disclosure of status; the right to marry and found a family regardless of HIV status; the right to initiate, prevent, maintain, or terminate pregnancies, irrespective of HIV status.

Right to Liberty and Freedom from Cruel, Inhuman and Degrading Treatment – The Right to Dignity:[155] protection against imprisonment, segregation, or isolation in a special hospital ward; freedom from violence, including sexual violence; freedom from mandatory testing; the right not to be harassed, arrested and imprisoned on the basis of HIV status.

Right to Information and Education:[156] the right to access all HIV prevention education and information; sexual and reproductive health education and information, including access to accurate, comprehensive, accessible, and linguistically and culturally appropriate information and education about HIV prevention, treatment and care, including prevention of transmission from mother to child.

Right to Health:[157] the right to access all health care prevention services, including for sexually transmitted infections (STIs), voluntary counseling and testing, and to male and female condoms; the right not to be denied health care or treatment on the basis of HIV status, including access to high quality healthcare, and the full range of reproductive options and services.

Right to Participate in Public Life and Decision Making:[158] the right to participation of affected communities and individuals in the formulation and implementation of HIV policy; participation must be active, free and meaningful, especially by disadvantaged and marginalized groups.

B. The Federal And D.C. Governments Must Uphold International Human Rights Standards

International human rights standards are relevant to the every day lives of people living with HIV/AIDS in D.C. because their human rights are realized or abrogated at the local level. Under the U.S. federal system, the national government, as well as the state and local government must fulfill the obligations of the U.S. under international treaties. Especially because Washington, D.C. is governed by both federal and city government, both federal and local officials must implement human rights standards to ensure the security and well-being of D.C. residents. The International Bill of Human Rights consists of the Universal Declaration of Human Rights (UDHR), a U.N. founding document, together with its treaty offshoots, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[159] U.S. President Franklin Delano Roosevelt laid the groundwork for the key rights contained in the UDHR, modeled after the "four essential human freedoms" he outlined in 1941, including freedom from want.[160] Two other relevant core human rights treaties - the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) and the Convention on the Elimination of Discrimination Against Women (CEDAW) – expand on the scope of non-discrimination on the ground of race and sex, respectively.

When the U.S. Senate ratifies an international human rights treaty, or convention, it becomes "supreme law of the land" under Article VI of the U.S. Constitution.[161] The executive branch, in Executive Order 13,107, affirmed that it "shall be the policy and practice of the government of the United States" to fully "implement its obligations under the international human rights treaties to which it is a Party."[162] The U.S. has ratified, and is therefore legally bound to "respect" the rights set forth in the ICCPR and the ICERD and to ensure those rights "to all individuals in their territory and subject to their jurisdiction" and to "take appropriate measures or to exercise due diligence to prevent, punish, investigate or redress" violations of the rights protected therein.[163] Article 2(1) of the ICERD expressly obligates the United States not only to "ensure that all public authorities and public institutions, national and local, shall act in conformity" with the Convention but to "take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists."[164] The U.S. government noted in its 2007 report on its compliance with ICERD, that even where the U.S. has yet to explicitly recognize certain economic, social, and cultural rights – Article 5 of CERD requires that it takes immediate action to "prohibit discrimination in the enjoyment of those rights to the extent they are provided in domestic law." [165]

The U.S. and D.C. governments must also act consistently with treaties that the Senate has signed, but has yet to ratify, to signify their good faith intent to comply with the human rights standards contained in those treaties. The U.S. government has signed – though not yet ratified – the ICESCR,[166] which protects key rights necessary for the welfare of all without discrimination,[167] including access to healthcare and adequate housing.[168] The U.S. has also signed, but is yet to ratify CEDAW, which prohibits discrimination against women in both purpose and effect in all spheres of life, including women's access to healthcare, ability to determine the number and spacing of their children, and to be free from harmful gender-stereotypes.[169] While the U.S. has not formally ratified these treaties, by signing them, the government has pledged to uphold their "object and purpose," and therefore has a duty not to contravene the human rights principles contained therein.[170] The ratified treaties, ICCPR and ICERD, along with the signed treaties, ICESCR and CEDAW, form the legal and normative framework for the human rights protection and standards to inform the D.C. government's scope of obligations.

The United Nations General Assembly, which consists of all 192 members states, including the U.S. as one of its founding members,[171] has adopted resolutions and consensus documents on human rights.[172] While these standards do not constitute legally binding obligations, they represent the consensus of the community of nations. The 2001 Declaration of Commitment on HIV/AIDS is a consensus document in which every UN member state has committed "to combat HIV/AIDS" both domestically and globally. The Declaration recognizes "that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS."[173] The document also reflects the international community's understanding that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS."[174]

Regional human rights standards to which the U.S. is bound include the founding treaty of the Organization of American States, and the American Declaration on the Rights and Duties of Man, which upholds core civil, political, and social rights.175 The Inter-American Commission on Human Rights, which interprets the Declaration, has held that the Declaration, though not a ratified treaty, is binding upon the United States.[176]

U.N. agencies and expert international organizations, such as the World Health Organization (WHO), the Joint U.N. Programme on HIV/AIDS (UNAIDS), and the U.N. Office of the High Commissioner for Human Rights (OHCHR), promulgate high-level policy documents to elucidate the content of broad human rights in specific contexts. Based on rights contained in international human rights treaties, these bodies issue specific guidance to policymakers on a human-rights based approach to addressing HIV/AIDS.[177] The International Guidelines on HIV/AIDS and Human Rights, co-drafted by the OHCHR and UNAIDS, instruct that "[o]ne essential lesson learned from the HIV epidemic is that universally recognized human rights standards should guide policymakers in formulating the direction and content of HIV-related policy and form an integral part of all aspects of national and local responses to HIV."[178] The International Guidelines provide 12 specific guidelines for states, ranging from creating an integrated HIV policy, to enhancing anti-discrimination laws to protect people living with HIV/AIDS and women's equality, to access to HIV-related goods and services.[179]

<u>All levels of government must uphold international human rights law</u>

Every branch of government (executive, legislature, and judiciary) and every level of government (national, state, and local) has an obligation to respect human rights and to ensure those rights are enjoyed equally by all individuals.[180] By ratifying a treaty, the U.S. government agrees to take appropriate measures to implement the human rights contained in that treaty at all levels, including the state and local level, such as the D.C. government and its specialized agencies. The U.S. has specifically declared that such treaties will be implemented by the federal government "to the extent that it exercises jurisdiction over the matters covered therein, and otherwise by the state and local governments," all of which have a duty to "take appropriate measures to ensure the fulfillment" of international human rights obligations.[181] In its first report to the Human Rights Committee which monitors compliance with the ICCPR, the U.S. government clarified that "the federal government established by the Constitution is a government of limited authority and responsibility, [and] state and local governments exercise significant

responsibilities in many areas, including matters such as education, public health, business organization, work conditions, marriage and divorce, the care of children and exercise of the ordinary police power."[182] During its latest review in 2007, the U.S. has reassured the CERD Committee, which oversees the implementation of ICERD, that it has "taken, and continues to take, necessary measures to ensure the application of the provisions of the Convention at all levels of government."[183]

International human rights law is a part of U.S. domestic law, which imposes concrete obligations on legislatures and courts.[184] Ratified treaties – considered the legal equivalent of federal statutes - trump conflicting older federal laws, and any state or local law.[185] Domestic laws must not conflict with ratified treaties. The Supreme Court has explicitly affirmed the importance of international human rights law in interpreting issues affecting fundamental rights, such as privacy, freedom from degrading treatment and torture, and non-discrimination.[186] In 2005, Justice Kennedy's majority decision in Roper v. Simmons, rejecting the continued application of the death penalty to juveniles, emphasized that the Supreme Court has, on several occasions, "referred to the laws of other countries and to international authorities as instructive for its interpretation" of provisions of the U.S. Constitution.[187] Moreover, the Court found it "proper [to] acknowledge the overwhelming weight of international opinion against the juvenile death penalty" finding that "the opinion of the world community, while not controlling our outcome, does provide respected and significant confirmation for [the Court's] conclusions."[188] State courts likewise look to international human rights law, including in interpreting domestic legal standards. For example, in Boehm v. Superior Court, the California Supreme Court, citing the UDHR, held that general state assistance and benefits must be kept at sufficient levels for survival and required local authorities to consider citizens' rights to food, housing, transportation, clothing, and medical care.[189]

State-level implementation of international human rights obligations

National and local governments are under a legal obligation to take "deliberate, concrete, and targeted steps towards the full realization" of that right for every person within the state's jurisdiction.[190] In particular, all municipalities are expected to implement policies and programs that prevent public health epidemics and may not "remain passive in a situation where health rights are deteriorating,"[191]

Local and state bodies across the United States have been working to integrate international human rights law and standards into their laws and policies. In Pennsylvania, the state legislature successfully passed two resolutions, HR 473 (2002) and HR 144 (2003), establishing a committee to investigate integrating human rights standards into state laws and policies. A report issued by the committee found that "…for development of economic and social policy to address the issues brought forth in these hearings, it is critical to define human economic rights as those basic individual rights to healthcare, nutrition, housing, quality education and sustainable employment at a living wage."[192] In California, the city of San Francisco incorporated the principles of the CERD and CEDAW as municipal law;[193] Berkeley submitted a report to the CERD Committee on its compliance with that treaty.[194] A Massachusetts 2005 House Bill would establish a special commission to initiate the incorporation of international human rights standards into local laws and policies, including those of CERD and other international human rights treaties.[195] The "New York City Human Rights Government Operations Audit Law" bill introduced in 2004 would implement principles based on the CERD and the CEDAW; it would adopt the definition of discrimination in the CERD, and require a city-wide review of the effect of policies and programs on racial minorities.[196]

VI. HIV/AIDS RATES AND HEALTH OUTCOMES IN D.C. REFLECT EXTREME RACIAL AND GENDER DISPARITIES

The District, as in other parts of the United States, reflects a history of neglect and discrimination evidenced by the extreme disparities in the rates of HIV/AIDS and other health outcomes among racial minorities and in particular minority women. This section highlights the 1) discrimination inherent in race and gender disparities in health, such as the disproportionately high rates of HIV/AIDS among minority women; 2) failure to address the gender dimension of the epidemic in favor of a gender-blind approach to HIV/AIDS; and 3) the need to marshal disaggregated data to develop women-centered intervention strategies.

A. Gender and Racial Disparities in Access to Healthcare and Health Outcomes Constitute in Effect Discrimination Against Minority Women

Gender and racial disparities in access to healthcare and treatment and in health outcomes constitute in effect discrimination against minority women. A consortium of U.S.-based NGOs submitted a compelling report highlighting racial and gender disparities in healthcare to the UNCERD Committee ahead of its review of U.S. compliance with ICERD.[197] The report highlights stark health inequities among women:

> *Women of color in the United States fare significantly worse than white women in every aspect of reproductive health. The maternal mortality rates in the United States are the highest among western developed nations[198] due to the shockingly high rates of mortality among women of color…*[199]

As with related reproductive and sexual health indicators,[200] minority women are disproportionately affected by HIV/AIDS. According to the CDC, nationwide, "African American women are infected with HIV/AIDS at a rate 23 times that of white women[201] and comprised 66 % of the new HIV infections among women in 2005.[202] At the 2009 HIV/AIDS Prevention Conference in Atlanta, Secretary of Health and Human Services Kathleen Sebelius commented on the dramatic disparate impact of the HIV epidemic on minority communities:

> *Today, African Americans make up just over a tenth of the population. But they account for nearly half of new HIV infections. One in 30 African-American women will be diagnosed in her lifetime. One in sixteen African-American men will be diagnosed with HIV. …. The situation is also dire for Latinos. Think about that. Imagine if it were half the straight white women in Atlanta. Wouldn't we be calling this a national emergency? Shouldn't we be?*[203]

Yet, little has been done to address the startling disparities in infection rates. AIDS is the leading cause of death for African American women aged 25 to 34."[204] In D.C., Women are becoming more rapidly infected with the virus than men.[205] In 2007, for example, Black and Hispanic women combined constituted 97.6% of all newly reported AIDS cases among women in the District.[206] New data on AIDS and women in D.C. reveals that "[i]n Wards 7 and 8, the ratio of males to females infected with HIV/AIDS is 50/50."[207] According to D.C.'s own 2009 epidemiology report, while Ward 8, which is 93% Black, has the highest rate of persons living with HIV/AIDS and of new HIV infections in the city, only 13 of 126 publicly-funded HIV care and service

providers currently operate there.[208] The CERD Committee instructed the U.S. to do more to eliminate this type of "unequal distribution of health-care resources" that creates "persistent health disparities among racial, ethnic, and national minorities.[209]

Stark disparities in HIV/AIDS rates indicate that existing HIV/AIDS programs – even if facially neutral – fail to equitably serve women of color because they do not account for the systemic and differential social drivers that disparately impact women of color. The CERD Committee in General Recommendation 25 on the implementing of ICERD outlined the scope of "Gender related dimensions of racial discrimination" to ensure that governments account for race and ethnic discrimination which carries disproportionate or adverse consequences for women.[210] The Committee stressed that "some forms of racial discrimination have a unique and special impact upon women."[211]

The District government is under an obligation to modify its policies and develop new interventions to eliminate these disparities. The city of San Francisco, for example, attempted to remedy indirect discrimination against women by addressing the ways in which "different social roles, responsibilities, opportunities, and needs" for men and women "permeate our society [and] affect how decisions and policy are made."[212] The city adopted the principles of CEDAW and passed an ordinance requiring "preventive and forward-thinking measures to ensure that city resources, policies and actions neither intentionally nor unintentionally discriminate against women and girls."[213] The gender analysis completed by these departments resulted in, inter alia, a restructuring of the policies that discouraged women with child-care responsibilities from taking full advantage of government programs and led to a heightened awareness of the way the city's physical infrastructure contributes to women's feelings of safety or lack thereof.[214] Such changes helped to ensure the realization of women's human rights to equality and non-discrimination.

B. Assuming a Gender-Blind Approach to HIV/AIDS Prevention, Care, and Treatment Undermines Women's Right to Non-Discrimination

Existing HIV/AIDS programs in D.C. overlook the unique range of overlapping and interrelated gender-based risks and vulnerabilities. Current strategies fail women by assuming "an idealized world in which everyone is equal and free to make empowered [and fully informed] choices, and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently."[215] Within the U.S., the HIV/AIDS epidemic is often viewed as a "single homogeneous entity" shaped largely by the historic unfolding of the epidemic among homosexual (predominantly white) men and injecting drug users.[216] Yet, even as the virus spreads to women and minority communities, "the manner by which the epidemic is described, referenced, and treated has not changed." [217] The National Alliance for State and Territorial AIDS Directors (NASTAD) identified this dynamic as an obstacle to HIV/AIDS prevention, care, and treatment efforts and protested the fact that "policies, interventions, activities, and funding dedicated to preventing new infections" continue to be modeled on systems developed in the 1980s and 1990s and intended to address the specific needs of historically affected populations. [218]

As a result of this outdated approach to HIV/AIDS, current prevention, care, and treatment plans and programs fail to respond to women who themselves may not engage in traditionally high-risk behaviors, but whose partners' may be, or may be living in

a community like Washington D.C. where the community viral load is so high that any unprotected sex is risky.[219] Dr. Hader of D.C.'s HIV/AIDS Administration recognizes that "one of the primary challenges for addressing HIV among women in the District is this low or outdated risk perception" that presumes only individuals engaged in traditionally unprotected homosexual sex or injecting drug use are at risk for HIV.[220] Dr. Deborah M. Smith, a Staff Physician in Gynecology and Women's Health at the Whitman Walker Clinic, lamented that some policymakers have "tried to make a lot of women into injection drug users because that's what fits" when HIV/AIDS policies are not "ready to deal with other aspects of the epidemic as [they begin] to unfold."[221] Based on her experience, for example, she believes many women are actually placed at risk for HIV because their male partners are having sexual relationships outside of their primary relationship. [222]

In the absence of an HIV policy with revised guidance, many medical providers in D.C., operating under outdated notions that fundamentally misunderstand how HIV impacts women, continue to tell women they do not need routine HIV screening, or are unable to provide women with the accurate and up-to-date medical information they need. Heterosexual contact accounts for nearly 60% of HIV transmission among D.C. women.[223] Yet, some healthcare providers continue to be reluctant to test women in the District. One District woman said, "I'm still encountering some problems…. My doctor will say, 'You have nothing to worry about.'"[224] Another woman explained, "Every year, if I ask my doctor for an HIV test, I get grilled on why I need it."[225] HIV-Positive women of all ages require gender-specific healthcare and treatment.

Access to quality healthcare is particularly crucial for HIV-positive women because they suffer from gender-specific ailments exacerbated by HIV infection and related side effects. Most early HIV/AIDS research was conducted on males. Even with increasing numbers of women living with HIV/AIDS, little awareness and few studies exist about the gender-specific health impact of the virus and its treatments. Women living with HIV/AIDS tend to suffer from anemia, greater frequency of yeast infections, abnormal pap smears indicating presence of HPV and greater likelihood of cervical cancer, hormonal changes (some associated with greater risk for cardiovascular disease), and osteoporosis.[226] Hormone replacement therapy for HIV-positive women, including in the context of menopause, has yet to be studied. One HIV-positive woman in her late 40s at The Women's Collective focus group related that she was excluded from a study on menopause because she was on HIV medication. She was distressed by the lack of medical research about HIV and menopause.[227] A literature review of medical research published between 1980 and 2007 on HIV and health implications for reproductive aging confirmed that "[s]tudies on the relationship between HIV, HAART [highly active antiretroviral therapy], and conditions associated with menopause are sparse."[228]

Gender and racial equality and non-discrimination are not achieved by merely offering access to a one-size fits all solution. Rather, they require "the removal of institutional barriers and disadvantages to ensure that women" equally "access, use and benefit" from government programs.[229] To ensure that HIV/AIDS programs serve men and women equally and fulfill international human rights legal obligations, the D.C. government must develop new intervention strategies and address programs and plans that presume traditional risk patterns apply across gender and race. The District has a duty to ensure that healthcare providers, community and service organizations, and women themselves are exposed to and implement programs that use accurate information and educational materials reflecting the unique needs and experiences of women affected by HIV.

VII. INADEQUATE RESOURCES FOR PREVENTION, TESTING, AND TREATMENT OF HIV/AIDS HAVE EXACERBATED THE HIV/AIDS CRISIS IN D.C.

When a city exhibits the nation's highest prevalence of HIV, the right to health of its residents is violated. The right to health, recognized universally as a fundamental human right, derives from numerous international human rights documents and the constitution of the World Health Organization (WHO), of which the U.S. is an active member state.[230] The right to health is requisite for the realization of other widely recognized core human rights, including the rights to dignity, life, housing, freedom from violence, non-discrimination and equality.

A. Inconsistent and Discretionary HIV/AIDS Testing and Counseling Result in Preventable Infections Among Women

Because of the lack of consistent testing for HIV, D.C. has a high rate of "late testers," or people who are diagnosed with AIDS within one year of testing positive for HIV.[231] In 2007, 66% of newly reported AIDS cases in the District were late testers.[232] The District further estimates that between one-third and one-half of people living with HIV/AIDS in the District do not know they carry the virus.[233] When patients are tested and begin treatment late, their health deteriorates and they may miss an opportunity to delay the onset of AIDS. When people do not know their HIV status, they are unable to take preventive measures. Studies indicate that many people who know they are HIV positive will take preventive measure to reduce the risk of transmitting the infection to others.[234] In addition, when HIV/AIDS is being treated, the virus is less likely to be transmitted.

The District fails to ensure that HIV/AIDS testing and counseling is consistently provided as part of primary or emergency medical care, resulting in missed opportunities to prevent HIV and enter early treatment. Providers are under no obligation to offer voluntary HIV tests as the District has no laws or policies governing testing for patients accessing medical care, including pregnant women.[235] Among newly diagnosed D.C. residents surveyed for the 2008 D.C. HIV Behavioral study, nearly 75% had visited a healthcare provider in the 12 months before testing positive, but had not been tested or diagnosed.[236] Patients often hold mistaken perceptions that they receive HIV tests as part of their routine medical care.

Patchy HIV/AIDS testing and counseling results in needless HIV infections and precludes early diagnosis and treatment

Early and routine testing is critical to reduce the number of late testers in the District and to identify cases early to aid prevention and treatment efforts. HIV/AIDS testing programs help to identify people living with HIV so that they can get into care and treatment and be counseled on ways to avoid transmitting the infection. Testing programs also provide an invaluable opportunity to counsel those who test negative about how to protect themselves against infection.

Most doctors interviewed indicated that they regularly offer HIV tests, but each doctor follows different guidelines, or their own personal philosophies on testing. No standard guideline is followed by all healthcare providers in the District and only 40% of D.C. residents surveyed for the 2008 D.C. HIV Behavioral study were offered an HIV test at their last medical visit.[237] Dr. Regina Zopf of Washington Hospital Center and Unity Healthcare said "there is no written policy about annual HIV screening, but it's basically what everybody is doing."[238] Dr. Jessica Osborn, in private practice with Medstar, said "During a physical, I ask

about HIV status and partners' status. I ask how long ago were you tested. Can we test again? Also I will test if there are some other indicators like they have hepatitis."[239] Dr. Randi Abramson says she offers all of her patients at Bread for the City an HIV test as part of their initial intake.[240] Yet, social service providers indicate that some doctors are reluctant to test for HIV. A Public Policy Coordinator at Metro Teen AIDS said "there seems to be a reluctance in the medical setting for dealing with HIV… there is a reluctance to engage in [testing], for whatever reason. The reality is, there's still stigma surrounding HIV, even in the medical setting."[241]

In particular, women who are more likely to access healthcare services than men, are impacted by this lack of testing or a mistaken belief that they are being tested during routine or specialized medical visits.[242] Dr. Randi Abramson, at Bread for the City, noted that about two-thirds of patients at Bread for the City's clinic are women, which is typical of outpatient care.[243] Even though women are accessing healthcare more frequently, because HIV testing and counseling is not required, they are missing opportunities to be tested, enter treatment if they test positive for HIV, and be provided prevention information.

Although some women mistakenly believe that they are being testing during their annual gynecological exams, regular physicals, or when receiving other medical care, HIV testing and counseling is not routinely covered.[244] An HIV-positive woman in D.C. who was a late tester and initially diagnosed with AIDS when she first tested positive, believes that she was HIV-positive when she was undergoing tests for a possible cancerous tumor and assumed she was tested for HIV during diagnostic visits, but now realizes she was never tested for HIV during those procedures.[245] Heidi Williamson of Sister Song, a national reproductive justice organization for women of color, noted:

> *Doctors only test for the main three: syphilis, gonorrhea and tricamonious with pelvic swab and [say] you are fine. The communication that doctors have with these patients is broken down. People are not finding out that they have HIV and when they do it is so late.*[246]

Many women in D.C. are not offered a test because they are assumed to not be at high-risk for HIV. Dr. Shannon Hader, Senior Deputy Director of HAHSTA, emphasized that, "A lot of the women who are getting infected have no idea they are at risk, because they have one partner, they don't necessarily have what you think of as high-level individual risk factors."[247] In any area with a high rate of infection like D.C., even "low-risk" behaviors can put individuals at risk of contracting HIV. Dr. Hader explains that the high rate of HIV in the District puts even those engaging in "low-risk" behaviors at a higher risk:

When you live in the District where 3 to 5 percent of the population is infected, you don't need to be a sex worker to be exposed to HIV. A lot of the women who are getting infected have no idea they are at risk, because they have one partner, they don't necessarily have what you think of as high level, individual level risk factors… Our condom rates are not any lower than the rest of the country, but it makes a big difference here because we have a lot of HIV.[248]

Many patients want to be tested and in fact think they have been tested. The lack of testing guidelines and incentives works as an unnecessary barrier to testing, prevention, and education for D.C.'s residents.

D.C. Women must have uniform access to HIV counseling and testing as part of primary and emergency medical care

By failing to ensure consistent HIV testing and counseling, the District violates residents' right to health in disregard of the testing guidelines promulgated by the CDC and the WHO. The WHO recommends that in areas of generalized HIV/AIDS epidemics, like D.C., healthcare providers offer HIV testing and counseling to all adults and adolescents seen in all health facilities, including medical and surgical services, public and private facilities, inpatient and outpatient settings, and mobile or outreach medical services.[249] The WHO also recommends that HIV testing and counseling be recommended as part of the normal standard of care provided to patients, regardless of the patient's reason for accessing the health facility.[250] Since 2006, the CDC has recommended routine HIV testing be performed for all patients 13-64 years old in all health-care settings where the prevalence of HIV is greater than 0.1%.[251]

For maximum outreach, HIV testing and counseling should be offered in both urgent and non-urgent healthcare settings. The CDC has piloted routine testing programs in urgent care settings. A pilot program, "Think HIV" was implemented at four hospital-associated urgent care centers in areas with high HIV prevalence in Massachusetts. After registration for urgent care, patients at these care centers were offered the opportunity to speak with a counselor specifically trained in sexually transmitted infections, hepatitis C, and HIV.[252] Patients who agreed to speak with a counselor were told that voluntary, confidential HIV testing was now offered routinely to urgent care patients.[253] During the first year of the program, over 10,000 patients were offered HIV counseling at the four centers, 32% participated in the testing.[254] Of those tested, 60 new cases of HIV were identified. The majority of the newly identified HIV patients likely would not have been identified until later in the course of their disease without the program.[255] By likewise offering testing and counseling to all patients accessing medical care in D.C., the District could help ensure that residents are able to enjoy their right to health.

The District should follow international norms in testing by ensuring all clients and patients are offered voluntary and confidential HIV counseling and testing with informed consent

The District should require that HIV testing include appropriate counseling to permit genuine informed consent. While the CDC recommends opt-out testing – in which the testing is conducted unless the client or patient affirmatively declines - such an approach carries concerns about patients' ability to refuse a test or to provide informed consent.[256] The District should conform to international norms on HIV testing which require HIV testing to be accompanied by pre- and post-test counseling that explains the benefits and risks of being tested, requires informed consent from patients, and guarantees the confidentiality of the test result.

Countries worldwide, including the U.S., committed themselves under the UN Political Declaration on HIV/AIDS (2006) to "ensuring effective interventions for women living with HIV, including voluntary and confidential counselling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care."[257] According to the International Guidelines on HIV and Human Rights, "states should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information

and counseling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose."[258]

The WHO and UNAIDS advocate for Provider-Initiated Testing and Counseling (PITC), which while similar to an opt-out approach, provides additional guarantees that the test is not coerced upon clients / patients. The WHO provides specific guidance about the "process and elements" of testing and counseling initiated by healthcare providers, including information and considerations for pre- and post-test counseling and frequency of initiating such testing.[259] The American Medical Association echoes these principles in its opinion on HIV testing, requiring that "[t]he physician should secure the patient's informed consent specific for HIV testing before testing is performed. Because of the need for pretest counseling and the potential consequences of an HIV test on an individual's job, housing, insurability, and social relationships, the consent should be specific for HIV testing. Consent for HIV testing cannot be inferred from a general consent to treatment."[260]

Absent explicit guidance and consistent HIV testing and counseling HIV transmission from mother to child during pregnancy, labor, and delivery is more likely

Because the District lacks a policy requiring that all pregnant women be offered voluntary HIV testing, women are denied the opportunity to receive treatment that could prevent HIV transmission to their children. According to the D.C.'s DOH webpage on Universal Perinatal HIV Testing and Treatment, "Though nationally the number of perinatally acquired AIDS cases has declined 94 percent, DOH reports that the number of new cases in the District may be as high as double the national case rate."[261] Yet, there are no policies in place to ensure that all pregnant women are offered HIV testing with counseling. The DOH merely "urges all medical providers to conduct universal perinatal HIV screening to reduce the transmission of HIV from mother to child." In June 2007, DOH sent a two-page letter to healthcare providers "calling for universal perinatal HIV testing and treatment" and referring them to the CDC's website, "One Test, Two Lives," for additional information and tools.[262] The DOH provided no additional guidance on perinatal transmission counseling for doctors working with pregnant women, or HIV-positive women who are considering pregnancy. The letter stated only that the DOH is "prepared to …offer training and technical assistance" and that "in some cases, [it] may be able to provide free rapid HIV testing devices for use in labor and delivery rooms."[263] The DOH has not sent a letter to medical providers since June 2007 and no District-lead monitoring efforts are in place to determine whether and how this guidance is being implemented.

Between 1983 and 2007, prenatal transmission accounted for 312 cases of HIV-positive children in the District.[264] Black children accounted for 95.5% of the total pediatric cases.[265] According to D.C.'s 2008 Epidemiology Report, in 2005 with ten perinatal transmissions, "the District had 9% of all reported pediatric case in the country, far disproportionate to our population." Only one perinatal transmission was reported per year for 2006 and 2007.[266]

According to the WHO, the risk of mother to child transmission of HIV - during pregnancy, labor and delivery and via breastfeeding - can be reduced to below two percent by interventions that include antiretroviral (ARV) prophylaxis given to women during pregnancy and labor and to the infant during the first weeks of life, obstetrical interventions, including elective caesarean delivery, and complete avoidance of breastfeeding. [267] Without intervention or treatment, the transmission rate is

15-30% in non-breastfeeding populations and 20-45% in breastfeeding populations.[268] Throughout the U.S., with the incorporation of perinatal testing and antiretroviral therapy, the number of HIV cases passed from mother to child has declined by 95%.[269]

Even though perinatal transmission can be nearly eliminated, pregnant women in D.C. still go untested for HIV. Most women participating in the D.C. government's 2008 focus group on consumer needs related to HIV/AIDS noted they were not offered HIV tests during regular prenatal visits.[270] In addition, not all providers in the District provide accurate information to women of child-bearing age about the role of perinatal transmission. Linda Lopez, a family-centered case manager at The Women's Collective, spoke of the lack of guidance many HIV-positive women have when considering pregnancy: "women are still worried that they will pass the infection to their children. They're afraid to take the meds. They think that the medication is toxic and causes side effects."[271] Charlie Lytle, Health Project Coordinator/Trainer at the Center for Health & Behavioral Training added "most women who are positive think that they can't have children."[272] This misinformation and fear among women living with HIV/AIDS or those who believe they might be at risk for HIV/AIDS may keep them from getting tested or seeking medical care related to their HIV/AIDS status during pregnancy, meaning neither the mother nor the child will benefit from available treatment or preventive care.

B. Insufficient Mental Healthcare and Substance Abuse Treatment Programs Undermine HIV/AIDS Prevention and Treatment Efforts

Poor access to mental healthcare and substance abuse treatment undercut HIV/AIDS prevention and treatment strategies.[273] As many as 50% of people living with HIV/AIDS have some form of mental illness and more than one-third of reported AIDS cases in the District are linked to substance abuse.[274] A social service provider working at The Women's Collective with women living with HIV/AIDS estimated that 60 to 70% of her clients have mental health issues.[275] The 2008 D.C. HIV Behavioral Study with a sample of 750 participants indicates high use of drugs and alcohol among D.C. residents. Over 60% of residents surveyed had used non-injection drugs in the past year.[276]

While the District offers programs to assist low-income residents in accessing healthcare, these programs do not adequately address mental health and substance abuse treatment needs. When asked what some of the general challenges are for low-income residents of the District accessing care, Vivian Cativo, Nurse Manager at Mary's Center, responded that D.C. Alliance is restrictive and can only be used at certain hospitals for certain services.[277] In particular, the D.C. Alliance program does not provide coverage for mental health treatment or substance abuse programs. City-run mental health services are insufficient to meet the demand, and the District does not have enough mental health providers willing to serve low-income clients.[278] Dr. Joan Miles and Dr. Randi Abramson at Bread for the City, serving low-income clients, both noted that D.C. Alliance's lack of coverage of mental healthcare presents a huge gap in services for their clients.[279] Mental health professionals in the District have recognized that the government-run healthcare system needs to be expanded to help low-income residents who cannot afford to pay for private care but do not qualify for Medicaid and are falling through the gaps of the District's mental healthcare system.[280]

Currently, the District is in the process of transitioning the government-run mental health services offered by the D.C. Community Service Agency (CSA) to private healthcare providers in order to make mental healthcare services "stronger, more responsive, more accessible and better able to serve more District residents."[281] Social service and healthcare providers are not sure how this transition will affect their clients and expressed concerns that given the "overwhelming problem before [when the CSA transition to private healthcare providers is completed], keeping the service level stable [will not be] enough."

Mental healthcare is a critical aspect of HIV prevention and treatment

According to the American Psychiatric Association, without services for mental healthcare, the physical healthcare efforts to prevent and treat HIV/AIDS will not be fully effective. Clients receiving mental health treatment are more likely to adhere to HIV/AIDS treatment and take preventive measures.[282] A Women's Collective provider who works with HIV-positive women noted, "Mental health is huge, [it is] such a main weakness to your overall ability to negotiate and prioritize your own health."[283] Nearly half of the D.C. residents surveyed for the 2008 D.C. HIV Behavioral Study reported depressive symptoms in the past week with women significantly more likely to report depressive symptoms than men.[284]

Untreated mental health issues can be disruptive to physical healthcare, preventing a patient from taking medicine, visiting the doctor, and following good nutrition or other healthy living instructions. Disruptive behavior can significantly impact treatment options,[285] including loss of subsidized housing, which severely undercuts treatment adherence.[286] If a patient discontinues use of an HIV treatment regime once it is started, the body can develop resistance to the drugs, making the HIV infection more difficult to treat.[287] For maximum effectiveness, some antiretrovirals require adherence rates as high as 90 to 95%.[288] As resistance to antiretrovirals develops, treatment options are increasingly limited. Thus, people living with untreated mental illness who may engage in risk behaviors or be less likely to engage in regular preventive medical care are more likely to develop drug resistance and could run out of treatment options.[289]

Many health service providers in D.C. recognize the stark need for mental health services in the low-income population, but do not have the financial or staff resources to provide these services.[290] Ari Ross, a nurse practitioner at Whitman Walker Clinic, noted that even though Whitman Walker has a psychiatrist and three psychotherapists, "the need far exceeds the amount of services that can be provided."[291] She identified this lack of mental health services as a major need for their clients, including clients with a recent HIV diagnosis, and also as a way of preventing behaviors that put clients at risk of contracting HIV.[292]

Women living with HIV/AIDS in the District identify the need for mental health services as well. For example, the participants in a focus group for HIV-positive women at Miriam's House, a transitional and long-term housing program for women living with HIV/AIDS, identified the need for mental health services.[293] One participant explained, more mental health services are needed "because a lot of people, including myself, are codependent, suffer from depression or anxiety, or have dual diagnoses."[294] This includes mental health concerns that arise after testing positive for HIV, like the onset of depression. One participant in the focus groups noted, "You go through a lot of changes due to the diagnosis. A lot of that causes depression -being alone [and] the fear of letting people know."[295] Without services for mental healthcare, efforts to prevent and treat HIV/AIDS will not

be fully effective. The District must address mental health issues in order to fully realize the desired results from spending on physical healthcare and to ensure that District residents are able to realize their right to health.

Insufficient substance addiction treatment programs lead to increased HIV transmission and ineffective treatment

The District's failure to meet the demand for substance abuse treatment programs[296] results in the increased risk of HIV transmission and ineffective HIV/AIDS treatment. The D.C. Department of Mental Health has estimated that more than one-third of reported AIDS cases in the District have been linked to substance abuse.[297] Doctors and outreach workers have reported that patients who struggle with addiction, often have trouble sticking to an HIV treatment regime and prioritize behavior related to addiction over treatment or care.[298] Substance abuse increases HIV risk in two ways, through shared drug injection equipment and through the increased practice of high-risk sexual behavior.[299] Ari Ross, nurse practitioner at Whitman Walker said, "substance abuse is a factor in contracting HIV, either because of IV drug use or when people are high they engage in risky sex or exchange sex for substances."[300] Studies have shown that women who use crack cocaine are more likely to engage in unprotected sex in exchange for money or drugs.[301] Alcohol abuse is also associated with high-risk sexual behavior.[302] The 2008 D.C. HIV Behavioral Study shows that many District residents are having sex while using drugs or alcohol, potentially putting themselves at risk of contracting HIV.[303] Almost half of people surveyed used alcohol and/or drugs the last time they had sex.[304]

According to Thomasine Guberski, Director of Nursing Care and Education at the University of Maryland School of Medicine, for some women with untreated substance abuse, the "drive to use drugs overcomes reason."[305] An interviewed HIV-positive woman in the District said, "When you're in your addiction, you'll do whatever it takes to feed the addiction. If he's got something for you to get high on and he says he wants to do it without a condom, trust me, you're going to do it without a condom."[306]

The District has a shortage of substance abuse treatment facilities, in particular residential detoxification facilities. Carol Marsh, Executive Director of Miriam's House, a residential facility for HIV-positive women, explained that, "there are so few treatment beds; you can barely get detox in this city anymore. Detox [is] mostly in hospital psych wards but you have to say you're ready to commit suicide and in some places you have to be high when you walk in the door."[307] The limited number of beds for substance abuse treatment and the strict requirements for admission into the programs have resulted in too few people being treated. For people living with HIV/AIDS in D.C. this can interfere with prevention and treatment efforts as untreated substance abuse can lead to higher risk behavior and lower adherence to treatment.

C. Gender-Specific Barriers Impede Effective HIV/AIDS Testing, Prevention, Treatment, and Care for Women

Ancillary barriers disproportionately impact women's access to healthcare depriving them of timely HIV/AIDS testing, prevention efforts, and treatment.[308] Women are most often responsible for not only themselves but also the care taking of partners, children, and other family members. These responsibilities often result in women leaving their own health and wellbeing in last place. For HIV-positive women this additional stress and responsibility can lead to dangerous and sometimes

fatal health outcomes. Without systematic support to assist HIV-positive women with both their infection, and their ancillary responsibilities, medical treatment can only go so far.

Transportation, work schedules, and care giving commitments complicate prevention efforts

For many women living with HIV/AIDS who lack flexible work hours, child-care options, and depend on public transportation, keeping medical appointments can be difficult and time consuming. One study by the U.S. Department of Health and Human Services (HHS) showed that more than one-third of people living with HIV delay or do not access medical treatment due in part to unavailable transportation and employment obligations.[309] These challenges can be particularly difficult for women who are single parents or primary care givers. An international study that echoes the challenges faced by HIV-positive women surveyed in D.C. found that a majority of HIV-positive women do not adhere to their treatment regimens because of their care-giving commitments.[310] Dr. Randi Abramson from Bread for the City noted that barriers exist for her patients including transportation and getting time off from work. She noted that so many of her patients "have chaotic lives" and so "their health goes on the back burner."[311] Women participating in the D.C. government's 2008 focus group on consumer needs related to HIV/AIDS noted inadequate transportation as a barrier to healthcare.[312] People living with HIV/AIDS, especially those with complications or concurrent medical conditions, often require more extensive medical treatment and monitoring including increased screenings, examinations, and evaluations, meaning more visits to the doctor and pharmacy. Flexible clinic hours, on-site child care, and better access to transportation would allow more women to access healthcare.[313]

Greater emphasis is needed on health literacy of patients and cultural competency of healthcare providers

Numerous service providers noted that their clients, in particular amongst Blacks and Latino immigrants, feel a lack of empowerment around their own healthcare. Some providers mentioned a historic or lingering distrust of medical providers.[314] For example, Dr. Regina Zopf of Unity Healthcare and Washington Hospital Center shared her sense that there is a general distrust of the medical system within the Black community because of past abuses by the system.[315] She mentioned an example of a doctor in a government healthcare clinic in D.C. that is no longer open that would not talk to or treat HIV patients without a mask.[316] Recognizing this distrust of the medical community and because the government is not addressing it, Sister Song, a national reproductive justice organization for women of color has been educating and empowering women about their own healthcare:

We are trying to educate women to understand their bodies, because giving medical providers a carte blanche is like giving the doctor a loaded gun. Historically, we have been abused so much… collectively we have been so beat down in the struggle mode that it has never occurred to people to be proactive… We figure out how to educate women and take control of their bodies.[317]

Similarly, a local organization, HIPS, which assists sex workers in D.C. to lead healthy lives, is developing a workshop on "How to Survive your Doctor's Appointment" and shares information about how to be informed and assertive in doctor's appointments

with its clients.[318] The District should undertake a comprehensive effort to increase health literacy among residents of D.C., which could lead to more residents accessing preventive healthcare.

Promoting cultural competency among healthcare providers is as important as increasing health literacy among patients. According to the National Minority AIDS Education and Training Center, increasing cultural competency among healthcare providers can help address barriers such as distrust of the medical community and cultural stereotyping of minority patients.[319] Training and materials on cultural competency for medical providers exist; however it is not mandatory for healthcare providers to be trained on this information.[320] Requiring cultural competency training for all healthcare providers practicing in the District would be a critical step toward reducing related barriers to care.

D. The District's Inadequate Provision of Preventive Care, Testing, and Treatment Curtails D.C. Residents' Right to Health

The D.C. government has taken significant steps to ensure that all residents are able to access healthcare, as evidenced by its D.C. Alliance, Healthy D.C., and the D.C. Healthy Families programs. However, such efforts fall short given the high rates of HIV/AIDS in D.C. The official failure to curb and address barriers to comprehensive HIV/AIDS prevention and treatment jeopardizes the health and wellbeing of D.C. residents. The right to health is recognized universally as a fundamental human right. The WHO Constitution, of which the United States is a party and active member, recognizes the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[321] The right to health is further proscribed by numerous international human rights instruments. The UDHR outlines that "[e]veryone has the right to a standard of living adequate for the health and well-being…, including …medical care. "[322] This right is codified in the ICESCR, as it recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and calls on governments to take steps "to achieve the full realization of this right."[323] The CESCR Committee, which monitors compliance with the ICESCR, recognizes the right to health is closely related to and dependent upon the realization of other human rights, widely recognized in international law, including the rights to dignity, life, housing, freedom from violence, non-discrimination, and equality[324] The American Declaration of the Rights and Duties of Man, which obligates members of the Organization of American States including the United States, recognizes that "Every person has the right to the preservation of his health."[325]

The right to health includes the provision by the government of facilities, services, and conditions necessary for the realization of the highest attainable standard of health.[326] This includes providing high quality affordable healthcare and removing barriers to accessing that care.[327] The right to health includes "access to a full range of high quality and affordable health care" and "the removal of all barriers interfering with access to health services, education and information."[328] Specifically, the WHO recognizes that "the extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health."[329] Further, According to General Comment 14 of the CESCR Committee, to ensure the right to health, all health facilities, goods and services must be respectful and culturally appropriate, including being respectful of the culture of minorities and sensitive to gender.[330] Furthermore, General Comment 14 states that the "prevention, treatment and control of epidemic, endemic, occupational and other diseases" requires the establishment of prevention and education programs for behavior-related health concerns, in particular HIV/AIDS.[331]

States and municipalities nationwide have increasingly framed access to health care as a fundamental human right. Right to health care as a human right amendments to state constitutions have been introduced – albeit to mixed success – in Florida, Massachusetts, Michigan, Minnesota, North Carolina, Oregon,[332] and Montana.[333] In 2008, the Connecticut general Assembly passed a law to establish a Commission on Health Equity. In its preamble, the state assembly found that "[e]qual enjoyment of the highest attainable standard of health is a human right and a priority of the state" (emphasis added).[334] The commission is tasked with "eliminating disparities in health status based on race, ethnicity and linguistic ability, and improve the quality of health for all of the state's residents." The Pennsylvania House of Representatives Unanimously adopted Resolution 473 mandating the "integration of human rights standards in Pennsylvania's laws and policies" to "assure the well-being" of its citizens. The 2002 study by the committee designate under the act plans to further investigate "health care and adequate housing" as "critical to resolving the issues facing the poor."[335]

Furthermore, as discussed earlier in this report, both the D.C. Human Rights Act and CERD provide a right to access healthcare without discrimination.[336] While D.C. law clearly prohibits discrimination in places of public accommodation, including clinics and hospitals, discrimination continues to occur. The CERD Committee has noted that wide racial disparities continue to exist in the field of sexual and reproductive health particularly evidenced by the growing disparities in HIV infection rates for minority women.[337] The barriers to affordable healthcare and the lack of routine testing are affecting Black women in particular, violating their right to healthcare free from discrimination.

VIII. LACK OF ADEQUATE HOUSING FUELS HIGH HIV/AIDS RATES AMONG WOMEN IN D.C.

The District's efforts to stem the HIV/AIDS epidemic fail to incorporate a full response to the affordable housing crisis that increases women's vulnerability to HIV/AIDS. Housing plays a crucial, dual role in any successful HIV policy, in the realms of both treatment and prevention. Compared to the general population, homeless individuals have a three to nine times higher HIV prevalence rate and are seven to nine times more likely to die from HIV/AIDS.[338] Additionally, homeless people living with HIV/AIDS die at a rate five times higher than housed HIV-positive people.[339] As caretakers for their children, the women who head most homeless families[340] may find themselves more likely to engage in high-risk behaviors linked to homelessness, such as exchanging sex for shelter, food, or money[341] or tolerating abuse.[342] Homeless women with children are therefore less likely to prioritize their own health needs as they focus on finding shelter for their families. Without responding to housing – a first concern of those most at risk for HIV – D.C. cannot effectively fight the epidemic.

Housing is a priority for women affected by HIV in the District and an internationally recognized human right, but in D.C., the need for housing is unmet. During a focus group at Miriam's House,[343] when asked what rights HIV-positive women should have, one positive woman responded immediately, "We should have the right to housing first." The international community recognizes the right of everyone to "an adequate standard of living for himself and his family, including adequate… housing."[344] Yet the resources dedicated to housing do not do justice to D.C. residents' rights or to the role of housing in both the treatment and prevention of HIV. Existing housing programs for HIV-positive people – most notably, the federal HOPWA program –

acknowledge the link between housing and HIV treatment, but D.C. and the federal government must increase their efforts in order to fully recognize and respond to the role of stable housing in HIV prevention to succeed in stemming the epidemic.

The D.C. government's failure to fulfill the right to housing for its residents in turn violates the right to health. The importance of stable housing in HIV/AIDS treatment is well-documented and recognized. Without housing, those already affected by HIV/AIDS may not be able to focus on less immediate needs related to their HIV status, such as attending doctor's appointments, taking medication, and staying healthy. This prevents homeless people living with HIV/AIDS from keeping viral loads low and fighting off opportunistic infections, limiting the ability of HIV-positive people to enjoy the right to health even when healthcare services are available. As a doctor at Bread for the City's medical clinic put it, "Housing is the most important issue for everyone… You can tell someone they have HIV, but if they don't have a house, their HIV doesn't become very important. They don't see it, feel it… But if you are homeless, it immediately affects you."[345] If other fundamental needs prevent those most at risk for HIV from accessing healthcare, the D.C. government does not fulfill its obligation to protect its citizens' right to health[346] or accomplish its goal of stemming the HIV epidemic.

In response to the importance of housing in HIV treatment, federal law has taken affirmative steps to provide housing to PLHA and to the general population, but these steps are not enough to meet the need for affordable housing in D.C. Federal initiatives like the Section 8 voucher program, the HOPWA program, and other programs are implemented in D.C. to provide much-needed housing assistance to people at risk for and affected by HIV. Nonetheless, about 26,000 people are on the waitlist for housing assistance in D.C.,[347] and nearly 300 are waiting for HOPWA assistance geared specifically to PLHA.[348] It can take three to five years to get a Section 8 voucher, and once a voucher is secured, the recipient may not be able to find an affordable unit to which she can apply it.[349] Although D.C. law prohibits landlords from discriminating against tenants because they are voucher-holders,[350] there are simply too few affordable housing units to accommodate residents' needs. These long waiting lists are evidence that for people in the District of Columbia, the human right to housing is unfulfilled, and their right to health lacks a crucial foundation. To address the epidemic and to fulfill the human rights of its people, the D.C. government must also address the urgent need for affordable housing.

Just as housing is a vital element in treatment success, stable housing is also linked inextricably with HIV prevention along two key pathways. First, treatment adherence is linked to viral suppression, which reduces the transmissibility of HIV. When PLHA are able to manage their health and suppress the virus, they are much less likely to pass on HIV to others, even if they continue to engage in behaviors that might transmit the virus. Second, housing can help reduce the incidence of "risky behaviors" (such as drug use and transactional sex) that increase vulnerability to HIV,[351] particularly among women. Homelessness affects both the ability of the most vulnerable populations to access educational resources and, by extension, their knowledge of and ability to protect themselves from HIV. At a focus group at The Women's Collective, one woman told her story of outreach:

> *I took in a homeless girl. She'd been out there for a while and I took her in, let her clean herself up—and I talked to her about HIV and AIDS and she said she didn't know. So I called my old case manager and told her, and she talked to her. I helped her get an appointment and she got one.*[352]

Even when individuals know how to protect themselves from HIV, when making decisions in their daily lives, people respond to the more immediate task of finding a place to sleep, rather than considering the HIV-related risks of their coping strategies. In D.C., where the prevalence rate is consistent with a generalized epidemic, the odds are stacked even higher against them. As a result, the failure of the D.C. government to provide sufficient affordable housing for its residents is crippling existing prevention efforts.

Policymakers must recognize that housing is necessary to stop the spread of HIV and prioritize housing as an intervention in both HIV treatment and prevention, thereby reducing the risk for D.C.'s most vulnerable populations. Responding to the overall need for affordable housing will enhance the effect of existing and future efforts to combat HIV and AIDS. Organizations like Housing Works, a national-level advocacy group focused on ending the twin crises of AIDS and homelessness, have long emphasized this connection. An interviewee at Housing Works, explained:

> *When you take [the housing] worry off their head, you let them pay more attention to their medical, physical and emotional needs. . . If you have no place to stay you're not going to make your appointments. If you don't have a place to store meds, you won't prioritize taking them. If you don't have a place for your kids, you won't take care of yourself. Having that stable, affordable housing allows people to actually access the other services that are important to making sure they stay healthy."353*

The D.C. government must respond to the role of housing in the HIV epidemic by providing the resources necessary to ensure that housing is affordable and accessible to all D.C. residents.

A. Homelessness Dramatically Increases HIV Vulnerability Among Women With Children

Women in particular suffer as a result of homelessness, and more women are affected each year. Families with children are one of the fastest growing segments of the homeless population, and 80% of homeless families in D.C. are headed by women.[354] The percentage of women-headed households on the housing voucher waitlist is nearly as high.[355] According to an HIV-positive woman who is an HIV Testing Counselor and Field Supervisor for The Women's collective, "Women still have the primary responsibility of caring for the children and the majority of men don't pay to help." Homelessness affects female heads of household uniquely. Women who have responsibility for caring for their children must find a way to provide for their children's needs and care for them in the face of a lack of affordable or employer-sponsored child care. Women who are primary caregivers may take risks or tolerate abuse in order to find a roof for their families. According to a domestic violence attorney at Women Empowered Against Violence (WEAVE).[356]

The numbers of people who are homeless are actually way higher than reported. The numbers of women in D.C. who are literally homeless, who don't have a home, are way higher than it looks like because so many women stay with people, women who exchange sex for a place to stay or stay in abusive relationships with someone so that they actually have that place to stay.[357]

For many women, immediate needs, especially those associated with caring for children, take precedence over their own needs related to HIV prevention and treatment. Homeless women are at greater risk for HIV infection and, once infected, less able to protect their health and live with the disease.

B. Existing Laws Recognize the Importance of Housing and Acknowledge Its Role in HIV Treatment but Fail to Fulfill the Human Right to Housing

Federal housing assistance programs attempt to provide a safety net for homeless throughout the United States, but in D.C. they fall well short of residents' needs. Through a variety of programs, the U.S. Department of Housing and Urban Development (HUD) provides funding for local housing assistance programs in the form of grants to individual jurisdictions and, in some cases, directly to non-profit organizations that administer particular housing programs or facilities.

D.C.'s affordable housing crisis prevents residents from enjoying the rights to housing and health and fuels the HIV/AIDS epidemic

Although housing programs are in place at the federal and local levels, they fall well short of fulfilling the right to housing and of providing a solid foundation for upholding a right to health and other rights connected to housing. According to the Washington Legal Clinic for the Homeless, at least 17,800 people are homeless in D.C. per year, and families represent 30.4% of that population.[358] About 6,044 people were homeless per day in D.C. in 2008.[359] The D.C. DOH reported different numbers[360] in its Comprehensive HIV Care Plan, reporting a total of 11,752 homeless individuals in 2008.[361] The Comprehensive Care Plan also estimates that 5,751 people in D.C. were homeless when diagnosed with HIV, amounting to 13.6% of the total population of PLHA in the District, and 49% of total homeless individuals.

The combined forces of a high cost of living and a large low-income population create an urgent shortage of affordable housing in D.C. The estimated costs of living in D.C. are three times the official poverty level.[362] Because the District has the nation's third highest poverty rate in the nation, at 19.8%,[363] the housing crisis affects thousands of people, and homelessness is a reality for many. At minimum wage, a worker would need to work 145 hours per week – 21 hours per day, seven days a week – to afford a two bedroom apartment at D.C.'s fair market rent.[364] As noted above, about 26,000 D.C. residents are on the waitlist for housing assistance, as well as 300 waiting for HOPWA assistance geared specifically for PLHA. For individuals on those lists, finding a place to live is the top priority, and treating HIV or protecting themselves from it takes a backseat.

In addition to the lack of available affordable housing, one expert explained the following:

> *There are not enough services to put people in the units or vouchers to make housing available. And there aren't enough ways to give people enough money to afford the affordable housing… People aren't making enough to afford it, there aren't enough supports or subsidies to let people get into and keep an apartment… More funds need to be allocated for addressing homelessness, not just about housing people but providing strategies so people can afford housing. Bring the residents up out of poverty… It is more than just giving people a place to live.*[365]

Eric Tars, Human Rights Staff Attorney at the National Law Center on Homelessness and Poverty (NLCHP), expressed a similar observation. "People get their SSI [Supplemental Security Income, a federal income supplement program] checks, but it's not actually enough to afford housing. It's only enough to keep them alive and living in a shelter and not to provide decent housing."[366] According to an outreach worker at the Washington Legal Clinic for the Homeless, part of the problem is prioritizing resources away from low-income residents:

> *The last HUD Secretary had the philosophy that the housing coming out of HUD should be for middle-income people, and also that the voucher program should be temporary… I haven't known anyone that treated the voucher as temporary. In the District, there is a significant percentage of people in poverty. You have to work with people and retool them, get them on an income earning track.*[367]

Another expert explained:

> *It would not be enough to house those 293 people on the HIV-positive list because there's no system to prevent it from growing again. It needs fixing. And there are a lot of other people who need that housing and who may be homeless and have other needs as well. It's broader than HIV and AIDS.*[368]

The lack of affordable housing in D.C. cripples existing housing assistance programs. It can take three to five years to get a voucher off the waitlist,[369] and even those who are able to secure a housing assistance voucher may not be able to find a unit to use it on. The D.C. Human Rights Act prohibits landlords from discriminating against voucher-holders,[370] but even without such discrimination, there are simply too few affordable units to meet the needs of D.C. residents. As a result, D.C.'s poorest residents may look to other forms of housing, including emergency shelters and transitional housing.

Emergency shelters serve as a temporary, short-term intervention to prevent individuals from sleeping on the streets or in other places not meant for human habitation. They are not designed to replace stable, permanent housing. Shelter services address basic needs such as food and a place to sleep for short periods ranging from a one-night stay to seven nights per month to a thirty-day stay.[371] They may be designed to serve specific populations such as survivors of domestic abuse, or may be resources for homeless individuals generally, often with gender restrictions. Shelter beds in the District are available on a first-come, first-served basis, with a 4:00 p.m. deadline to get a bed and a 7:00 a.m. "check-out" time;[372] individuals who use the shelter system are expected to leave during the daytime hours. The instability of shelter life can interfere with children's ability to attend school consistently and expose them to other harmful dynamics. For example, although many shelters require residents to be sober, the reality is that drug use does happen.[373] As a result, many women may avoid the shelter system to protect their children and maintain stability, even if that means "doubling up" with other families, trading sex for shelter, or staying in an abusive home.

Transitional housing goes beyond addressing fundamental needs to provide services, to helping residents achieve greater independence[374] and ultimately obtain permanent housing. Transitional facilities generally provide more privacy, as well as more intensive service provision and expectations for resident participation in community activities. Most transitional facilities

are time-limited but longer term than emergency shelters, with residency periods ranging from three months to two years.[375] Like shelters, transitional housing may be designed to serve specific populations and screening and application procedures for such facilities can be extremely arduous.[376] Many transitional housing facilities do not allow children,[377] making them a difficult option for women who have custody of their children. Mothers may be forced to choose between a safe and supportive home for themselves and keeping their families together.

C. Unstable Housing Obstructs Women's Right to Health and Undercuts the Effectiveness of HIV Treatment

Existing housing programs are a good start, but by omitting housing from the goals and scope of its Comprehensive HIV Care Plan, the D.C. government fails to acknowledge the fundamental role that housing must play in addressing the HIV/AIDS epidemic in D.C., particularly for women. For many PLHA, housing is a prerequisite for treatment adherence, which is in turn essential for their health. The stability that housing provides to women living with HIV/AIDS and their children enables mothers to prioritize their own health, helping them to prevent the onset of AIDS and to fight off opportunistic infections. The international community recognizes the interdependence of the right to housing and the right to health, and the D.C. government must as well, by explicitly integrating housing into its efforts to stem the HIV epidemic.

Housing must serve as the foundation for the fulfillment of other human rights, especially the right to health. According to the U.N. High Commissioner on Human Rights (UNHCHR), which coordinates human rights activities throughout the U.N. system, "The indivisibility and interdependence of all human rights find clear expression through the right to housing."[378] In a fact sheet on the interpretation of the right to housing, the UNHCHR stresses the vital importance of housing for the enjoyment of human rights:

> *Housing is a foundation from which other legal entitlements can be achieved. For example: the adequacy of one's housing and living conditions is closely linked to the degree to which … the right to the highest attainable level of mental and physical health can be enjoyed.*

The WHO has asserted that housing is the single most important environmental factor associated with disease conditions and higher mortality and morbidity rates.[379] As a signatory of the WHO Constitution, the U.S. must take heed of this assertion and implement housing as a component of health policy, especially in its response to HIV/AIDS.

Lack of housing undercuts treatment adherence, leading to diminished health and greater likelihood of HIV transmission. 380 A Public Policy Coordinator at Metro Teen AIDS, explained, "If you're homeless, HIV is not your main concern. Your biggest concern is 'Can I find a roof?'"[381] Particularly for women with caretaking responsibilities for their children, finding a safe place for their families to sleep takes priority over doctors' visits and taking medications. The lack of stability associated with homelessness can make treatment adherence impossible even if it is a top priority. Some HIV medications require refrigeration;[382] others must be taken with food or two hours before or after a meal.[383] The kind of stability such regimens require is a luxury many homeless PLHA cannot afford. Still other medications have side effects that limit the ability of homeless people to take their medication consistently. Donna Crews, Government Affairs Director at AIDS Action, explained,

"You're not going to take any medication that's going to cause diarrhea if you don't have a place to live, and you'll stop taking the medicine."[384]

Patients who do not have stable housing may experience difficulties sticking to their treatment, including taking medication regularly or even keeping track of their medication. Discussing patients who are "staying all over the place," Dr. Randi Abramson of Bread for the City noted, "They lose medicine all the time. There's so much movement it's hard for them to keep things organized."[385]

In the face of the obstacles homelessness creates to treatment adherence, many PLHA may take medication whenever they are able, further endangering their health. In many cases, inconsistent use of medications is worse for health outcomes than never starting treatment at all because the virus may become resistant to treatment that is only intermittent.[386] Those who cannot take medications consistently may end up in worse health, or may need to begin a more intensive regimen with more serious side effects. For these patients, it may be impossible to prevent AIDS onset and to fight off opportunistic infections, and ultimately to prolong their lives.

Experts agree that housing directly affects HIV/AIDS health outcomes. According to David Vos, Director of HOPWA, "There doesn't seem to be any debate around that."[387] Indeed, HOPWA's existence is an acknowledgement of this connection; similarly, its success – the highest program success rating by the U.S. Office of Management and Budget[388] – is evidence that housing is an effective treatment intervention for PLHA. Yet not all policymakers recognize the link between housing and HIV vulnerability. Asked whether housing contributed to HIV vulnerability, D.C. Congresswoman Eleanor Holmes Norton responded:

> *What a stretch that is... Just because I don't have a house over my head I am more at risk for HIV? I don't buy that… Somebody's on welfare, homelessness, all of that. That is the kind of alibi and excuse that people, especially in the community, love to hear.*[389]

In addition to the copious data on the connections between insecure housing and HIV, the experiences of positive women in D.C. also demonstrate that treatment adherence is more difficult for homeless PLHA. In a focus group at The Women's Collective, one woman shared: "If you don't have housing and you aren't settled, [you're] not gonna take [your] meds, or go to the doctor. [You] can't get to it. [You] can't feel better about [your]self. If you don't feel good about yourself… you'll take recreational drugs."[390] A woman at Miriam's House, a housing facility for positive women, described what would happen if she could not stay at Miriam's House: "I would go back to my aunt's house. I'd be bad about taking meds. I would just lay there and not take them when I didn't feel good. I would be lax about doctor's appointments. Miriam's House puts stability in my life . . . I need some [stability]."[391] For many PLHA, the structure that housing provides is a psychological prerequisite for treatment adherence with physical implications for health.

An independent study by CDC scientists Kidder et al, "Health Status, Health Care Use, Medication Use, and Medication Adherence Among Homeless and Housed People Living With HIV/AIDS,"[392] indicates that housing is associated with improved health outcomes for PLHA along a variety of indicators, including viral load, CD4 (T-cell) count, treatment adherence,

hospitalizations, and emergency room visits. Homeless respondents were less likely than housed respondents to report good or excellent health, less likely to have a self-reported CD4 count of 200 or above, less likely to have a self-reported undetectable viral load, more likely to have visited an emergency department in the past year, less likely to be taking HIV medications, and less likely to have been treatment adherent in the past 48 hours.[393] Even when studies controlled for demographic and social variables, drug use, and alcohol use, housing status remained a good predictor of overall health status, viral load, ER use, treatment status, and treatment adherence.[394]

D. Housing Instability is a Crucial Factor in Women's Vulnerability to HIV

The D.C. government's failure to address the affordable housing crisis thwarts its efforts to prevent the spread of HIV. Homelessness and unstable housing increase vulnerability to HIV through a link to increased risk behaviors including transactional sex, substance abuse, multiple sex partners, and domestic violence.[395] Women who struggle to ensure that their children's needs are met are especially likely to engage in informal transactional sex to secure shelter for their families, trading sex for the basic things they need to survive.[396] This limits their ability to negotiate condom use and increases women's risk for HIV.[397] If the policy to address HIV/AIDS fails to respond to the housing needs of its most vulnerable residents, it will never succeed in stemming the epidemic.

Housing plays a critical role in preventing HIV transmission and must be part of the D.C. government's response to the epidemic. Unstable housing's effect on treatment adherence has a direct impact on HIV transmissibility. When an HIV-positive woman is healthy, with the low viral loads and good T-cell counts that treatment can help maintain, her partner is at "minimal risk,"[398] although, of course, she herself is still at risk for opportunistic infection and re-infection. For this reason, suppressed viral loads are linked to diminished HIV transmission.[399] But viral suppression is not the only way that housing contributes to HIV prevention. Housing reduces so-called "risky behaviors" that may lead to HIV infection, including substance abuse (especially injecting drug use and needle sharing), sex with multiple partners, unprotected sex, and exchanging sex for food, drugs or shelter. David Vos, Director of HOPWA, affirms this finding:

> *The research on this shows that people with housing are very much less likely to expose other people to HIV – so that hits prevention right there. It's… a way of expressing that this program [HOPWA] has results.*[400]

The 2007 Kidder study discussed above reviews research indicating that homeless people are more likely to engage in risk behaviors that can lead to HIV infection, including "risky sexual practices, injection drug use and needle sharing, and performing sexual acts in exchange for money, drugs, or a place to stay."[401] A CDC-funded study in 2005, "Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy," revealed findings by researchers from CDC and HUD that the likelihood of recent drug use, needle use or sex exchange was two to four times higher among the homeless than among stably-housed subjects. When the researchers followed up six to nine months later, they found that a change in housing status affected the likelihood of risk behaviors:

Persons whose housing status improved between baseline and follow-up significantly reduced their risks of drug use, needle use, needle sharing and unprotected sex by half in comparison to individuals whose housing status did not change. In addition, for clients whose housing status worsened between baseline and follow-up, their odds of recently exchanging sex was over five times higher than for clients whose housing status did not change.[402],[403]

Women may resort to transactional sex to provide shelter for their families, putting them at risk for HIV

Women are especially likely to exchange sex for money and shelter because of resource limitations and dependence on men to meet their needs, both emotionally and financially. An outreach worker for The Women's Collective explained why this dynamic disproportionately affects women:

> *Most of the women have children, and care of children tends to fall to the women, they're also at a disadvantage. This, and their financial dependency often leads to depression... The women don't have the resources. They may have 5 babies and no man. A lot of the jobs they have the skills for don't provide daycare, so they opt to stay at home with their children instead, because the cost of child care takes too much out of their paychecks.*[404]

According to Emily Pavetto, a family-centered case manager at The Women's Collective, many of the women she serves have finished 8th grade or "high school, if they're lucky."[405] Their ability to provide for themselves is severely compromised by this lack of education; without job skills to work at a living wage and without access to affordable housing, they have little choice but to trade sex for fulfillment of basic needs. This may mean that they engage in commercial sex work to earn money to pay rent on housing they could not otherwise afford. Whether they sell sex for money or engage in transactional sex in exchange for shelter or a meal, women cannot effectively demand condom use. According to Dr. Joan Miles at Bread for the City, "If you're selling your body to make rent payments, any time when people don't have full options, they're at higher risk."[406] This dynamic is amplified when they have children to provide for as well.

Women who must provide for their children may trade or sell sex in order to put a roof over their families' heads, putting themselves and others at risk for HIV.[407] Lauren Broussard, Fellow at the Office of the Secretary for the U.S. Department of HHS, noted the awareness of women's unique vulnerability, stating that "Women specifically, we acknowledge… are in positions in which sex is survival. So they are not in a position where they can negotiate sex. They're put in violent situations, or sex is their rent payment."[408] In situations where sex is survival, women's ability to negotiate condom use is dramatically reduced. When the most important thing is to find a place to stay, women may take risks that expose them to HIV – or, if they are positive themselves, may expose others to HIV. As one HIV-positive woman in a focus group at The Women's Collective explained:

> *If you [are] a woman, and you [are] homeless, and you meet a guy who has his own place, you [are] gonna go with him because then you have someplace to lay your head for the night. That's common. You've got a lot of people and especially women. If you miss that 4 o'clock bed [deadline to be admitted to shelters in D.C.] then you can't get into a shelter. So you meet John Doe at the gas station and you go to his house and sleep with him so you've got*

someplace to stay. You ain't using no condom, and you know, when you [are] out there, you [are] streetwalking, you sell your body. [If] I give you an extra $10 not to use a condom then you [are] gonna go bareback without the condom.[409]

Another HIV-positive woman at a focus group at Miriam's House explained how a sex-for-shelter arrangement, even a long-term arrangement, might come about:

If you don't have a place to stay, you're out on the street. A man is going to offer you a place… to stay. But what you've got to do is sleep with that man to stay some place warm and sheltered in. If it's cold outside, she might stay for the winter… If she wants to stay there, that's what he wants… But after they don't have more use out of you, you've got to go... When they're tired of banging you, its time to go. Somebody will take you out of the cold and feel sorry for you but in return they want something back.[410]

Women may stay in abusive relationships to keep a stable home, increasing their vulnerability to HIV

Survivors of domestic violence likewise often find themselves with similarly limited housing options and thus greater vulnerability to HIV. Linda Lopez, an HIV-positive case manager at The Women's Collective, explained why her clients who are domestic violence survivors remain with their abusers: "They're homeless, they have children with this guy, they're uneducated, or they're waiting for housing but the list is as long as 6 years."[411]

Domestic violence is one of the leading causes of homelessness in the United States,[412] but many women may stay with an abuser because they have no alternative housing. This means they remain in a situation where survival sex and unprotected or forced sex are likely.[413] Homeless women experience domestic violence at greater rates than the stably housed,[414] but some women may accept violence, which puts them at risk for HIV because they have no housing alternatives. According to an attorney at WEAVE:

I think one of the most common reasons for staying in an abusive relationship is for housing…I have had very very few clients who had their own stable housing that was not connected in some way shape or form to the abuser. And those who have, many of them have wanted to relocate because they're afraid of their abuser coming after them at their previous residence.[415]

Survivors may be forced to choose between homelessness or staying with an abuser, or their housing may be compromised through abuse. A Domestic Violence Staff Attorney at NLCHP, described possible scenarios that might affect a survivor's housing status:

You either leave the abuser and the situation, or the problem was that people are evicted for noise complaints, calling the police, destruction of property – and those things are directly related to domestic violence. But there are

reasons that are also indirectly related to domestic violence; for example, if the abuser messes with the survivor's credit, or withholds money for paying rent.[416]

The housing provisions in the Violence Against Women Act (VAWA) are intended to protect survivors of domestic violence from eviction on the basis of their status as a survivor.[417] The D.C. Human Rights Act includes a similar provision protecting victims of intrafamily offenses from housing discrimination.[418] But to avail themselves of these protections, survivors must report the violence they experience, something that HIV-positive women may hesitate to do for fear of their abuser "outing" their HIV status. Survivors may be reluctant to report the violence they experience because they feel they have nowhere else to go, because they face the same limitations on housing that others in D.C. face: there is simply not enough affordable housing. Laurie Kohn, Director of the Domestic Violence Clinic at Georgetown University Law Center, described the housing situation in D.C. as "horrible." She related a common concern amongst domestic violence survivors with children:

I had a client who I had been working with for years, and had 3 little kids. Her husband has a very good income and she has tried to leave so many times, but she can't find a place to live with 3 little kids that she can afford – even when we get an order where he pays her alimony. So she has gone back to him maybe 5 times. We even got a protection order where he lives in the basement, but that never works. So housing I think is one of the biggest impediments to women leaving.[419]

Each of the legal provisions do, however, include a narrow exception allowing a landlord to terminate tenants who constitute an "imminent threat" in VAWA,[420] or a "direct threat" in the D.C. Human Rights Act.[421] This exception may put women who are abused at risk of eviction due to mental health issues or illegal actions by their abusers; no provision is made to help them access alternative housing. The D.C. Crime Victims' Compensation Fund will put survivors who report their abuse in a hotel for 30 days, but after that, they may return to their abuser for lack of alternatives. According to Kohn, "Victims' Compensation also provides the first month's rent and a deposit, but that doesn't help if the client doesn't have the second month's rent."[422] Furthermore, the hotels that serve as "safe houses" for survivors are often just as dangerous as an abusive home. An attorney at WEAVE described these hotels as "incredibly sketchy," explaining:

I have had clients who are terrified of walking outside their door… It's a hotel that's near lots of sex work, lots of drug trafficking, lots of murders, lots of crazy fights. It's not a safe place. I have had clients call me from the floor and say I can't go open the door I am terrified. I am more afraid of the people outside my hotel, my safe hotel door, than I am of my abuser because I at least know him. I know how he's going to hurt me but I don't know how these people will.[423]

Navigating the available housing resources is also extremely difficult, especially for survivors of domestic violence. According to Cecilia Levin at NLCHP, "There's still a lot of confusion over how to do emergency transfers, whether VAWA applies to project-based Section 8. Because there is a lack of guidance, people are doing things as they come up."[424] Laurie Kohn of the Georgetown Law Domestic Violence Clinic explained:

> *I think the big issue with Section 8 clients is that they may want to move to get away from where he knows where she is and just to get a transfer from a Section 8 house to another is incredibly difficult. I have never successfully seen that done…I think just administratively because there is such a long waiting list, if something opens up they'd rather just put someone in there rather than trying to transfer between two facilities.*[425]

The HUD issued guidance on the implementation of VAWA provisions in Section 8 in September 2008,[426] but the guidance is not complete. According to Cecilia Levin, "Because there's no clear guidance, a lot of folks nationally are doing things within their own discretion... and so right now it's up to the landlord or housing manager. There's too much that could go wrong because there's no clear guidance saying this is how it's supposed to be."[427]

E. Insufficient Housing Assistance Gravely Impacts Women

Although local and federal initiatives are in place to fight homelessness in D.C., they are not enough to meet the needs of residents and effectively stem the HIV epidemic. Existing transitional and emergency facilities are too scarce and have high barriers to entry; they cannot substitute for stable housing's role in treatment adherence and health promotion or in HIV prevention. Programs to provide assistance to accessing permanent supportive housing are under-resourced in light of the affordable housing crisis in D.C., with long waiting lists and too few available units. D.C. must respond to the severity and urgency of its residents' need for housing along the entire continuum of care in order to reduce HIV prevalence.

IX. THE D.C. GOVERNMENT'S FAILURE TO INTEGRATE GENDER-BASED VIOLENCE AND HIV/AIDS SERVICES UNDERMINES EFFECTIVE PREVENTION AND TREATMENT OF THE DISEASE AND VIOLATES THE RIGHTS OF D.C. RESIDENTS

Currently, the D.C. government has failed to acknowledge and address the intersection of two major threats plaguing the District—gender-based violence and HIV/AIDS. Failure to address this link leaves residents, many of them women, at higher-risk for exposure to both HIV/AIDS and gender-based violence. In 2008, the D.C. Metropolitan Police Department received more than 30,000 domestic violence-related calls, an increase of 10 percent over the past three years.[428] Additionally, a D.C. DOH behavior study on HIV and heterosexual relationships showed that nearly half of female participants reported having been emotionally or physically abused.[429] These statistics exemplify the interwoven nature of the HIV epidemic in D.C. and how the government has failed to address drivers of the disease, like gender-based violence.

This section will examine the link between gender-based violence and HIV/AIDS, identifying different ways in which the rights of women are violated in D.C. because of a lack of policies and services to address this link. Based on research, interviews of service providers and survivors, people who experience gender-based violence at any point in their lives face a multitude of barriers to prevention, care and treatment of HIV, including fear of demanding safe sex practices in their relationships, and entrapment and coercion from partners who use the woman's HIV status as a tool of abuse.

This type of violence against women violates their rights to physical integrity, dignity, freedom from violence and degrading treatment, access to healthcare and health-related information, and life. Understanding how gender-based violence and HIV/AIDS combined can catalyze violations of the rights of women in D.C. is essential to ameliorate the current situation in the District. In order for D.C. to decrease the number of women affected by both gender-based violence and HIV/AIDS, it must adopt new policies to help protect the rights of survivors affected by both life-threatening forces

A. Current Programs and Policies in the District Fail to Meet the Needs of Individuals Affected by Both Gender-Based Violence and HIV/AIDS

Service providers must "understand the links between [gender-based] violence and HIV, the relevance of these associations to their own work, and how they can practically respond to these concerns."[430] Without any assistance or training resources from the government, service providers working with survivors of gender-based violence that have recognized this link have not yet been able to implement systematic screening or other HIV/AIDS related services. The government must develop, implement, and monitor such programs to ensure that service providers can adequately screen and provide assistance to women that have already found a way into the system. WEAVE, like other organizations in D.C., has clients affected by HIV/AIDS, and recognizes that those clients need services relating to HIV/AIDS, but is unable to fulfill their needs because the integration and coordination described above has not been facilitated by the D.C. government. An attorney fellow at WEAVE, explained their dilemma:

> *[There] is no systematic way to screen for other risk factors right now [at WEAVE]. We have clients whose partners are drug abusers and spend nights away from the house, which clearly create risk factors for health, but right now we don't screen for those things in our initial questioning…Part of the issue in doing [this] is presently we don't have the system in place to immediately refer clients for aid in those situations.*[431]

Examples of programs that have been developed to integrate services for HIV/AIDS and gender-based violence in other states and countries emphasize the importance of those cross-referral services. In its conclusion and recommendations, The Center for the Study of Violence and Reconciliation in South Africa[432] stressed that "a thorough review of referral services needs to be undertaken prior to implementation of screening procedures, and this information should be made available to health workers."[433] Although WEAVE is one of D.C.'s leading service providers for women survivors of domestic violence and has committed itself to providing "holistic services,"[434] attorneys report that if the client does not bring up HIV, it is not currently something they ask about.[435] Similarly, in discussing screening for domestic violence, Dr. Haile-Mariam, an Emergency Department physician at George Washington Hospital Center, said the following:

> *Yes, there is supposed to be as part of our triage process screening that occurs. Nurses screening. It basically says 'In the last x time has anyone hit, kicked, punched or shouted at you.' That is supposed to be asked. I say supposed to because like any routine screening test, the feedback loop isn't there to ensure that it has been asked. And many times in the [emergency department] the chief complaint is such that screening for other things is not really that applicable. But along with advance directed questioning the intimate partner violence questions is supposed to be asked. I am a great*

believer in asking the intimate partner violence question. And many times even if they have been screened out front, I will ask again in the back. But I can't give you percentages. I'm sure that our percentages are abysmal.[436]

The health-related costs of intimate partner violence in the U.S. exceed $5.8 billion annually.[437] However, "only about 10% of primary care physicians routinely screen for intimate partner abuse during new patient visits and 9% routinely screen for intimate partner abuse during periodic checkups."[438] People working with survivors and women affected by HIV clearly recognize the intersection of health issues, like HIV, and gender-based violence and have individual goals to ensure that screening is actually happening at WEAVE and George Washington Hospital Center, respectively.[439] However, this acknowledged and necessary screening has been lost on a District-wide scale without a systematic policy developed by the District to ensure that service providers working with survivors of violence are screening for HIV, and that medical providers, HIV testers, and counselors are screening for gender-based violence. Without an explicit policy integrating HIV/AIDS and gender-based violence screening and services, the D.C. government is perpetuating the violation of women's rights to health, information, educational services, and life every time a woman seeks one of these services but is unable to be treated for the other.

B. The District Fails to Protect the Rights of Women in the District Affected by HIV/AIDS and Gender-Based Violence

The District's failure to systematically recognize that victims of gender-based violence are more vulnerable to HIV/AIDS exposure continues to leave women at a higher risk for HIV infection, compromising their rights to health and life. The intersection between gender-based violence and HIV is prevalent in the District. Service providers in D.C. working with the affected population "talk about whether it is the chicken or the egg. Being HIV-positive often leads to greater risk of violence. And exposure to violence, particularly intimate partner violence, leads to greater risk of exposure to HIV."[440] This dichotomy emphasizes the link between two serious threats to women in the District that have been severely unaccounted for by D.C. policy and laws. VAWA, the Federal Act adopted to improve criminal justice and community-based responses to domestic violence, dating violence and sexual assault in the U.S., recognizes that "women who have been abused are much more likely to suffer from…sexually transmitted infections, including HIV/AIDS."[441]

CEDAW, which has been signed by the U.S. but not yet ratified, defines gender-based violence as "a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men."[442] This inequality creates a power imbalance that infringes on a woman's physical, mental, and sexual self-control. Women who are in relationships where violence is used as a means of control are generally incapable of protecting themselves, let alone, determining when and how they want to have sex.[443] Furthermore, women who know that they are HIV-positive may be terrified to inform their partner, or suggest safer sex practices to decrease risk of transmission out of fear of violent retribution. The complications of violent and coercive relationships endanger the health and safety of both women and their partners.

Women who fear violence forego HIV testing or treatment

In addition to the HIV exposure women face from aggressors who are positive, women who are positive themselves and suffering gender-based violence are often afraid to disclose their status or to even get tested, which can also contribute to the spread of HIV. This fear of violence can also keep women from accessing HIV/AIDS treatment thereby violating their rights to health and life. The U.N. Secretary-General's study on all forms of violence against women found that, "Fear of violence prevents women from accessing HIV/AIDS information, being tested, disclosing their HIV status, accessing services for the prevention of HIV transmission to infants and receiving treatment and counseling, even when they know they have been infected."[444] Patricia Nalls, the founder and director of The Women's Collective, who is HIV-positive herself, explained this issue in relation to how some women in D.C. experience stigma in a different way from men. She related that women who are HIV-positive feel greater anxiety that they will be alone for the rest of their lives and "if you tell someone about your status you will suffer domestic violence."[445]

Women who suffer violence are unable to recognize the benefits of knowing their HIV status. A report by the WHO showed that women and girls who are victims of gender-based violence often perceive knowledge of their status to create greater risk for harm than benefit to their well being. The report indicated that, "in studies among women in sub-Saharan Africa, fear of a partner's negative reaction, including abandonment, violence, rejection, loss of economic support, and accusations of infidelity were the most commonly reported barriers to HIV testing and disclosure of HIV status."[446] Foregoing testing and non-disclosure not only prevents many women from accessing healthcare or adhering to treatment regiments, but can also increase the likelihood that they will transmit the disease to their partner. A WHO report on "HIV Status Disclosure to Sexual Partners" stressed that, "Disclosure is an important public health goal for a number of different reasons… disclosure may motivate sexual partners to seek testing, change behaviour and ultimately decrease transmission of HIV."[447] However, these benefits are often overshadowed in relationships where gender-based violence dominates.

In order to address this fear and assist and empower women to exercise their right to health, information, and protect their right to life, the District must raise awareness of the linkages between HIV and violence at different levels, including, but not limited to, healthcare providers, counselors and service providers working with both survivors of gender-based violence, individuals affected by HIV/AIDS, and government officials. One way to raise such awareness and assist women affected by gender-based violence and HIV is to facilitate community-based empowerment programs that seek to change gender norms and improve communication between partners.[448] One program that has worked in several countries and could be adapted for use in the District is Stepping Stones, a program created by Strategies for Hope that was designed to enable women and men of all ages to explore their social, sexual, and psychological needs, to analyze the communication blocks they face, and to practice behavioral changes in their relationships.[449] Women suffering gender-based violence in the District are currently without programs or services that address their abuse and HIV/AIDS related issues, like testing and disclosure.

C. HIV-positive Women Suffer From Abuse Because of Their HIV Status

Aggressors sometimes use a woman's HIV status as a tool for abuse and coercion, violating her rights to dignity, freedom from violent and degrading treatment, and physical integrity. A case manager at The Women's Collective, explained, "When your partner knows you are positive they have this power over you."[450] That power leaves women vulnerable and often dependent

on the relationship with the abuser. Dr. Margo Smith, Director of Infectious Disease Medicine at Washington Hospital Center, explained that her approach to partner notification includes encouraging her patients to bring their partner with them and have them tested at their next visit.[451] She explained that among her patients, "two-thirds of women don't want to hear anything about it."[452] When asked why, she explained, "[They] don't want their partner to leave…. Many women have been sexually abused—[the] abuse often happened in [their] youth and influences [their] present relations."[453] As the doctor explains, for some women in D.C. who have suffered abuse, both past and present, the fear of violence, rejection, and isolation from partners who might learn about their HIV status trumps all else.

One way a woman's HIV status is used as a tool for abuse is by threatening to "out" her status to friends and family if the woman threatens to report the violence, leave the aggressor, or take any other act considered disobedient by the aggressor.[454] Since many women who are HIV-positive keep their status a secret out of fear of isolation or stigma from friends and family, this type of threat is particularly powerful. Professor Laurie Kohn, who published an article in the Hastings Constitutional Law Quarterly,[455] explained, "survivors who are HIV-positive who are threatened to be outed as HIV-positive by their batterers, they may have endured years of abuse, but any time they tried to leave, [they] were threatened by their status."[456] Aggressors also find other ways to use a partner's HIV status against her. An attorney working at WEAVE described stories from her clients where, "[t]he abuser might take the survivor's meds, hide the prescriptions…They might be disruptive in the doctor's appointment. They might do all sorts of things around HIV status of a survivor who is HIV-positive, making that survivor more vulnerable."[457] Aggressors find ways to weaken an HIV-positive partner, making it less likely for her to fight back, protect herself or less likely to seek help.[458]

Gender-based violence alone exudes coercive and manipulative tactics, but when combined with HIV, these elements are heightened. And if the survivor is perceived as the one who infected the aggressor, the emotional coercion intensifies with statements like, "this is your fault, it's your fault that I'm here anyway, you need to stay with me…"[459] Because so many women already feel a sense of stigma and discrimination because of their HIV status, they are more vulnerable to manipulation and further psychological and physical abuse.[460]

D. Gender-Based Violence Against Women Affected by HIV/AIDS Violates Their Rights to Physical Integrity, Dignity, Freedom From Violence and Degrading Treatment, Information, Healthcare, and Life.

Gender-based violence - physical, mental, and sexual abuse - plagues many women living in the District, especially those affected by HIV/AIDS, and undermines their ability to access prevention and treatment. The District's failure to address this intersection and the several related issues that stem from it violates these women's rights to physical integrity, dignity, and freedom from violence, cruel, inhuman and degrading treatment,[461] diminishes their right to information and education related to their health and well-being,[462] violates their right to healthcare,[463] and can even violate their right to life.[464]

Violations in the District

By neglecting to integrate services for women affected by HIV/AIDS and gender-based violence, the D.C. government fails to protect several rights guaranteed to women. This neglect not only has an adverse impact on women living in the District, but also works against D.C.'s efforts to stem its HIV/AIDS epidemic. As reported by UNAIDS, "The protection of human rights, both of those vulnerable to infection and those already infected, is not only right, but also produces positive public health results against HIV."[465] Understanding the intersection between gender-based violence and HIV and promoting policies based on that link is essential to D.C.'s fight against the disease. The former Executive Director of UNAIDS, Peter Piot, explained, "It is patently clear that we need to make real headway against the fundamental drivers of this epidemic, especially gender inequality, stigma and discrimination, deprivation, and the failure to protect and realize human rights. This challenge is perhaps the greatest of all those facing the AIDS response."[466] Human rights are compromised for women affected by HIV/AIDS when government policies fail to address the necessity for integrated services to assist women in the unique position of dealing with both gender-based violence and HIV/AIDS.

Women across the District who suffer gender-based violence are often unable to negotiate safe sex or even if and when they want to have sex, thereby leaving them at higher risk for exposure to HIV. This lack of bodily autonomy violates their rights to physical integrity, dignity, and freedom from cruel, inhuman, and degrading treatment. Under the UDHR, adopted in 1948 by the U.N. General Assembly without dissent, member states including the U.S. pledge to protect the rights to physical integrity, dignity, and freedom from cruel, inhuman, and degrading treatment.[467] The right to dignity is one of the most fundamental human rights, protected by many established treaties and recognized specifically as related to violence against women under the Inter-American Commission's Convention of Belém do Pará,[468] which acknowledges that the Americas, as State Parties to the Convention, are concerned that "violence against women is an offense against human dignity" and under Article 4 protects that:

> *Every woman has the right to the recognition, enjoyment, exercise and protection of all human rights and freedoms embodied in regional and international human rights instruments. These rights include, among others:*
>
> *The right to have her life respected;*
>
> *The right to have her physical, mental and moral integrity respected;*
>
> *The right to personal liberty and security;*
>
> *The right not to be subjected to torture;*
>
> *The rights to have the inherent dignity of her person respected and her family protected.*[469]

As a member of the Inter-American Commission and party to the Convention, the U.S. has a duty to protect these rights. By failing to integrate services for women affected by HIV/AIDS and suffering gender-based violence, the District creates barriers for women to access the information and services they need to prevent or treat both issues. Those barriers directly contribute to the violation of women's rights to physical integrity, dignity, and freedom from cruel, inhuman, and degrading treatment.

Additionally, aggressors who use a woman's HIV status as a means to control, abuse, and victimize her violate her right to access information relating to her health and well-being and her right to healthcare and related medical services. Under CEDAW, which the U.S. has signed, Article 10(h) instructs that States Parties shall take all appropriate measures to ensure to

women "[a]ccess to specific educational information to help to ensure the health and well being of families."[470] For many HIV-positive women in the district, this right is seriously overshadowed by a fear of violence. Under the ICESCR, which the U.S. has signed but not yet ratified, Article 12 instructs that "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[471] HIV-positive women who fear violence often forego seeking medical treatment, information, or other services related to the disease, which can pose a serious detriment to their health and in some cases even lead to death. The right to life is the most universally recognized fundamental human right. The U.S. recognizes this right under the Fourteenth Amendment of its Constitution, and proclaims that no State "shall deprive any person life…"[472] The District's failure to address the link between gender-based violence and HIV, however, deprives persons of their right to life when aggressors prevent women from testing, treating, or preventing transmission of HIV by using physical, mental, and sexual abuse.

X. RECOMMENDATIONS

A. HIV/AIDS and Discrimination Against Women and Minorities

The District government must conduct a gender analysis of its laws and policies to modify, restructure, and develop new approaches to HIV/AIDS care, prevention, and supportive services in order to remedy discrimination against women by addressing the ways in which "different social roles, responsibilities, opportunities, and needs" for men and women "permeate our society [and] affect how decisions and policy are made."[473]

The District should develop a multi-sectoral Gender and HIV/AIDS Policy Council that includes strong representation by women living with HIV to implement effective HIV policy. A Gender and HIV/AIDS Policy Council would include the directors of every D.C. agency with responsibilities for responding to the epidemic, community leaders from local HIV/AIDS service providers, healthcare facilities, advocates, businesses and corporations, faith-based organizations, and HIV-positive women. The U.N. International Guidelines on HIV/AIDS and Human Rights emphasize that HIV-related human rights "are more likely to be addressed if there is leadership" from the government and if "multisectoral structures are established and maintained" because "the involvement of affected communities, together with relevant professionals … as equal partners" is "vital to any policy development and implementation." [474] Regular monthly meetings of a multisectoral body would encourage more productive collaboration because all participants would stand on equal footing and contribute cooperatively to a comprehensive plan. A Gender and HIV/AIDS Policy Council would encourage more productive coordination, a comprehensive examination of the cross-cutting nature of HIV/AIDS, and more creative interventions to protect the rights of women infected and affected by HIV/AIDS in the District.

In line with the Beijing Platform and Declaration of Action, adopted in 1994 by 189 governments including the United States, this Gender and HIV/AIDS Policy Council would "promote an active and visible policy of mainstreaming a gender perspective" in all government policies and programs.[475] It will "ensure that the response to gender considerations is integrated not grafted on, it is critical that all institutional gender expertise not remain centralized in one department or with one 'key' gender 'point-

person.'" Integration must extend "to ensure that all staff understand the gender-differentials related to: risk factors of HIV infection; barriers to accessing health services; the impact of homelessness and gender-based violence on women's ability to engage in safe-sex practices; and the differential social and economic burdens of AIDS morbidity and mortality."[476]

B. HIV/AIDS Health Care and Prevention Services for Women

Provider-initiated voluntary HIV testing with counseling should be offered to all patients accessing primary and emergency medical care in the District, including prenatal care, and informed consent should be obtained. The District should require that healthcare providers offer HIV/AIDS testing with appropriate counseling to all patients accessing primary or emergency medical care in the District. Specifically, the District should create a policy for testing with counseling that references current best practices and observes human rights standards. The District should also require that healthcare providers offer HIV testing with counseling to all pregnant women or women considering pregnancy in the District. The counseling should include an explanation of the test and its importance and what the results could mean for the woman. Included in the counseling should be information about how HIV-positive women can pursue a healthy pregnancy if they so choose. The testing and counseling policy for all should be modeled after the WHO's current best practices and conform to international human rights standards.

The District should work to reduce barriers to healthcare by ensuring that affordable healthcare is available, and includes free childcare and extended operating hours. Specifically, the District could create financial incentives for low-income health insurance providers to provide childcare or create child care vouchers and to have extended evening or weekend hours.

Coverage and availability of mental healthcare and substance abuse detox programs should be expanded in order to strengthen coverage and availability of programs. Specifically, the District should extend coverage of the D.C. Alliance program to address the lack of coverage for mental health and substance abuse services, offer financial incentives to mental health providers and substance abuse providers to include programs targeting low-income clients, and increase government funding for mental health and substance abuse programs.

The District should take steps to increase the health literacy of patients and the cultural competency of healthcare providers in the District by undertaking a comprehensive health literacy campaign aimed at empowering individuals to take charge of their own health. This could include a public media and outreach campaign as well as offering individuals cards that they can take into their appointments that outline what a routine medical appointment should cover and what questions they should ask. For the medical community, the District should implement a systematic method of ensuring cultural competency among healthcare providers, by requiring cultural competency training for all healthcare providers practicing in the District.

C. HIV/AIDS and Housing and Homelessness

The District must prioritize the provision of stable and permanent housing for all residents and implement housing programs as a form of HIV/AIDS prevention and care. Permanent supportive housing, as well as shelters and transitional housing facilities, must be available to shelter the growing number of homeless families with children. The D.C. government must work with

housing providers to give them the flexibility they need to design effective strategies for their work and to enable a broader range of facilities to house women across the spectrum of needs.

Housing options must be available to meet women "where they are" to get them off the streets – to deal with their mental health issues and with substance abuse, whether women need clean and sober facilities or whether they are not ready for that environment.

Definitions of homelessness must be amended to include the housing arrangements many women employ to avoid living on the streets or in shelter that expose them to similar HIV risk. When the terms of their housing arrangement put women at risk, women who do not qualify as homeless under current definitions may actually be more in need than those who are in transitional or temporary housing that fits the definition. Women must have access to the housing resources they need to protect themselves from HIV.

D. HIV/AIDS and Gender-Based Violence

The D.C. Government should develop training modules to integrate services for HIV/AIDS and gender-based violence. The training modules should include information on implementing screening, counseling, and referral services for HIV/AIDS in settings that provide services to survivors of gender-based violence, as well as screening, counseling, and referral services for gender-based violence in settings that provide medical services and more specifically locations that provide HIV testing. In developing these training modules, the District should investigate successful programs and projects in other regions and refer to reports on best practices or recommendation that detail the successes of other programs, such as the WHO report and the World Bank Report on Integrating Gender into HIV/AIDS Programmes.[477] Once these training modules have been developed, the District should mandate that all service providers are adequately trained and develop a policy to ensure that the screenings and referrals are actually occurring with a monitoring system in place.

The government must conduct a structural and behavioral study on the intersection of gender-based violence and HIV/AIDS. This study must go beyond merely integrating HIV/AIDS and gender-based violence services, but also include research on other drivers to this link by coordinating networks between government branches such as the justice system and the health, education, and employment sectors.[478] Research conducted by international organizations, such as the World Bank, have recognized the importance of understanding the interaction of various drivers and HIV/AIDS in order to develop effective policies and programs. The World Bank reported, "Because the epidemic is largely fuelled by gender-based cultural, social, economic, and legal vulnerabilities and risks, addressing the interconnections between gender inequality and the risk factors for infection or the burden of care can yield significant payoffs."[479] Conducting a study to evaluate the factors that contribute to gender-based violence and women's exposure to HIV/AIDS in the District will significantly enhance prevention efforts and compliment the treatment focus that integrated screening and counseling will provide.

XI. CONCLUSION

The HIV/AIDS crisis in D.C. is a modern epidemic. The statistics are shocking. At least 3% of District residents are living with HIV/AIDS, giving D.C. the highest rate of any city in the country. Some estimates indicate that as many as one in twenty people in the District is living with HIV/AIDS. While the District has programs to prevent and treat HIV/AIDS, D.C. falls short in many ways, violating numerous human rights of District residents. As shown throughout this report, the District's HIV/AIDS programs fail to serve the needs of women living with the HIV/AIDS through systemic discrimination, inadequate access to healthcare, the insufficient provision of mental health and substance abuse programs, the absence of affordable housing options, and the failure to address the alarming and pervasive rates of gender-based violence directed at women. In order to protect the human rights of women living in D.C. and to ensure effective prevention and treatment of HIV/AIDS, the District government must take action to correct these shortcomings.

About The Women's Collective

The mission of The Women's Collective (TWC) is to meet the self-defined needs of women, girls and their families living with or at-risk for HIV/AIDS, reducing barriers to care and strengthening their network of support and services. As a Washington DC-based nonprofit organization led by women with HIV and their allies/advocates, TWC works to fulfill its mission by:

- Providing services that are peer-led, woman and girl-focused, family-centered, and culturally appropriate.
- Providing a safe, non-judgmental environment for all women, girls and families.
- Providing a voice for women, girls and their families who are living with or at-risk for HIV/AIDS through advocacy at the local, national, and international levels.
- Creating partnerships among service providers, governmental, non-governmental and private entities.

Our services are divided between three programs: 1.) HIV care management for women ages 18+ and families living with HIV/AIDS, 2.) HIV prevention for women, girls and families at risk for HIV/AIDS, and 3.) Policy & Advocacy to address the needs and issues of women and girls locally and nationally. Contact TWC at 202-483-7003 or visit www.womenscollective.org for more information.

About the International Women's Human Rights Clinic (IWHRC) at Georgetown University Law Center

The IWHRC was established at Georgetown University Law Center in August 1998. The IWHRC advances women's human rights globally through partnerships with local women's rights NGOs, as well as through research and scholarship. Many of our partners are African lawyers who have completed their graduate law degrees (LLMs) as part of Georgetown University's Leadership and Advocacy for Women in Africa (LAWA) Program. Contact IWHRC at 202-662-9000 or visit www.law.georgetown.edu/clinics/iwhrc.

ENDNOTES

[1] The Women's Collective is a Washington D.C.-based non-profit organization led by women with HIV and their advocates working to meet the self-defined needs of women, girls and their families living with or at-risk for HIV/AIDS, reducing barriers to care, and strengthening their network of support and services.

[2] The International Women's Human Rights Clinic (IWHRC) was established at Georgetown University Law Center in August 1998. The IWHRC advances women's human rights globally through partnerships with local women's rights NGOs, as well as through research and scholarship. This report is the clinic's first partnership with a women's organization based in and primarily working on issues affecting women in the United States.

[3] DISTRICT OF COLUMBIA HIV/AIDS EPIDEMIOLOGY UPDATE 2008 [hereinafter HIV/AIDS EPIDEMIOLOGY UPDATE 2008].

[4] *Id.* (referencing the United Nations Joint Program on HIV/AIDS (UNAIDS) and the CDC which consider a 1 percent prevalence rate to be a "generalized and severe" epidemic.

[5] Interview with Tiffany West-Ojo, Chief, MSPH, MPH, Surveillance Division Bureau Chief, D.C. HIV/AIDS Administration Bureau of Strategic Information, in Washington, D.C. (Feb. 17, 2009). D.C.'s 2008 Epidemiology Report estimates that between one third and one half of residents do not know they are infected with HIV/AIDS. DISTRICT OF COLUMBIA, DEPARTMENT OF HEALTH, HIV/AIDS EPIDEMIOLOGY UPDATE 2008 (released Feb. 2009) *available at* http://doh.dc.gov/doh/lib/doh/pdf/dc_hiv-aids_2008_updatereport.pdf.

[6] Jose Antonio Vargas, *Once at Front Line of AIDS War, District is Now Fighting Blind*, WASH. POST, Mar. 26, 2006, at A01.

[7] *Id*.

[8] HIV/AIDS EPIDEMIOLOGY UPDATE 2008.

[9] Interview with Myra, HIV Testing Counselor and Field Supervisor, The Women's Collective, in Washington, D.C. (Feb. 7, 2009).

[10] Global Coalition on Women and AIDS, *Quick Facts*, *at* asphttp://womenandaids.unaids.org/ *citing* information gathered from the Country Progress Reports of 2008 on the UN General Assembly Special Session HIV/AIDS (UNGASS), *available at* http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries (last visited June 10, 2009).

[11] HIV/AIDS EPIDEMIOLOGY UPDATE 2008 at 40.

[12] HIV/AIDS EPIDEMIOLOGY UPDATE 2008 at 2.

[13] U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS AMONG WOMEN – FACT SHEET (2008), *available at* http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf

[14] *Id.*

[15] *Id.*

[16] HIV/AIDS EPIDEMIOLOGY UPDATE 2008 at 20-21.

[17] *Id.* at 37.

[18] *Id.* at 55

[19] *Id.*

[20] *Id* at 26.

[21] HIV/AIDS EPIDEMIOLOGY UPDATE 2008 at 55. Injecting drug users (IDU) account for 22% of all living cases nationally, compared with 18% in D.C. The DOH credits needle exchange programs for reducing new infection. *Id.* Black MSM account for 58% of all MSM cases in the district. Young people 13-24 account for 8% of living HIV/AIDS in the District, compared with 4% nationally. *Id.* at 55-56.

[22] *Id.* at 58. Of Black youth in D.C. (13-24), the bulk of cases 42%) were attributed to heterosexual sex. MSM accounted for 34.7% of case). *Id.* at 62.

[23] *See, e.g.,* the instant NY Times Bestseller by J.L. KING, ON THE DOWN LOW: A JOURNEY INTO THE LIVES OF "STRAIGHT" BLACK MEN WHO SLEEP WITH MEN (2004). King dedicated his book to 'all the women whose health has been jeopardized and emotional state compromised by men living on the DL [down low]."

[24] D.C. DEPARTMENT OF HEALTH, *Heterosexual Relationships and HIV in Washington, D.C.* (March, 2009) *available at* http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/pdf/dc_hiv_heterosexualstudy.pdf.

[25] The Central Detention Facility (CDF/D.C. Jail) or the Correctional Treatment Facility.

[26] D.C. DEPARTMENT OF HEALTH, DISTRICT OF COLUMBIA COMPREHENSIVE HIV CARE PLAN 2009-2011, at 42, *available at* http://dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/part_a_comprehensive_plan-final.pdf [hereinafter HIV CARE PLAN]. In 2009, the average daily population in D.C. facilities was 4,807, a decrease from a daily average of 5,867 in 2005. D.C. Department of Corrections, Statistics (April 2009) *at* http://doc.dc.gov/doc/frames.asp?doc=/doc/lib/doc/populationstats/DCDepartmentofCorrectionsFactsnFiguresApr09.pdf.

[27] HIV/AIDS EPIDEMIOLOGY UPDATE 2008.

[28] Interview with Tara Linh Leaman, Deputy Director, Our Place in Washington, D.C. (March 20, 2009).

[29] Protection Against Transmission of HIV for Women and Youth Act of 2007, H.R. 1713, 110th Cong. §2(4) (2007). *See also*, Protection Against Transmission of HIV for Women and Youth Act of 2007, S. 2415 110th Cong. §2(4) (2007).

[30] Interview with Emily Pavetto, Family-Centered Case Manager, The Women's Collective, in Washington, D.C. (Feb. 12, 2009).

[31] Interviews during Focus Group at Miriam's House, a residential facility for women living with HIV/AIDS, in Washington, D.C. (Feb. 17, 2009).

[32] United Nations General Assembly Special Session (UNGASS), Declaration of Commitment on HIV/AIDS, 2001, para. 60, *available at* http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf [hereinafter HIV/AIDS UNGASS].

[33] PEPFAR was launched by President Bush in 2003 and reauthorized in July, 2008. Through FY2013, PEPFAR plans to work in 20 nations to support treatment for at least 3 million people, prevention of 12 million new infections, and care for 12 million people. According to PEPFAR Country Profiles available online, eight PEPFAR countries with prevalence rates lower than Washington, D.C. are Cambodia (.8 percent), Ethiopia (0.9-2.1 percent), Guyana (2.5 percent), Haiti (2.2 percent), India (.3 percent), Russia (1.1 percent), Rwanda (2.8 percent), and Vietnam (.5 percent). Nigeria's prevalence resembles that of the District at 3.1 percent. U.S. President's Emergency Plan for AIDS Relief – Countries, http://www.pepfar.gov/countries/index.htm.

[34] Global Coalition on Women and AIDS, *Quick Facts*, *at* asphttp://womenandaids.unaids.org/ *citing* information gathered from the Country Progress Reports of 2008 on the UN General Assembly Special Session HIV/AIDS (UNGASS), *available at* http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries (last visited June 10, 2009). Notably, the 2008 U.S. report on progress with the HIV/AIDS UNGASS declaration, reports that "the epidemic is increasingly affecting women," yet provided no information about national or local policies that would address this growing trend. See U.S. Government, Department of Health and Human Services, *National HIV/AIDS Report: United States of America* (last revised July 31, 2008) *available at* http://data.unaids.org/pub/Report/2008/united_states_of_america_2008_country_progress_report_en.pdf.

[35] Suzanne Maman et al. *HIV Testing During Pregnancy: A literature and Policy review – background paper* (Submitted to the Open Society Institute Law and Health Initiative, July 31, 2008) pp. 24, 38-39 (on file with the IWHRC).

[36] UNIFEM, *Transforming the National AIDS Response: mainstreaming gender equality and women's human rights into the 'Three Ones"* (2008) *at* 1, *available at* http://www.unifem.org/attachments/products/TransformingTheNationalAIDSResponse_eng.pdf.

[37] *Id. at* vii.

[38] *See, e.g.,* Global Coalition on Women and AIDS, *Keeping the Promise: An Agenda for Action on Women and AIDS, at* http://womenandaids.unaids.org/documents/AgendaforActionSheet.pdf

[39] Interview with Shannon Hader, Senior Deputy Director, D.C. Department of Health, HIV/AIDS Administration, in Washington, D.C. (Feb. 25, 2009).

[40] *Id*.

[41] Peter Piot, Interview on the Jim Lehrer NewsHour (Dec. 1, 2004), *available at* http://www.pbs.org/newshour/bb/health/july-dec04/aids_12-01.html.

[42] HIV/AIDS EPIDEMIOLOGY UPDATE 2008, at 57.

[43] UNIFEM, Transforming the National AIDS Response: mainstreaming gender equality and women's human rights into the 'Three Ones" (2008) *at* vii, *available at* http://www.unifem.org/attachments/products/TransformingTheNationalAIDSResponse_eng.pdf

[44] Human Rights Act of 1977, D.C. CODE §2-1402.21(e) (2009) [hereinafter D.C. Human Rights Act].

[45] *Id*.

[46] Int'l Convention for the Elimination of All Forms of Racial Discrimination (ICERD), arts. 2(1)(c), 5, Mar. 7, 1966, 660 U.N.T.S. 195 [hereinafter ICERD].

[47] *Id*.

[48] Int'l Covenant on Civil and Political Rights (ICCPR), U.N. Doc. A/6316 (1966) at preamble, 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976, *ratified by U.S.* June 8, 1992, *available at* http://www.ohchr.org/english/law/ccpr.htm [hereinafter ICCPR], ratification status *available at* http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en. Int'l Covenant on Civil and Political Rights, art. 26, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR].

[49] *Id*.

[50] U.S. Const. amend. XIV §2.

[51] D.C. Code §§ 2-1401.02(24) and 2-1402.01 (2007).

[52] D.C. Code § 2-1401.01 (2007).

[53] Int'l Convention for the Elimination of All Forms of Racial Discrimination, arts. 2(1)(c), 5, Mar. 7, 1966, 660 U.N.T.S. 195 (emphasis added).

[54] *Id*. In the ICERD ratification process, there were a number of clarifications proposed by the Administration that the Senate foreign relations committee adopted in its report to the full Senate. Claiborne Pell, Comm. on Foreign Relations, International Convention on The Elimination of All Forms of Racial Discrimination, S. Exec. Rep. No. 103-29, at 27-32 (1994) and S. Exec. Rep. No. 103-29, at 28-29 (1994).

[55] PERIODIC REPORT OF THE UNITED STATES OF AMERICA TO THE U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION CONCERNING THE INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION at ¶6.

[56] *See, e.g., Alexander v. Sandoval*, 532 U.S. 275 (2001); *Regents of Univ. of Cal. v. Bakke,* 438 U.S. 265 (1978).

[57] CERD, *Sixth Periodic Reports of States Parties to CERD, para. 258,* U.N. Doc. CERD/C/USA/6 (2007), *available at* http://www.ohchr.org/english/bodies/cerd/docs/AdvanceVersion/cerd_c_usa6.doc [hereinafter 2007 U.S. Report to CERD].

[58] Comm. on the Elimination of Racial Discrimination (CERD), *Concluding Observations: United States*, ¶ 33, U.N. Doc. CERD/C/USA/CO/6 (May 8, 2008), *available at*

http://www2.ohchr.org/english/bodies/cerd/cerds72.htm (scroll down to "USA," and " Concluding Observations."

[59] *Id.* at para. 33.

[60] *See* U.S. DEPT. OF STATE, PERIODIC REPORT OF THE UNITED STATES OF AMERICA TO THE U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION CONCERNING THE INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION ¶ 148 (2007), *available at* http://www.state.gov/documents/organization/83517.pdf.

[61] CERD Working Group on Health and Environmental Health, *Unequal Health Outcomes in the United States* at 62 (Jan. 2008) available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Unequal%20Health%20Outcomes%20in%20the%20U.S.pdf (citing U.S. COMM'N ON CIVIL RIGHTS, 1 THE HEALTH CARE CHALLENGE 20 (1999)).

[62] *See, e.g.,* "Inequalities in income and education underlie many health disparities in the United States." Healthy People 2010, A Systematic Approach to Health Improvement, http://www.healthypeople.gov/document/HTML/uih/uih_bw/uih_2.htm.

[63] SARAH JOSEPH ET AL, THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES MATERIALS AND COMMENTARY 694 (2d ed. 2004).

[64] ICERD.

[65] "'Discrimination'… should be understood to imply any discrimination…based on any ground,,, which has the purpose *or effect* of nullifying and impairing the recognition, enjoyment, or exercise by all persons, on an equal footing, of all rights and freedoms" (emphasis added). Human Rights Committee, *General Comment No. 18*, *Non-discrimination* (37th Sess., 1989), para. 7,U.N. Doc. HRI\GEN\1\Rev.1 at 26 (1994) *available at* http://www.ohchr.org/english/bodies/hrc/comments.htm [hereinafter *HRC General Comment 18*].

[66] Convention on the Elimination of All Forms of Discrimination against Women, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) art. I, U.N. Doc. A/34/46, *entered into force* Sept. 3, 1981, *available at* http://www2.ohchr.org/english/law/cedaw.htm. [hereinafter CEDAW]

[67] *Id*.

[68] Comm. on the Elimination of Racial Discrimination, *Concluding Observations: United States*, ¶32, U.N. Doc. CERD/C/USA/CO/6 (May 8, 2008).

[69] OPERATIONAL GUIDE ON GENDER AND HIV/AIDS, A RIGHTS BASED APPROACH at 26.

[70] *See e.g.,* Comm. on the Elimination of Discrimination Against Women, *Report of the Committee on the Elimination of Discrimination Against Women*, art. 12, U.N. Doc. A/54/38/Rev.1 (Aug. 20, 1999) (recommending that national statistical services responsible for social and economic surveys collect and disaggregate data by gender, and calling for data disaggregated by sex in the area of healthcare in order to evaluate the impact of health policies, plans, and laws on women); Comm. on the Elimination of Discrimination against Women, *Concluding Comments: Sweden*, ¶ 335, U.N. Doc. A/56/38 (July 20, 2001) (commending "the Government [of Sweden] for its efforts to incorporate gender mainstreaming into its overall policy framework and at all stages of the policy-making processes, while at the same time implementing women-specific programmes to encourage gender equality.").

[71] UNAIDS INTERAGENCY TASK TEAM ON GENDER AND HIV/AIDS, OPERATIONAL GUIDE ON GENDER AND HIV/AIDS, A RIGHTS BASED APPROACH at 42-43, *available at* http://www.unfpa.org/hiv/docs/rp/op-guide.pdf.

[72] Interview with West-Ojo.

[73] The 2008 D.C. Epidemiology Report states that "Blacks continue to be the most severely impacted with over 4 percent of Black residents infected with HIV" and "Blacks are disproportionately affected by AIDS in the District." HIV/AIDS EPIDEMIOLOGY UPDATE 2008 at 20, 30.

[74] *Id.* at 116.

[75] Of the promising interventions targeting women cited in the Prevention Plan, nearly all lack training or replication / intervention packages. *See e.g.,* Insights (targeting Young Heterosexual Women; no training or replication packages are available) *id.* at 136; Project Connect

(targeting Black and Hispanic/Latino couples or women Only; still under development) *id.* at 146; Project FIO (targeting Black Heterosexual Women; no training or replication packages are available) *id.* at 146-147; Project S.A.F.E. (targeting Black and Hispanic/Latina Heterosexual Women; no training is available, but intervention packages may be purchased) *id.* at 145; Safer Sex (targeting adolescent Heterosexual Women; no training or replication packages are available). *id.* at 151; SiHLE (intervention emphasizes ethnic and gender pride targeting Black adolescent women (14-18); no training available but packer is under development intervention emphasizes ethnic and gender pride) *id.* at 156. Sisters Saving Sisters (targeting Black and Latina adolescent women; no training or replication packages are available) *id.* at 157. *But see,* SISTA (targeting Black Heterosexual Women, "emphasizing gender and ethnic pride as a means to reduce HIV risk behaviors;" training and intervention materials are available through the CDC-funded DEBI project) *id.* at 175.

[76] HIV PREVENTION PLAN, at 129.

[77] *Id.*

[78] Beijing Declaration and Platform of Action, ¶ 106, A/CONF.177/20 (1995).

[79] Gender mainstreaming" was part of the mandate that emerged from the Vienna World Conference on Human Rights and the 1995 World Conference on Women in Beijing. These mandates carry substantial weight as the Vienna Declaration and Programme of Action was endorsed by 171 participating states and the Beijing Declaration and Platform for Action was endorsed by 189 governments and more than 5,000 representatives from 2,100 non-governmental organizations.

[80] OPERATIONAL GUIDE ON GENDER AND HIV/AIDS, A RIGHTS BASED APPROACH at 8.

[81] WORLD HEALTH ORGANIZATION, INTEGRATING GENDER INTO HIV/AIDS PROGRAMMES at 42, *available at* http://www.unfpa.org/hiv/docs/rp/integrating-gender.pdf.

[82] KIM CRENSHAW, BACKGROUND PAPER FOR THE EXPERT MEETING ON THE GENDER-RELATED ASPECTS OF RACE DISCRIMINATION (2001), *available at* http://www.wicej.addr.com/wcar_docs/crenshaw.html.

[83] D.C. DEPARTMENT OF HEALTH, HIV/AIDS ADMINISTRATION, available at http://doh.dc.gov/doh/cwp/view,a,1371,q,573205,dohnav_gid,1802,dohnav,|33200|34259|.asp.

[84] D.C. APPLESEED CENTER AND HOGAN & HARTSON, LLP, HIV/AIDS IN THE NATION'S CAPITAL: IMPROVING THE DISTRICT OF COLUMBIA'S RESPONSE TO A PUBLIC HEALTH CRISIS 46 (August 2005).

[85] *Id.*

[86] *Id*. at 47.

[87] D.C. DEPARTMENT OF HEALTH, ELIGIBILITY REQUIREMENTS FOR D.C. AIDS DRUG ASSISTANCE PROGRAM, available at http://dchealth.dc.gov/doh/cwp/view,a,1371,q,598706.asp.

[88] *Id.*

[89] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, THE HIV/AIDS PROGRAM: RYAN WHITE PARTS A-F, available at http://hab.hrsa.gov/aboutus.htm.

[90] *Id.*

[91] D.C. DEPARTMENT OF HUMAN SERVICES, INCOME MAINTENANCE ADMINISTRATION APPLICATION FOR BENEFITS, available at http://dhs.dc.gov/dhs/cwp/view,a,3,q,568277,dhsNav,%7C30980%7C.asp.

[92] D.C. DEPARTMENT OF HUMAN SERVICES, D.C. HEALTHCARE ALLIANCE, available at http://dhs.dc.gov/dhs/cwp/view,a,3,q,638613.asp.

[93] *Id.*

[94] D.C. DEPARTMENT OF HEALTH, D.C. HEALTHY FAMILIES INSURANCE PROGRAM, available at http://doh.dc.gov/doh/cwp/view,a,1371,q,575879,dohNav_GID,1807.asp.

[95] DAVID CATANIA, D.C. COUNCIL AT LARGE, HEALTHY D.C. available at http://www.davidcatania.com/content/view/284.

[96] *Id*.

[97] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2008 HHS FEDERAL POVERTY GUIDELINES available at http://aspe.hhs.gov/poverty/08Poverty.shtml.

[98] David Nakamura, *Budget Woes: Catania Seeks Delay of Healthy D.C.*, WASH. POST, Oct. 28, 2008.

[99] KAISER FAMILY FOUNDATION, HIV/AIDS POLICY, FACT SHEET, RYAN WHITE PROGRAM (2009).

[100] HIV/AIDS EPIDEMIOLOGY UPDATE 2008.

[101] Interview with Carter Hewgley, Program Manager for Health and Human Services in the Office of the City Administrator in Washington, D.C. (Mar. 19, 2009).

[102] Housing and Community Development Act of 1974, 42 U.S.C. §1437(f) (2009).

[103] Housing Choice Vouchers Fact Sheet – HUD, http://www.hud.gov/offices/pih/programs/hcv/about/fact_sheet.cfm (last visited May 11, 2009).

[104] *Id.*

[105] McKinney-Vento Homeless Assistance Act, 42 U.S.C. §§11301-11472 (2009).

[106] Homeless Assistance Programs – Homeless Assistance – CPD – HUD, http://www.hud.gov/offices/cpd/homeless/programs/index.cfm (last visited May 11, 2009).

[107] *See, e.g.*, DISTRICT OF COLUMBIA HIV CARE PLAN, , at 42. ("The EMA utilizes the U.S. Department of Housing and Urban Development's definition of homelessness that includes individuals residing in a place not met for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street as well as individuals living in an emergency shelter, transitional, or supportive housing program.")

[108] McKinney-Vento Homeless Assistance Act, 42 U.S.C. §11434(a) (2009). ("The term homeless children and youths includes… children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;").

[109] *Id.* at §11302 (2009).

[110] OFFICE OF CMTY. PLANNING AND DEV., U.S. DEP'T OF HOUS. AND URBAN DEV., HUD'S HOMELESS ASSISTANCE PROGRAMS: A GUIDE TO COUNTING UNSHELTERED HOMELESS PEOPLE, at 5 (Oct. 2004) *available at* http://www.hud.gov/offices/cpd/homeless/library/countinghomeless/countingguide.pdf.

[111] Housing Opportunities for Persons with AIDS (HOPWA) Program – CPD – HUD, http://www.hud.gov/offices/cpd/aidshousing/programs/index.cfm (last visited May 11, 2009).

[112] Interview with David Vos, Director of Housing Opportunities for Persons with AIDS Program, U.S. Dep't of Hous. and Urban Dev., Office of Cmty. Planning and Dev., in Washington, D.C. (Feb. 19, 2009).

[113] *Id.*

[114] *Id.*

[115] *Id.* (In D.C., housing resource priority is given to groups including families who are homeless. (In fiscal year 2008, the Department of Housing and Community Development "continued to give priority, in our funding process, to the special needs population which includes seniors, individuals and families who are homeless, people with disabilities, and people living with HIV/AIDS."))

[116] AIDS Foundation of Chicago, Chicago Housing for Health Partnership Study: Hospital-to-Housing [publication pending] *available at* http://www.aidschicago.org/care/chhp.php.

[117] D.C. DEP'T OF HOUS. AND CMTY. DEV., 2008 CONSOLIDATED ANNUAL PERFORMANCE AND EVALUATION REPORT (CAPER), at 44 (Jan. 2009) *available at* http://www.dhcd.dc.gov/dhcd/frames.asp?doc=/dhcd/lib/dhcd/info/dhcdfy2008caper.pdf.

[118] *See* Aids Health Care Act, D.C. ST § 7-1601-04 (2001).

[119] Section 7-1604 states: "Disseminate information on AIDS to the public; Assist officials from the federal government, community groups, nursing homes, hospitals, and others in the coordination of AIDS plans, programs, and services delivery for persons with AIDS living in the District of Columbia; Conduct community outreach and education programs." *Id*..

[120] *See Heterosexual Relationships and HIV in Washington, D.C.*.

[121] See e.g. *New York State Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral & Partner Notification*, available at http://www.health.state.ny.us/nysdoh/rfa/hiv/guide.htm.

[122] WASHINGTON D.C. HIV CARE PLAN, at 73.

[123] D.C. DEPARTMENT OF HEALTH, HIV/AIDS ADMINISTRATION, 2009 DIRECTORY OF HIV/AIDS SERVICES IN THE DISTRICT OF COLUMBIA, *available at* http://doh.dc.gov/doh/cwp/view,a,1371,q,602920,dohNav_GID,1839,dohNav,|33815|,.asp.

[124] *Id*. at 68.

[126] D.C..Gov, Metropolitan Police Department: Domestic Violence Intake Center, http://mpdc.dc.gov/mpdc/cwp/view,a,1232,q,541152,mpdcNav_GID,1557.asp (last visited, March 29, 2009).

[127] *See* The Violence Against Women and Department of Justice Reauthorization Act (VAWA) of 2005, Sec. 501(3), H.R. 3402, 109th Cong. (2005); ADDRESSING VIOLENCE AGAINST WOMEN IN HIV TESTING AND COUNSELING: A MEETING REPORT at 2-3.

[128] *Id*. at Sec. 102.

[129] *Id.*

[130] *Id.* at Sec. 41202.

[131] *Id*. at Sec. 204.

[132] In Bragdon v. Abbott, the U.S. Supreme Court ruled that a person with HIV is protected by the ADA "from the moment of infection." *See* Bragdon v. Abbott, 524 U.S. 624, 637 (1998).

[133] ADDRESSING VIOLENCE AGAINST WOMEN IN HIV TESTING AND COUNSELING: A MEETING REPORT, at 19, Geneva (Jan. 16-18, 2006).

[134] *Id.* at 10.

[135] *In-depth Study On All Forms of Violence Against Women* at 72.

[136] Interview with Shannon Hader, Senior Deputy Director, D.C. Department of Health, HIV/AIDS Administration, in Washington, D.C. (Feb. 25, 2009).

[137] Interview with Eleanor Holmes Norton, District of Columbia Delegate to the U.S. House of Representatives, in Washington D.C. (February 18, 2009). Notably, nine Congressional Representatives have affirmed the responsibility of the federal government to "do more to address the disproportionate impact of HIV and AIDS in minority communities." Expressing the sense of Congress on the need for a national AIDS strategy, H.R. 24, 111th Cong. (2009).

[138] Comprehensive HIV Prevention Plan Act of 2009, leg. no. B18-0135,*at* http://www.dccouncil.washington.dc.us/lims/searchbylegislation.aspx

[139] Colbert I. King, *What the Mayor Won't Tell You About D.C.,* WASH. POST, Mar. 21, 2009.

[140] Interview with Jessica Ladd, Public Policy Associate, AIDS Institute, in Washington, D.C. (Feb. 20, 2009) (describing the way HIV/AIDS programs have evolved in the U.S., "All these programs sprung up in kind of a haphazard way. Suddenly you have AIDS and you have to research stuff so you have someone doing research. And then … you have Medicaid and then … Medicare and then there are some people who aren't covered by all of this so then you have Ryan White. It's very much plugging the holes.").

[141] Interview with Meredith Owensby, Social Services Manager, Miriam's House, in Washington, D.C. (Feb. 13, 2009).

[142] Interview with Owensby.

[143] Comm. on the Elimination of Discrimination Against Women, *Concluding Comments: Egypt*, ¶¶ 336-337, U.N. Doc. A/56/38 (Apr. 19, 2001), *available at* http://www1.umn.edu/humanrts/cedaw/egypt2001.html.

[144] Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2, ¶ 14 U.N. Doc A/RES/S-26/2 (Jun. 27, 2001), *available at* http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf.

[145] WASHINGTON D.C. HIV CARE PLAN, at 36.

[146] D.C. DEPARTMENT OF HEALTH, HIV/AIDS ADMINISTRATION AND THE D.C. HIV PREVENTION COMMUNITY PLANNING GROUP, DISTRICT OF COLUMBIA HIV PREVENTION PLAN FOR 2006-2009 (updated July 2008), at 104, *available at* http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/hiv_prevention_plan_2006-2009.pdf [hereinafter HIV PREVENTION PLAN].

[147] INTERNATIONAL GUIDELINES ON HIV/AIDS.

[148] INTEGRATING GENDER INTO HIV/AIDS PROGRAMMES.

[149] Eleanor Roosevelt, Address at the Presentation of "In Your Hands: A Guide for Community Action for the Tenth Anniversary of the Universal Declaration of Human Rights" (Mar. 27, 1958), *available at* http://www.udhr.org/history/inyour.htm.

[150] U.N. Human Rights Comm., General Comment No. 31, ¶¶ 3 and 8, 2187th Mtg. (2004), *available at* http://www2.ohchr.org/english/bodies/hrc/comments.htm.

[151]Focus Group with HIV-Positive Women, The Women's Collective, in Washington, D.C. (Feb. 12, 2009).

[152] *See* UNAIDS, *Human Rights and HIV* *at* http://www.unaids.org/en/PolicyAndPractice/HumanRights/default.asp (last visited June 6, 2009).

[153] *See. e.g.,* arts. 3 and 26 of International Covenant on Civil and Political Rights, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *ratified by U.S.* June 8, 1992, *available at* http://www.ohchr.org/english/law/ccpr.htm [hereinafter ICCPR]; the International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, *ratified by U.S.* Oct. 21, 1994, *available at* http://www2.ohchr.org/english/law/pdf/cerd.pdf [hereinafter CERD]; and art. II of the American Declaration on the Rights and Duties of Man, O.A.S. Res. XXX, (1948), OEA/Ser.L.V/II.82 doc.6 rev.1 at 17 (1992), *available at* http://www.oas.org/consejo/general%20assembly/decs%20-%20res%20ag/ga-res98/eres1591.htm [hereinafter American Declaration]. And while signed by the U.S. but not yet ratified, arts.2 and 3 of International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *signed by the U.S.* Oct. 5, 1977, *available at* http://www2.ohchr.org/english/law/pdf/cescr.pdf [hereinafter ICESCR] and the Convention on the Elimination of All Forms of Discrimination against Women, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46), U.N. Doc. A/34/46, *signed by the U.S.* July 17, 1980, *available at* http://www2.ohchr.org/english/law/cedaw.htm [hereinafter CEDAW].

[154] The right to privacy is enshrined in art. 17 of the ICCPR and art. V of the American Declaration; right to physical integrity and security appears in 6 of ICCPR, and art. 3 of the Universal Declaration of Human Rights, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948) [hereinafter UDHR]; and art. I of the American Declaration .

[155] The right to liberty is mandated by art. 3 of UDHR and art. 9 of ICCPR; the right to dignity and to be free from degrading treatment appear in nearly every regional and international human rights document, including treaties ratified by the U.S., such as, art. 7 of the ICCPR, and Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. res. 39/46, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), *entered into force* June 26, 1987, *ratified by the U.S. Oct.21, 1994*, *available at* http://www1.umn.edu/humanrts/instree/h2catoc.htm [hereinafter CAT].

[156] The right to access and impart information and to education is enshrined in e.g., art. 19(2) of the ICCPR and art. 19 of UDHR.

[157] The right to non-discrimination in healthcare is mandated by *inter alia* art. 5 of CERD; the right to the highest attainable standard of health is included in art. 12 of the ICESCR and art. 25 of UDHR.

[158] *See e.g.,* UDHR art. 27;

[159] Universal Declaration of Human Rights, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948). For a discussion of the "International Bill of Human Rights," *see* UNITED NATIONS, FACT SHEET NO. 2 (REV.1), THE INTERNATIONAL BILL OF HUMAN RIGHTS, available at http://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf.

[160] In President FDR's State of the Union address, he envisioned a future world "founded upon four essential human freedoms. The first is freedom of speech and expression—everywhere in the world. The second is freedom of every person to worship God in his own way—everywhere in the world. The third is freedom from want, which, translated into world terms, means economic understandings which will secure to every nation a healthy peacetime life for its inhabitants—everywhere in the world. The fourth is freedom from fear, which, translated into world terms, means a worldwide reduction of armaments to such a point and in such a thorough fashion that no nation will be in a position to commit an act of physical aggression against any neighbor—anywhere in the world." The Roosevelt Institution, Four Freedom Speech (Jan. 6, 1941) at http://otis.rooseveltinstitution.org/publicawareness/fourfreedoms.

[161] U.S. Const. art. VI § 2.

[162] Exec. Order No. 13,107, 63 Fed. Reg. 68,991 (Dec. 10, 1998).

[163] U.N. Human Rights Comm., General Comment No. 31, ¶¶ 3 and 8, 2187th Mtg. (2004), *available at* http://www2.ohchr.org/english/bodies/hrc/comments.htm; Int'l Covenant on Civil and Political Rights, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976, *ratified by U.S.* June 8, 1992, *available at* http://www.ohchr.org/english/law/ccpr.htm [hereinafter ICCPR]; International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969, *ratified by U.S.* Oct. 21, 1994, *available at* http://www2.ohchr.org/english/law/pdf/cerd.pdf [hereinafter CERD].

[164] CERD, art.2(1)(a), (c) (emphasis added) *quoted in U.S. CERD Obligations and Domestic Implementation - Article 2 (*Submitted to the CERD Committee Dec. 10, 2007), at p. 8, *available at* http://www2.ohchr.org/english/bodies/cerd/docs/ngos/usa/USHRN7.doc [hereinafter *U.S. CERD Obligations*]

[165] *See* U.S. DEPT. OF STATE, PERIODIC REPORT OF THE UNITED STATES OF AMERICA TO THE U.N. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION CONCERNING THE INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION ¶ 148 (2007), *available at* http://www.state.gov/documents/organization/83517.pdf.

[166] ICCPR; CEDAW.

[167] ICESCR at art. 3.

[168] *Id.* at art. 12.

[169] CEDAW at art. 1.

[170] Vienna Convention on the Law of Treaties, art. 18, 1155 U.N.T.S. 331, 8 I.L.M. 679, *entered into force* Jan. 27, 1980, *available at* http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf [hereinafter Vienna Convention]. The United States has not ratified the Vienna Convention, but the obligations of Article 18 apply to a State when "it has signed the treaty." As a signatory to both the Vienna Convention and ICESCR, the United States is bound not to take actions which "defeat the object and purpose" of either.

[171] U.N. General Assembly, Functions and Powers of the General Assembly, *at http://www.un.org/ga/about/background.shtml*.

[172] *See* Beijing Declaration and Platform of Action, ¶¶ 89-106, A/CONF.177/20 (1995); United Nations Millennium Declaration, G.A. Res. 55/2, at 4, U.N. GAOR, 55th Sess., Supp. No. 49, U.N. Doc. A/55/49 (2000); Declaration on the Elimination of Violence against Women, art. 3, G.A. Res. 48/104, 48 U.N. GAOR Supp. (No. 49) at 217, U.N. Doc. A/48/49 (1993); Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2, ¶¶ 14, 36-37, U.N. Doc A/RES/S-26/2 (Jun. 27, 2001); World Conference on Human Rights, June 14-25, 1993, *Vienna Declaration and Programme of Action*, ¶ 41, U.N. Doc A/CONF.157/23 (July 12, 1993).

[173] HIV/AIDS UNGASS.

[174] *Id.* at para. 14.

[175] American Declaration on the Rights and Duties of Man, O.A.S. Res. XXX, (1948), OEA/Ser.L.V/II.82 doc.6 rev.1 at 17 (1992), *adopted* 1948, *available at* http://www.oas.org/consejo/general%20assembly/decs%20-%20res%20ag/ga-res98/eres1591.htm.

[176] *See, e.g.*, Interpretation of the American Declaration of the Rights and Duties of Man Within the Framework of Article 64 of the American Convention on Human Rights, Advisory Opinion OC-10/89, July 14, 1989, Inter-Am. Ct. H.R. (Ser. A) No. 10, paras. 35-45 (1989). "As a consequence [of ratifying the Charter of the OAS]…the provisions of other instruments and resolutions of the OAS on human rights, acquired binding force." *White v. United States*, Inter-Am. Comm. Hum. Rts. 2141 (1981) 23/81.

[177] INTERNATIONAL GUIDELINES ON HIV/AIDS.

[178] *Id.* at para. 99.

[179] *Id.* at 17-19.

[180] U.N. Human Rights Comm., General Comment No. 31, ¶¶ 3, 4 and 8, 2187th Mtg. (2004), *available at* http://www2.ohchr.org/english/bodies/hrc/comments.htm

[181](emphasis added). 138 Cong. Rec. 8068, 8071 (1992) (U.S. Reservations, Declarations, and Understandings International Covenant on Civil and Political Rights); 140 Cong. Rec. 14326, 14326 (1994) (same Reservations, Declarations, and Understandings for International Convention on the Elimination of All Forms of Racial Discrimination).

[182] United States, *Initial Report of the States Parties to the U.N. Human Rights Committee*, (sess., 199), para. 3, U.N. Doc. CCPR/C/81/Add.4 (Aug. 24, 1994) (emphasis added) available at http://www.un.org/en/documents/index.shtml (insert UN Doc number in search by symbol)

[183] *Id.*

[184] *See Sosa v. Alvarez-Machain*, 542 U.S. 692, 729-30 (2004) ("For two centuries we have affirmed that the domestic law of the United States recognizes the law of nations.") *See also, Banco Nacional de Cuba v. Sabbatino,* 376 U.S. 398, 423, (1964) ("[I]t is, of course, true that United States courts apply international law as a part of our own in appropriate circumstances") *The Paquete Habana,* 175 U.S. 677, 700, (1900) ("International law is part of our law, and must be ascertained and administered by the courts of justice of appropriate jurisdiction, as often

as questions of right depending upon it are duly presented for their determination"); *The Nereide,* 9 Cranch 388, 423 (1815) (Marshall, C.J.) ("[T]he Court is bound by the law of nations which is a part of the law of the land").

[185] *See, e.g., Cook v. United States,* 288 U.S. 102, 119 (1933) (holding a later-in-time treaty supersedes a federal statute if there is a conflict). *See also, Murray v. Schooner Charming Betsy*, 6 U.S. 64, 118 (1804) (holding that "an act of Congress ought never to be construed to violate the law of nations if any other possible construction remains."); *The Paquete Habana*, 175 U.S. 677, 700 (1900) (recognized that "[i]nternational law is part of our law, and must be ascertained and administered by the courts of justice of appropriate jurisdiction.").

[186] *See, e.g., Roper v. Simmons*, 543 U.S. 551 (2005); *Lawrence v. Texas*, 539 U.S. 558, 576-77 (2003) (considering whether practices have "been accepted as an integral part of human freedom in many other countries" or "rejected elsewhere" in construing the constitutional concepts of privacy and due process); *Grutter v. Bollinger*, 539 U.S. 306, 342-43 (2003) (Ginsburg, J., concurring) (citing United Nations conventions and the "international understanding" as to affirmative action plans) *cited in* The Opportunity Agenda, *Human Rights in State Courts* 5 (ed. 2008) *available at* http://opportunityagenda.org/report_state_courts_and_human_rights_2008_edition.

[187] *Roper v. Simmons*, 543 U.S. 551, 575-76 (2005).

[188] *Id.* at 578.

[189] *Boehm v. Superior Court*, 178 Cal. App. 3d 494, 502 (1986).

[190] *See Id.*

[191] *See* AIM FOR HUMAN RIGHTS, HEALTH RIGHTS OF WOMEN ASSESSMENT INSTRUMENT 40 (2008), *available at* http://www.humanrightsimpact.org/fileadmin/hria_resources/HeRWAI_Centre/HeRWAI.pdf.

[192] *See* Report Of The Select Committee On House Resolution 473 Of 2002 (Nov. 26, 2002) *at http://www.nasw-pa.org/displaycommon.cfm?an=1&subarticlenbr=94 (last visited June 6, 2009);* The General Assembly of Pennsylvania, Report of the Select Committee on House Resolution 144 investigating the integration of human rights standards in Pennsylvania laws and policies (Nov. 30, 2004) *cited in* U.S. Human Rights Network, CERD Working Groups on Local Implementation and Treaty Obligations, *U.S. CERD Obligations and Domestic Implementation - Article 2* (submitted to the CERD Committee Dec. 10, 2007) available at http://www2.ohchr.org/english/bodies/cerd/docs/ngos/usa/USHRN7.doc [hereinafter U.S. CERD Obligations].

[193] See City and County of a San Francisco Government, Department on the Status of Women, CEDAW, *at* http://www.sfgov.org/site/dosw_page.asp?id=19725 (last visited June 6, 2009) ("In April 1998, San Francisco became the first city in this country to adopt an ordinance implementing CEDAW locally. It also established a Task Force which works with the Commission and City departments to identify discrimination against women and girls, and to implement human rights principles").

[194] Office of the City Manager of Berkeley, CA, *Information Calendar: Resolution on Eliminating Racial Discrimination*, (Feb. 27, 2007), *at* http://209.232.44.21/citycouncil/2007citycouncil/packet/022707/2007-02-27%20Item%2014b%20Resolution%20to%20End%20Discrimination%20-%20TBD.pdf *cited in U.S. CERD Obligations*.

[195] The General Assembly of Massachusetts, House Bill No. 706 (2005) *cited in* U.S. Human Rights Network, CERD Working Groups on Local Implementation and Treaty Obligations, *U.S. CERD Obligations and Domestic Implementation - Article 2 (*Submitted to the CERD Committee, Dec. 10, 2007) *available at* http://www2.ohchr.org/english/bodies/cerd/docs/ngos/usa/USHRN7.doc [hereinafter *U.S. CERD Obligations*].

[196] *Id.* at 13.

[197] CERD Working Group on Health and Environmental Health, Unequal Health Outcomes in the United States: A Report to the UN Committee on the Elimination of Racial Discrimination (January 2008), *available at*

http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Unequal%20Health%20Outcomes%20in%20the%20U.S..pdf [hereinafter Unequal Health Outcomes].

[198] *Id.* at 11 *citing* World Health Org., Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, UFPA (2004), *available at* http://www.who.int/reproductive-health/global_monitoring/RHRxmls/RHRmainpage.htmpublications/maternal_ mortality_2000/index.html (last viewed Oct. 31, 2007).

[199] *Id. citing* Nat'l Ctr. for Health Statistics, Ctrs. for Disease Control, *Maternal Mortality and Related Concepts*, Vital Health Stat., Feb. 2007, at 8.

[200] *Id.* citing Agency for Healthcare Research & Quality, National Healthcare Disparities Report, 2006, at 160 (2006), *available at* http://www.ahrq.gov/qual/nhdr06/nhdr06.htm. (stating that "the proportion women who initiated prenatal care in the first trimester was significantly lower" among all major ethnic groups compared with white women) [hereinafter 2006 National Healthcare Disparities Report]; NAT'L INST. OF HEALTH (NIH), WOMEN OF COLOR HEALTH DATA BOOK: ADOLESCENTS TO SENIORS 99 (3D ED. 2006).

Minority women also suffer from a disproportionately high rate of other STIs: "the rate of gonorrhea among African American women is 14 times higher than among white women. The prevalence of Chlamydia, an infection with particularly severe long-term health consequences for women, is 7 times higher among African American women...." *Id. citing* Ctr. for Disease Control, STD Surveillance 2005—Special Focus Profiles: Racial and Ethnic Minorities, http://www.cdc.gov/std/stats/minorities.htm.

[201] *Id.* citing Ctr. for Disease Control, Fact Sheet, HIV/AIDS among African Americans 2 (rev'd June 2007), *available at* http://www.cdc.gov/hiv/topics/aa/resources/factsheets/pdf/aa.pdf (last viewed Oct. 31, 2007).

[202] *Id.* citing Ctrs. for Disease Control, Fact Sheet, HIV/AIDS among Women 3 (rev'd June 2007), *available at* http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf [hereinafter HIV/AIDS among Women].

[203] REMARKS BY SECRETARY OF HEALTH AND HUMAN SERVICES KATHLEEN SEBELIUS AT THE 2009 NATIONAL HIV PREVENTION CONFERENCE (AS RELEASED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES) LOCATION: ATLANTA, GEORGIA, MONDAY, AUGUST 24, 2009

[204] *Id.* citing U.S. Dep't of Health & Human Servs., AIDS and Women (Dec. 2004), *available at* http://www.hab.hrsa.gov.

[205] HIV/AIDS EPIDEMIOLOGY UPDATE 2008 at 40.

[206] *Id.* at 37.

[207] DCWA: New data on AIDS and Women in D.C. Points to Sad Reality and Possible Solutions, http://thewomensfoundation.org/2008/dcwa-new-data-on-aids-and-women-in-dc-points-to-sad-reality-and-possible-solutions/

[208] HIV/AIDS EPIDEMIOLOGY UPDATE 2008, at 54.

[209] Comm. on the Elimination of Racial Discrimination, *Concluding Observations: United States*, ¶32, U.N. Doc. CERD/C/USA/CO/6 (May 8, 2008), *available at* http://daccessdds.un.org/doc/UNDOC/GEN/G08/419/82/PDF/G0841982.pdf?OpenElement.

[210] Committee on the Elimination of Racial Discrimination, *General Recommendation No. 25, Gender related dimensions of racial discrimination* (56th Sess., 2000), U.N. Doc. No. A/55/18, annex V (2000) [hereinafter Gen. Rec. No. 25].

In reviewing states compliance with ICRED, the Committee "monitor[s] racial discrimination against women, as well as the disadvantages, obstacles and difficulties women face in the full exercise and enjoyment of their civil, political, economic, social and cultural rights on grounds of race, colour, descent, or national or ethnic origin." *Id.*

[211] *Id.*at para 3.

[212] S.F., CAL., ORDINANCES ch. 12k (1998).

[213] WOMEN'S INST. FOR LEADERSHIP DEV. FOR HUM. RTS., RESPECT, PROTECT, FULFILL: RAISING THE BAR ON WOMEN'S RIGHTS IN SAN FRANCISCO 9 (2008), *available at* http://www.wildforhumanrights.org/documents/resources/respectprotect.pdf.

[214] The Arts Commission reorganized a program that provides economic opportunities for artists by allocating space on city streets that had previously required participants to appear in person at 8:30am daily to claim their space after realizing that some women had been unable to participate. The Department of Public Works addressed women's safety concerns by reducing the space between street lights.

[215] The United National Population Fund, The Gender Dimensions of the AIDS Epidemic, http://www.unfpa.org/gender/aids.htm.

[216] NAT'L ALLIANCE FOR STATE AND TERRITORIAL AIDS DIRECTORS, WHY WE CAN'T WAIT: THE TIPPING POINT FOR HIV/AIDS AMONG AFRICAN-AMERICANS (2007), *available at* http://www.nastad.org/Docs/highlight/200758_NASTAD_Monograph_FINAL.pdf.

[217] *Id.*

[218] *Id.*

[219] See Section VIII (a) for a further discussion of the ways in which the behavior of women's sexual partners leave women at risk for HIV/AIDS.

[220] Interview with Hader.

[221] Interview with Dr. Deborah M. Smith, MD, MPH, FACOG, Staff Physician, Gynecology and Women's Health, Whitman Walker Clinic/Elizabeth Taylor Medical Center, in Washington, D.C. (February 13, 2009).

[222] *Id.*

[223] HIV/AIDS EPIDEMIOLOGY UPDATE 2008 at 29, 21.

[224] Interview with a HIV/AIDS Policy Coordinator Metro TeenAIDS, in Washington, D.C. (Feb. 23, 2009).

[225] Interview with Christine Campbell, Vice President of National Advocacy & Organizing, Housing Works, in Washington, D.C. (Feb. 16, 2009).

[226] Laura Worby, RN, MSN, *Living with HIV in* Our Place, *Finding Our Place: HIV/AIDS Special Issue* 5 (Winter 2005) *at* http://www.ourplacedc.org/pages/documents/21890OurPlaceNL.pdf; see also De´lio Marques Conde, at al, *HIV, Reproductive Aging, And Health Implications In Women:*
A Literature Review, 16(1) MENOPAUSE: J. N. AM. MENOPAUSE SOC'Y 199-213 (2009);

[227] Focus Group with HIV-Positive Women, The Women's Collective, in Washington, D.C. (Feb. 12, 2009).

[228] De´lio Marques Conde, at al, *HIV, Reproductive Aging, And Health Implications In Women:*
A Literature Review, 16(1) MENOPAUSE: J. N. AM. MENOPAUSE SOC'Y 199 (2009); The head of the Infection Diseases at the Washington Hospital Center, Dr. Margo Smith, was likewise unaware of any specific studies on the interplay between HIV and menopause. Interview with Dr. Margo Smith, Director, Infectious Diseases at Washington Hospital Center in Washington D.C. (Feb. 13, 2009)

[229] *Id.*

[230] *See* Constitution of the World Health Organization, Basic Documents (45th ed. 2006); s*ee also,* International Covenant on Social, Economic and Cultural Rights, art. 12, Dec. 16, 1966, 999 U.N.T.S. 3.

[231] HIV/AIDS EPIDEMIOLOGY UPDATE 2008.

[232] *Id.*

[233] *Id.* at 43.

[234] U.S. Centers for Disease Control, *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*, 52 MORTALITY AND MORBIDITY WEEKLY REPORT, July 18, 2003, at 1.

[235] National HIV/AIDS Clinician's Consultation Center, *District of Columbia: A Quick Reference Guide for Clinicians to District of Columbia HIV Testing Laws* (January 27, 2009).

[236] *Heterosexual Relationships and HIV in Washington, D.C.,* at 1.

[237] *Heterosexual Relationships and HIV in Washington, D.C.,* at 10.

[238] Interview with Dr. Regina Zopf, Washington Hospital Center and Unity Healthcare, in Washington, D.C. (Feb. 12, 2009).

[239] Interview with Dr. Jessica Osborn, in Washington, D.C. (Feb. 16, 2009).

[240] Interview with Dr. Randi Abramson, Clinic Director, Bread for the City, in Washington, D.C. (Feb. 19, 2009).

[241] Interview with an HIV/AIDS Policy Coordinator.

[242] Interview with Hader (noting that women are more likely than men to access healthcare services).

[243] Interview with Abramson (noting that about two-thirds of the patients at Bread for the City's clinic are women, which is typical of outpatient care generally).

[244] *Heterosexual Relationships and HIV in Washington, D.C.,* at 8. (finding that some D.C. residents incorrectly believe they have been tested for HIV just because they have visited the doctor or had blood drawn and finding that many doctors are not routinely offering or doing HIV tests).

[245] Interview with an HIV-positive woman, The Women's Collective, in Washington, D.C. (Apr. 7, 2009).

[246] Interview with Heidi Williamson, Advocacy and Membership Coordinator, Sister Song (Feb. 16, 2009).

[247] Interview with Hader.

[248] *Id.*

[249] WORLD HEALTH ORGANIZATION, GUIDANCE ON PROVIDER INITIATED HIV TESTING AND COUNSELING IN HEALTH FACILITIES 7 (2007).

[250] *Id.*

[251]U.S. Centers for Disease Control, *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, 55 MORTALITY AND MORBIDITY WEEKLY REPORT, Sept. 22, 2006, at 1.

[252] U.S. Centers for Disease Control, *Voluntary HIV Testing as Part of Routine Medical Care - Massachusetts,* 2002, 53 MORTALITY AND MORBIDITY WEEKLY REPORT, June 25, 2004, at 523.

[253] *Id.*

[254] *Id*. The primary reasons for refusing the test included did not feel at risk for HIV, were previously tested for HIV, or felt too ill for testing at the time. *Id.*

[255] *Id*.

[256] See Section VII on testing.

[257] *Political Declaration on HIV/AIDS,* G.A. Res. 60/262, U.N. Doc. A/RES/60/262, para. 27 (June 2, 2006) *at* http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

[258] International Guidelines, Guideline 8, para. 60(f).

[259] WHO & UNAIDS, GUIDANCE ON PROVIDER-INITIATED HIV TESTING AND COUNSELLING IN HEALTH FACILITIES 36-43 (2007) *at* http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf

[260] American Medical Association, Opinion 2.23 - HIV Testing, at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion223.shtml**.**

[261] D.C. Department of Health (DOH) Website, *Universal Perinatal HIV Testing and Treatment*, *at* http://dchealth.dc.gov/doh/cwp/view,a,1371,q,603144.asp (last visited June 17, 2009).

[262] Letter from Gregg A. Pane, Director, Department of Health (June 2007) *at* http://dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/testing/perinataltesting.pdf

[263] *Id.*

[264] *Id.* at 67.

[265] *Id.*

[266] HIV/AIDS EPIDEMIOLOGY UPDATE 2008, at 66.

[267] WORLD HEALTH ORGANIZATION, ANTIRETROVIRAL DRUGS FOR TREATING PREGNANT WOMEN AND PREVENTING HIV INFECTION IN INFANTS: GUIDELINES ON CARE, TREATMENT AND SUPPORT FOR WOMEN LIVING WITH HIV/AIDS AND THEIR CHILDREN IN RESOURCE-CONSTRAINED SETTINGS 4 (2004).

[268] *Id.*

[269] *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings* at 1.

[270] HIV CARE PLAN, at 36.

[271] Interview with Linda Lopez, Case Worker, The Women's Collective, in Washington, D.C. (Feb. 12, 2009).

[272] Interview with Charlie Lytle, Health Project Coordinator/Trainer, Center for Health & Behavioral Training, in Washington, D.C. (Feb. 23, 2009).

[273] The right to health includes the provision by the government of facilities, services and conditions necessary for the realization of the highest attainable standard of health. Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (22nd Sess., 2000), para. 9, U.N. Doc. E/C.12/2000/4 (2000).

[274] INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, PUBLIC FINANCING AND DELIVERY OF HIV/AIDS CARE: SECURING THE LEGACY OF RYAN WHITE 80 (2004). *See also* D.C. DEPARTMENT OF HEALTH, SPECIAL SERVICES FOR PERSONS WITH HIV/AIDS, available at http://doh.dc.gov/doh/cwp/view,a,1374,q,575970,dohNav_GID,1803.asp.

[275] Interview with Pavetto.

[276] D.C. DEPARTMENT OF HEALTH, *Heterosexual Relationships and HIV in Washington, D.C.* 11 (March, 2009) *available at* http://doh.dc.gov/doh/cwp/view,a,1371,q,598650,dohNav_GID,1839,dohNav,|33815|,.asp.

[277] Interview with Vivian Cativo, Nurse Manager, Mary's Center, in Washington, D.C. (Feb. 17, 2009).

[278] Interview with Cativo. *See also* Interview with Abramson.

[279] Dr. Joan Miles and Dr. Randi Abramson at Bread for the City both noted that D.C. Alliance's lack of coverage of mental healthcare was huge gap in services for their clients.
Interview with Dr. Randi Abramson, Clinic Director, Bread for the City, and Dr. Joan Miles, Physician, Bread for the City, in Washington, D.C. (Feb. 19, 2009).

[280] Darryl Fears, *District Seeks To Privatize Services for Mentally Ill*, WASH. POST, Dec. 25, 2008 at B01; Interview with Dr. Joan Miles, Physician, Bread for the City, in Washington, D.C. (Feb. 19, 2009) (noting the need for mental healthcare services and a lack of coverage for these services by D.C. Alliance).

[281] D.C. DEPARTMENT OF MENTAL HEALTH, TRANSITION OF CONSUMERS FROM THE D.C. COMMUNITY SERVICES AGENCY, available at: http://dmh.dc.gov/dmh/cwp/view,A,3,Q,643247,dmhNav,%7C31262%7C.asp

The CSA was a direct provider of mental health services, operating out of six centers around the city and providing a safety net for uninsured city residents.

[282] AMERICAN PSYCHIATRIC ASSOCIATION, MENTAL HEALTH TREATMENT ISSUES HIV FACT SHEET: HIV AND PEOPLE WITH SEVERE AND PERSISTENT MENTAL ILLNESS 1 (Jan. 1999).

[283] Interview with Farah Nageer-Kanthor, Prevention Director, The Women's Collective, in Washington, D.C. (Feb. 12, 2009).

[284] *Heterosexual Relationships and HIV in Washington, D.C.,* at 14.

[285] M. Marin, *Relationship between adherence level, type of antiretroviral regimen, and plasma HIV type 1 RNA viral load: a prospective cohort study*, 24 AIDS RESEARCH AND HUMAN RETROINFECTIONS 1263-68 (2008).

[286] See infra section VIII on lack of housing.

[287] *Id.*

[288] *Id.*

[289] *Id.*

[290] Dr. Abramson and Dr. Miles at Bread for the City identified the lack of mental health services as a major challenge for their patients, although the organization does not currently provide mental health services. Interview with Dr. Randi Abramson, Clinic Director, Bread for the City, and Dr. Joan Miles, Physician, Bread for the City in Washington, D.C. (Feb. 19, 2009).

[291] Interview with Ari Ross, Nurse Practitioner, Whitman Walker Clinic, in Washington, D.C. (Feb. 25, 2009).

[292] *Id.*

[293] Interview with Focus Group, Miriam's House, in Washington, D.C. (Feb. 17, 2009).

[294] *Id.*

[295] *Id.*

[296] Programs that address the excessive use of or dependence on drugs or alcohol.

[297] D.C. DEPARTMENT OF HEALTH, SPECIAL SERVICES FOR PERSONS WITH HIV/AIDS, available at http://doh.dc.gov/doh/cwp/view,a,1374,q,575970,dohNav_GID,1803.asp.

[298] Interview with Dr. Randi Abramson, Clinic Director, Bread for the City, in Washington, D.C. (Feb. 19, 2009). See *also* Jeffrey H. Hsu, *Substance Abuse and HIV*, 14 THE HOPKINS HIV REPORT 9 (July 2002).

[299] See *also* Jeffrey H. Hsu, *Substance Abuse and HIV*, 14 THE HOPKINS HIV REPORT 9 (July 2002).

[300] Interview with Ross.

[301] *Id*.

[302] *Id.*

[303] *Heterosexual Relationships and HIV in Washington, D.C.* at 12.

[304] *Id.*

[305] Interview with Thomasine Guberski, Director, Nursing Care and Education, University of Maryland School of Medicine, in College Park, Md. (Feb. 24, 2009).

[306] Interview with Focus Group, Miriam's House, in Washington, D.C. (Feb. 17, 2009).

[307] Interview with Carol Marsh, Executive Director, Miriam's House, in Washington, D.C. (Feb. 17, 2009).

[308] Dr. Joan Miles at Bread for the City said some patients that come to Bread for the City haven't seen a doctor in years…some people, their illnesses make them come in. They haven't taken their meds in so long that they feel bad enough they finally come in." Interview with Miles.

[309] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DIRECTIONS IN HIV SERVICE DELIVERY & CARE – A PPOLICY BRIEF, NUMBER 4: REDUCING BARRIERS TO CARE 13 (2000).

[310] L. Lang, K. Bernstein, S. Jaeger, N. Naggy, M. Gertner, Masci, Barriers to care and adherence in HIV-positive women, 13th International AIDS Conference, (July 2000).

[311] Interview with Dr. Randi Abramson, Clinic Director, Bread for the City, in Washington, D.C. (Feb. 19, 2009).

[312] HIV CARE PLAN.

[313] Committee on Economic, Social and Cultural Rights*, General Comment 14, The right to the highest attainable standard of health* (22nd Sess., 2000), para. 21, U.N. Doc. E/C.12/2000/4 (2000).

[314] Interview with Zopf.

[315] The Black community still recalls the Tuskegee study withheld treatment from Black males with syphilis to observe them as a test group; participants in the study were never informed of the full scope of the study and as a result were not able to give informed consent to participate. TUSKEGEE INSTITUTE CENTER FOR BIOETHICS, INFORMATION ABOUT THE USPHS SYPHILIS STUDY, available at http://www.tuskegee.edu/Global/story.asp?S=6377076.

[316] Interview with Zopf.

[317] Interview with Williamson.

[318] Interview with JD Rosario, Peer Education Manager, HIPS, in Washington, D.C. (Feb. 17, 2009).

[319] NATIONAL MINORITY AIDS EDUCATION AND TRAINING CENTER, BE SAFE: A CULTURAL COMPETENCY MODEL FOR AFRICAN AMERICANS, *available at* http://www.nmaetc.org/capacity_building/besafe.php.

[320] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, CULTURAL COMPETENCE RESOURCES FOR HEALTHCARE PROVIDERS, *available at* http://www.hrsa.gov/culturalcompetence/.

[321] Constitution of the World Health Organization, Basic Documents, Forty-fifth edition, supplement (2006). *See also* The International Covenant on Economic, Social, and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In addition, the Covenant calls on State Parties take steps toward "the prevention, treatment and control of epidemic, endemic, occupational, and other diseases." International Covenant on Social, Economic and Cultural Rights, art. 12, Dec. 16, 1966, 999 U.N.T.S. 3.

[322] UDHR, Art. 25(1).

[323] International Covenant on Social, Economic and Cultural Rights, art. 12.1, Dec. 16, 1966, 999 U.N.T.S. 3.

[324] *Id.* at para. 3.

[325] American Declaration of the Rights and Duties of Man art. 11, adopted by the Ninth International Conference of American States (1948), reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 17 (1992).

[326] Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health* (22nd Sess., 2000), para. 9, U.N. Doc. E/C.12/2000/4 (2000).

[327] *Id.* at para. 21.

[328] Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health* (22nd Sess., 2000), para. 21, U.N. Doc. E/C.12/2000/4 (2000).

[329] Constitution of the World Health Organization, Basic Documents, Forty-fifth edition, supplement (2006).

[330] Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health* (22nd Sess., 2000), para. 12(c) and 16, U.N. Doc. E/C.12/2000/4 (2000).

[331] *Id.* at para. 16.

[332] The National Economic, Social Rights Initiatives and the national health Law Program, *Embedding the Human Rights to Health Care in U.S. State Constitutions* (Feb. 2009), *available at* http://www.nesri.org/programs/Constitutional_Amendment_Report_2-09.pdf.

[333] Senate Bill 414 introduced by Montana state Sen. Christine Kaufmann, will Constitutionally declare health care to be a human right (in 2009 the bill was tabled in the Senate Health & Welfare). *See* 2009 Legislative Status of Montana Women and Families Report (2009), *available at* http://www.montanawomenvote.org/pdf/Women%20and%20%20Families%20in%20the%202009%20Legislature%20Report.pdf (last visited May 28, 2009).

[334] State of Connecticut, *An Act Establishing A Commission On Health Equity,* Public Act No. 08-171, *available at* http://opportunityagenda.org/files/field_file/ct%20leg%20cmmn%20on%20health%20equity.pdf (last visited June 6, 2009).

[335] *Id.*

[336] D.C. Code §§ 2-1401.01-73 seq. (2007).

[337] Comm. on the Elimination of Racial Discrimination, *Concluding Observations: United States*, para. 33, U.N. Doc. CERD/C/USA/CO/6 (Oct. 24, 2007).

[338] NATIONAL AIDS HOUSING COALITION, HOUSING IS HIV PREVENTION AND HEALTH CARE – FINDINGS FROM THE NATIONAL HOUSING AND HIV/AIDS RESEARCH SUMMIT SERIES, Presenter's Guide 11 (2007), *available at* http://www.nationalaidshousing.org/toolkit/research_findings_PPguide.pdf.

[339] *Id.*

[340] WIDER OPPORTUNITIES FOR WOMEN, D.C. WOMEN'S AGENDA MAYOR'S FY 2010 BUDGET FOR WOMEN IN D.C. 2 (2008) (on file with author).

[341] Interview with Attorney, Women Empowered Against Violence (WEAVE), in Washington, D.C. (Feb. 13, 2009).

[342] *Id*.

[343] Miriam's House is a residential facility that provides medical care for positive women and their children.

[344] International Covenant on Economic, Social and Cultural Rights, art. 11, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976, *available at* http://www2.ohchr.org/english/law/pdf/cescr.pdf.

[345] Interview with Miles.

[346] *See* Committee on Economic, Social and Cultural Rights, *General Comment No. 14, The Right to The Highest Attainable Standard of Health*, (22nd Sess., 2000), U.N. Doc. E/C.12/2000/4, ¶12(b), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En. ("Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party.") According to the Committee, non-discrimination means that "health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact..." (emphasis added).

[347] D.C. WOMEN'S AGENDA MAYOR'S FY 2010 BUDGET FOR WOMEN IN D.C..

[348] Interview with Campbell.

[349] *Id*.

[350] D.C. Human Rights Act

[351] Angela Aidala et al, *Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy*, 9 AIDS AND BEHAVIOR 251 (Sept. 2005) [hereinafter *Housing Status and HIV Risk Behaviors*].

[352] Focus Group of HIV-Positive Women, The Women's Collective, in Washington, D.C. (Feb. 12, 2009).

[353] Interview with Campbell.

[354] D.C. WOMEN'S AGENDA MAYOR'S FY 2010 BUDGET FOR WOMEN IN D.C..

[355] *Id.*

[356] As of the publication of this report, Women Empowered Against Violence (WEAVE), will be closing its doors due to insufficient funding. WEAVE was one of the most comprehensive service organizations in the District serving the legal and emotional needs of both female and male survivors of domestic violence.

[357] Interview with Attorney at WEAVE.

[358] Washington Legal Clinic for the Homeless, Homelessness and Poverty – Washington, D.C., http://www.legalclinic.org/about/facts.asp (last visited May 6, 2009).

[359] *Id.*

[360] This fact may be due to a different definition of homelessness and/or to different boundaries for the D.C. metro area by various sources.

[361] HIV CARE PLAN at 42.

[362] SO OTHERS MIGHT EAT, POVERTY IN WASHINGTON, D.C. *available at* http://www.some.org/Poverty%20in%20DC.pdf (last visited May 6, 2009).

[363] *Id.*

[364] NATIONAL LOW INCOME HOUSING COALITION, OUT OF REACH INDEX 2007-2008 (2008), State Data for Washington, D.C. *available at* http://www.nlihc.org/oor/oor2008/pdf/D.C..pdf.

[365] Interview with Campbell.

[366] Interview with Eric Tars, Human Rights Staff Attorney, National Law Center on Homelessness and Poverty, in Washington, D.C. (Mar. 3, 2009).

[367] Interview with Mary Ann Luby, Outreach Worker, Washington Legal Clinic for the Homeless, in Washington, D.C. (Feb. 17, 2009).

[368] Interview with Campbell.

[369] *Id.*

[370] Human Rights Act of 1977, D.C. CODE §2-1402.21(a), (e) (2009). D.C. Human Rights Act §2-1402.21(a) provides:

> It shall be an unlawful discriminatory practice…, wholly or partially for a discriminatory reason based on the actual or perceived: … source of income: (1) To interrupt or terminate, or refuse or fail to initiate or conduct any transaction in real property; or to require different terms for such transaction; or to represent falsely that an interest in real property is not available for transaction."

§2-1402.21(e) provides: "The monetary assistance provided to an owner of a housing accommodation under section 8 of the United States Housing Act of 1937… either directly or through tenant, shall be considered a source of income under this section."

[371] *See* Susan Barrow and Rita Zimmer, *Transitional Housing and Services: A Synthesis*, 1998 National Symposium on Homelessness Research, U.S. Dep't of Hous. And Urban Dev. and U.S. Dep't of Health and Human Serv. (Aug. 1999) *available at* http://aspe.hhs.gov/homeless/symposium/10.htm [hereinafter *Transitional Housing and Services*].

[372] Interview with Lopez.

[373] Interview with Ashley Keller, HIV Services Coordinator, Our Place D.C., in Washington, D.C. (Feb. 20, 2009).

[374] *Transitional Housing and Services*

[375] *Id.*

[376] Interview with Marsh.

[377] Interview with Pavetto.

[378] U.N. High Comm'r on Human Rights, *Fact Sheet No. 21: The Human Right to Adequate Housing*, *available at* http://www.ohchr.org/Documents/Publications/FactSheet21en.pdf.

[379] *Id*.

[380] *See generally Housing Status and HIV Risk Behaviors*; *Health Status, Health Care Use*

[381] Interview with a Policy Coordinator.

[382] Interview with Donna Crews, Government Affairs Director, AIDS Action, in Washington, D.C. (Feb. 23, 2009).

[383] Interview with anonymous.

[384] Interview with Crews.

[385] Interview with Abramson.

[386] Interview with Guberski.

[387] Interview with Vos.

[388] *Id*.

[389] Interview with Holmes Norton.

[390] Focus Group of HIV-Positive Women, The Women's Collective.

[391] Focus Group of HIV-Positive Women, Miriam's House, in Washington, D.C. (Feb. 17, 2009).

[392] Daniel P. Kidder et al, *Health Status, Health Care Use, Medication Use, and Medication Adherence Among Homeless and Housed People Living with HIV/AIDS*, 97 AM. J. PUB HEALTH 2238 (Dec. 2007). [hereinafter *Health Status, Health Care Use*]

[393] *Id.* at 2242.

[394] *Id.*

[395] *See generally Housing Status and HIV Risk Behaviors.*

[396] *See* Elise D. Riley et al, *Poverty, Unstable Housing, and HIV Infection Among Women Living in the United States,* 4 CURRENT HIV/AIDS REPORTS 181 (2007). [hereinafter*Unstable Housing*].

[397] Interview with Miles.

[398] Interview with Lytle.

[399] *See* Interview with Deborah Smith.

[400] See interview with Vos.

[401] *Health Status, Health Care Use.*

[402] *Housing Status and HIV Risk Behaviors.*

[403]

[404] Interview with Myra.

[405] Interview with Pavetto.

[406] Interview with Miles.

[407] *See Unstable Housing.*

[408] Interview with anonymous.

[409] Focus Group of HIV-Positive Women, The Women's Collective.

[410] Focus Group of HIV-Positive Women, Miriam's House, in Washington, D.C. (Feb. 17, 2009).

[411] Interview with Lopez.

[412] Interview with Cecilia Levin, Domestic Violence Staff Attorney, National Law Center on Homelessness and Poverty, in Washington, D.C. (Mar. 3, 2009).

[413] For more on the link between gender-based violence and HIV risk, see section IX of this report.

[414] *Id.*

[415] Interview with Attorney at WEAVE.

[416] Interview with Levin.

[417] *See* The Violence Against Women and Department of Justice Reauthorization Act (VAWA) of 2005, §§ 601 *et seq.*, H.R. 3402, 109th Cong. (2005).

[418] Human Rights Act of 1977, D.C. CODE §2-1402.21(a) (2009). D.C. Human Rights Act §2-1402.21(a) provides: "It shall be an unlawful discriminatory practice… wholly or partially for a discriminatory reason based on the actual or perceived… status as a victim of an intrafamily offense…of an individual: (1) To interrupt or terminate, or refuse or fail to initiate or conduct any transaction in real property; or to require different terms for such transaction; or to represent falsely that an interest in real property is not available for transaction…".

[419] Interview with Laurie Kohn, Professor and Co-Director, Domestic Violence Clinic, Georgetown University Law Center, in Washington, D.C. (Feb. 17, 2009).

[420] Violence Against Women and Dep't. of Justice Reauthorization Act of 2005, 42 U.S.C. §1437(f)(9)(C)(v) (2009). (Nothing in this section "may be construed to limit the authority… to evict or terminate from assistance any tenant or lawful occupant if the owner, manager or public housing agency can demonstrate an actual and imminent threat to other tenants or those employed at or providing service to the property if that tenant is not evicted or terminated from assistance.")

[421] Human Rights Act of 1977, D.C. CODE §2-1402.21(d)(5) (2009). ("Nothing in this subsection requires that a dwelling be made available to an individual whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others.")

[422] Interview with Kohn.

[423] Interview with Attorney at WEAVE.

[424] Interview with Levin.

[425] Interview with Kohn.

[426] OFFICE OF HOUS., U.S. DEP'T OF HOUS. AND URBAN DEV., IMPLEMENTATION OF THE VIOLENCE AGAINST WOMEN AND JUSTICE DEP'T REAUTHORIZATION ACT OF 2005 FOR THE MULTIFAMILY PROJECT-BASED SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM (Sept. 2008) *available at* http://us-hc.com/sitebuildercontent/sitebuilderfiles/notice08-07hsgn.pdf.

[427] Interview with Levin.

[428] D.C. Metropolitan Police Department, 2009.

[429] *See Heterosexual Relationships and HIV in Washington, D.C.*.

[430] ADDRESSING VIOLENCE AGAINST WOMEN IN HIV TESTING AND COUNSELING: A MEETING REPORT at 10.

[431] Interview with Erin Scheik, Staff Attorney/Skadden Fellow, WEAVE, Washington, D.C. (Feb. 13, 2009).

[432] The Center for the Study of Violence and Reconciliation has been working since 2001 to train, advocate, research, and develop information and education materials for healthcare workers and HIV counselors working with women affected by violence.

[433] ADDRESSING VIOLENCE AGAINST WOMEN IN HIV TESTING AND COUNSELING: A MEETING REPORT at 11, Geneva (Jan. 16-18, 2006).

[434] *See* WEAVE: Mission, http://www.weaveincorp.org/about/ (last visited Apr. 28, 2009).

[435] See Interview with Scheik.

[436] *See* Interview with Dr. Tenagne Haile-Mariam, Outpatient Wound Center and Emergency Department Physician, Washington, D.C. (Feb. 17, 2009).

[437] The Violence Against Women and Department of Justice Reauthorization Act (VAWA) of 2005, Sec. 501(1), H.R. 3402, 109th Cong. (2005).

[438] *Id.*

[439] *See* Interview with Scheik. Also *see* Interview with Haile-Mariam.

[440] Interview with Owensby.

[441] *See* The Violence Against Women and Department of Justice Reauthorization Act (VAWA) of 2005, Sec. 501(3), H.R. 3402, 109th Cong. (2005); ADDRESSING VIOLENCE AGAINST WOMEN IN HIV TESTING AND COUNSELING: A MEETING REPORT.

[442] General Recommendation No. 19 (llth session, 1992), The Convention on Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., No. 46, U.N. Doc. A/34/46 (1979), Arts. 2(e), 15(1), *entered into force* Sept. 3, 1981, *signed by the United States*, Jul. 17, 1980, *available at* http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.

[443] Interview with Catalina Sol, HIV/AIDS Program Director, La Clinica del Pueblo, in Washington D.C. (Mar. 26, 2009).

[444] *In-depth Study On All Forms of Violence Against Women*. . at 48.

[445] Interview with Patricia Nalls, Executive Director and Founder, The Women's Collective, in Washington D.C. (Feb. 12, 2009).

[446] World Health Organization, ADDRESSING VIOLENCE AGAINST WOMEN IN HIV TESTING AND COUNSELING: A MEETING REPORT, at vii, Geneva (Jan. 16-18, 2006), *available at* http://www.who.int/gender/documents/VCT_addressing_violence.pdf.

[447] World Health Organization, HIV STATUS DISCLOSURE TO SEXUAL PARTNERS: RATES, BARRIERS AND OUTCOMES FOR WOMEN (2004), *available at* www.who.int/gender/documents/en/VCTinformationsheet_%5B92%20KB%5D.pdf.

[448] *Id.*

[449] *Stepping Stones*, Strategies for Hope, http://www.stratshope.org/t-training.htm (last visited, Apr. 27, 2009).

[450] Interview with Pavetto.

[451] Interview with Margo Smith.

[452] *Id.*

[453] *Id*.

[454] *Interview with Attorney at WEAVE.*

[455] For further reading, *see* Laurie Kohn, *Why Doesn't She Leave? The Collision of the First Amendment and Effective Court Remedies for Victims of Domestic Violence*, 29 HASTINGS CON. L. QUART. 1 (2001).

[456] Interview with Kohn.

[457] Interview with Attorney at WEAVE.

[458] *Id.*

[459] *Id.*

[460] World Health Organization, INTEGRATING GENDER ISSUES INTO HIV/AIDS PROGRAMMES: A REVIEW PAPER, June, 2002, at 20, *available at* www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf.

[461] *See* UDHR, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948) Arts. 3, 5, 6, *available at* http://www.unhchr.ch/udhr/lang/eng.htm.

[462] The Convention on Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., No. 46, U.N. Doc. A/34/46 (1979), Art. 10, *entered into force* Sept. 3, 1981, *signed by the United States*, Jul. 17, 1980, *available at* http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm.

[463] The International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, Art. 12, U.N. Doc. A/6316 (1966) Art. 12(1), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976, *available at* http://www1.umn.edu/humanrts/instree/b2esc.htm.

[464] Under the Fourteenth Amendment of The United States Constitution, no State "shall deprive any person life…" U.S. CONST. amend. XIV, § 1.

[465] UNAIDS, *UNAIDS Reference Group on HIV and Human Rights*, *available at* http://www.unaids.org/en/PolicyAndPractice/HumanRights/default.asp.

[466] Peter Piot, Former Executive Director, UNAIDS, Zambia (Dec. 2006), *available at* http://www.unaids.org/en/PolicyAndPractice/DriversOfTheEpidemic/default.asp.

[467] *See* UDHR, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948) Arts. 3, 5, 6, *available at* http://www.unhchr.ch/udhr/lang/eng.htm.

[468] The Convention of Belém do Pará, AG/RES. 2012 Sess. 24th (June 9, 1994), *available at* http://www.cidh.org/women/convention.htm.

[469] *Id*. at Article 4.

[470] The Convention on Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., No. 46, U.N. Doc. A/34/46 (1979), Art. 10, *entered into force* Sept. 3, 1981, *signed by the United States*, Jul. 17, 1980, *available at* http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm.

[471] The International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, Art. 12, U.N. Doc. A/6316 (1966) Art. 12(1), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976, *available at* http://www1.umn.edu/humanrts/instree/b2esc.htm.

[472] U.S. CONST. amend. XIV, § 1.

[473] S.F., CAL., ORDINANCES ch. 12k (1998).

[474] *See*, Comm. on the Elimination of Discrimination Against Women, *Concluding Comments: Egypt*, ¶¶ 336-337, U.N. Doc. A/56/38 (Apr. 19, 2001), *available at* http://www1.umn.edu/humanrts/cedaw/egypt2001.html and WHY WE CAN'T WAIT: THE TIPPING POINT FOR HIV/AIDS AMONG AFRICAN-AMERICANS.

[475] Beijing Declaration and Platform of Action, ¶ 106, A/CONF.177/20 (1995).

[476] INTEGRATING GENDER INTO HIV/AIDS PROGRAMMES.

[477] *See* INTEGRATING GENDER ISSUES INTO HIV/AIDS PROGRAMMES: A REVIEW PAPER; INTEGRATING GENDER ISSUES INTO HIV/AIDS PROGRAMS: AN OPERATIONAL GUIDE.

[478] *In-depth Study On All Forms of Violence Against Women* at 82.

[479] INTEGRATING GENDER ISSUES INTO HIV/AIDS PROGRAMS: AN OPERATIONAL GUIDE.