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**HIV AND WOMEN: INCONGRUENT  
POLICIES, CRIMINAL CONSEQUENCES**

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# HIV AND WOMEN: INCONGRUENT POLICIES, CRIMINAL CONSEQUENCES

By Aziza Ahmed<sup>1</sup>

UN Women must take an aggressive role in the standardization of laws and policies at the global and national level where their incongruence has negative and often criminal consequences for the health and lives of women and girls. This article focuses in on three such examples: opt-out testing for HIV, criminalization of vertical transmission, and the new World Health Organization guidelines on breastfeeding.

## Introduction

The new United Nations Agency, UN Women, represents a victory on the part of a global feminist movement to raise the status of women and girls in the context of development. This article asserts that UN Women must take an aggressive role in prioritizing the standardization of laws and policies at the national level where their incoherence has negative consequences for the health and lives of women and girls. In particular this article examines the criminalization of HIV transmission laws and public health policies in the context of HIV counteract despite the common purported goals of slowing the HIV epidemic. In some cases, this interplay of laws and policies makes women vulnerable to prosecution under laws that criminalize the transmission of HIV. In other cases the new laws created to criminalize HIV transmission undermine public health interventions designed to benefit women. This conflict affects women in both developed and developing countries.

This paper first gives a brief background on women living with HIV and moves on to a short description of the spread of criminalization of HIV transmission laws. The

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paper then outlines three ways that criminalization of HIV transmission laws interact with HIV-related policies pertaining to maternal and child health: opt-out testing, criminalization of vertical transmission, and breastfeeding. In these three law and policy contexts, criminalization undermines the public health intervention or the public health intervention makes a woman more vulnerable to being prosecuted. The potential impact of these laws is demonstrated through a brief presentation of how courts in the United States have addressed issues raised by HIV-positive women in the context of parenting and motherhood. The article concludes with a call for UN Women to play a leadership role in reconciling these laws and policies with the health and well-being of women, particularly HIV-positive women, in mind.

## **HIV and Women**

Women constitute approximately 50 percent of individuals living with HIV. The Centers for Disease Control (CDC) has suggested that eventually more women than men will be living with HIV.<sup>2</sup> In Sub-Saharan Africa, women already constitute over 60 percent of individuals living with HIV and in many Sub-Saharan African countries teenage girls are among the most vulnerable to contracting HIV.<sup>3</sup> In Swaziland, Lesotho, and Botswana the prevalence of women testing HIV-positive in antenatal clinics is as high as 30 percent.<sup>4</sup> Among women in developed countries, it is women of color that bear the brunt of the HIV epidemic. Black women are fifteen times more likely to become infected with HIV than white women in the United States.<sup>5</sup> High rates of sexual violence, the inability to negotiate safe sex – particularly in the context of marriage – and gender inequalities are some of the contributing factors that increase the vulnerability of women and girls to contracting HIV. Marginalized women, including drug users, sex workers, and women engaged in transactional sex are particularly vulnerable to contracting HIV.<sup>6</sup>

## **Criminalization of HIV Transmission and Exposure**

Criminalization of HIV refers to the use of HIV specific criminal law or non-HIV specific law (i.e. assault) to prosecute HIV transmission and exposure.<sup>7</sup> HIV specific laws that criminalize HIV transmission are largely found in national HIV/AIDS laws;<sup>8</sup> however, several provisions criminalizing HIV transmission are included in sexual offences laws.<sup>9</sup> Several of these jurisdictions criminalize exposure to HIV whether or not transmission has actually occurred. These provisions cast a wide net and allow for a much broader range of prosecution.

While criminalizing HIV transmission is not new, HIV criminalization laws have come into the forefront of the debate after the recent development of the Model HIV/AIDS Law. The model law was developed as part of a project funded by the United States Agency for International Development (USAID) and was adopted by several countries after a meeting held in N'djamena, Chad in 2004.<sup>10</sup> This Model Law encouraged a proliferation of laws that criminalize HIV transmission in West Africa (and other parts of the continent).<sup>11</sup> Amongst other provisions, the model law proposes punishing the willful transmission of HIV, contains broad partner disclosure provisions, and suggests mandatory testing during pregnancy.<sup>12</sup> For example, Article 36 of the Model Law

has a vague sentence stating that “any person who is guilty of willful transmission of HIV shall be sanctioned...”<sup>13</sup> Willful transmission is defined in the Model Law as the “transmission of HIV virus through any means by a person with full knowledge of his/her HIV/AIDS status to another person.” This language captures a range of behaviors including mother-to-child transmission of HIV and sex acts occurring even after the disclosure of one’s HIV status.<sup>14</sup>

Recent surveys of country laws have found that over thirty-one countries globally have laws which specifically criminalize the transmission of HIV, others use general criminal law provisions to prosecute individuals for transmitting HIV, and still other countries are considering developing criminal laws specific to HIV/AIDS.<sup>15</sup> For instance, Austria, Sweden, and Switzerland have had over thirty prosecutions each.<sup>16</sup> In the United States, one estimate suggests that there have been over 300 prosecutions for HIV transmission.<sup>17</sup> However, this is likely to be a very low estimate given the difficulty in collecting arrest, prosecution, and conviction data where it is not collected or properly recorded. This global trend to criminalize HIV transmission and exposure is not surprising. Many of these laws have come to fruition in a time when, potentially due to a departure from evidence-based programming, the impact of HIV prevention programs has not been as dramatic as intended and HIV rates continue to rise.<sup>18</sup>

Many of the laws that criminalize HIV transmission are similar despite the vast jurisdictional differences. Kenya’s HIV/AIDS Prevention and Control Act states that “a person who is [HIV-positive] and is aware of being infected with HIV or who is carrying and is aware of carrying HIV shall not, knowingly and recklessly, place another person at risk of becoming infected with HIV unless that other person knew that fact and voluntarily accepted the risk of being infected.”<sup>19</sup> The law of Uganda states that a person “who is and is aware of being infected with HIV and AIDS shall not knowingly and recklessly, place another person at risk of becoming infected with HIV and AIDS unless that other person knew that fact.”<sup>20</sup> In Kenya and Rwanda provisions criminalizing HIV transmission can also be found in sexual offense laws.<sup>21</sup> Several countries have laws that specifically criminalize mother to child transmission of HIV/AIDS.<sup>22</sup>

In the United States many HIV criminalization laws were put into place after the 1990 Ryan White Act articulated that states would not receive funding unless state laws criminalized knowingly exposing another to HIV.<sup>23</sup> The states vary in their criminal laws pertaining to HIV; however, approximately thirty-two states specifically criminalize transmission, exposure to HIV or both. In Alabama and Alaska it is a crime to expose another individual to HIV whether or not transmission has actually occurred. In California, “any person who exposes another to HIV by engaging in unprotected sexual activity (anal or vaginal intercourse without a condom) when the infected person knows at the time of the unprotected sex that he or she is infected with HIV, has not disclosed his or her HIV-positive status, and acts with the specific intent to infect the other person with HIV, is guilty of a felony.”<sup>24</sup>

Criminalization operates in a context of misinformation and further exacerbates incorrect information about HIV. Despite widespread efforts to educate and inform, there is still a lack of knowledge about HIV. A 2007 report by Physicians for Human

Rights indicated that a significant minority of respondents to a community survey in Botswana, a country with one of the highest HIV prevalence rates in the world, thought that HIV could be transmitted via mosquito bites, public toilets, or sharing meals with HIV-positive people.<sup>25</sup> This misinformation contributes to an ongoing stigma against HIV-positive individuals. Unfounded fears of contracting HIV lead HIV-positive individuals to be isolated from households, removed from families, and blamed for spreading HIV. Judges are not exempt from these biases and misinformation. Courts in the United States have found individuals guilty of attempting to transmit HIV by spitting and biting.<sup>26</sup> Court decisions that are based in fear and fiction reinforce stereotypes about the way HIV can be transmitted and legitimize unfounded fears of how HIV is spread and of HIV-positive people. Utilizing criminal law to address HIV transmission assumes that HIV-positive individuals are intentionally transmitting HIV. In truth, evidence suggests that most people who transmit HIV do so without knowing their status.<sup>27</sup>

### **Undermining Progress on HIV**

This paper highlights three ways criminalization of HIV transmission and public health laws and policies interact to undermine positive health outcomes for women and potentially increase the likelihood of prosecution: first, the recommended opt-out testing of women in antenatal care can lead to more prosecutions of women living with HIV under criminal HIV transmission laws; second, criminalization drives HIV-positive women away from recommended necessary services that prevent the transmission of HIV/AIDS from mother to child; and finally, in some jurisdictions laws that criminalize HIV transmission and exposure could create a situation in which women can be prosecuted for following the new World Health Organization (WHO) guidelines on breastfeeding.

#### *Opt-out HIV Testing*

The World Health Organization (WHO)<sup>28</sup> and Centers for Disease Control (CDC) both now recommend opt-out testing or “provider-initiated counseling and testing.”<sup>29</sup> In the context of provider-initiated counseling and testing, the WHO guidelines call for simplified pre-test information and maintains that verbal informed consent is satisfactory. The WHO calls on jurisdictions that “require consent to be given in writing” to “review this policy.” The CDC recommendations also limit the amount of pre-test information required for HIV testing and recommends that written consent for HIV not be required for adults, including pregnant women: “Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.” The CDC guidelines make clear that all pregnant women in the United States should be tested for HIV. Opt-out testing often takes place in antenatal clinics where women face unique challenges to informed consent; language barriers, literacy, and power dynamics all impact the ability of women to give informed consent. Further, it is unclear that a woman in labor is able to process the information necessary to make an informed decision, grant consent, and receive a potentially life-changing diagnosis.<sup>30</sup>

Criminal law has immediate consequences for women who are subject to opt-out testing. Relative to men, women are more likely to be tested and know their status because they access hospitals and clinics for reproductive needs. If a woman does not disclose her HIV status to her partner due to fear of violence or abandonment,<sup>31</sup> for example, her partner could attempt to hold her accountable for “knowingly” transmitting or exposing him to HIV. This could be true even in cases where she contracted the virus from him.<sup>32</sup> This potential dynamic is exacerbated by the fact that women are often blamed for bringing HIV into the home and experience violence as a result of disclosing their HIV status.<sup>33</sup> Proponents of opt-out testing assert that it is necessary to test a high volume of individuals and make people aware of their status. These assertions lack consideration for the potential negative ramifications of HIV disclosure on women.

Human rights communities have reacted strongly to the shift toward opt-out testing, asserting that in some cases governments do not maintain confidentiality, do not provide information related to prevention, and implement testing policies in a discriminatory manner. Further, in some settings, testing is offered with no counseling or relevant information.<sup>34</sup> A lack of counseling and informed consent often occurs in circumstances where women are in labor and where testing is seen to be integral to preventing the transmission of HIV from mother to child. Further, it is questionable whether or not a woman in labor is both able to consent and receive her positive test result in a manner that does not alienate her from further services.<sup>35</sup>

Criminalization of HIV transmission creates a new set of concerns around opt-out testing for women. Opt-out HIV testing policies can lead to a legal environment that makes women vulnerable to prosecution under criminal statutes. Because opt-out testing has taken hold despite resistance from women’s rights organizations, it is necessary to ensure that the interaction of criminalization laws and opt-out testing policies do not create situations in which women – after being blamed for spreading HIV – are being prosecuted for transmitting HIV to their partners. The interaction of criminalization and opt-out testing may also have a negative impact on broader public health goals including a woman’s desire to access services. Stigma and discrimination are deterrents for women seeking services at hospital settings. Where opt-out testing creates an environment of distrust and increases stigma, the added potential of prosecution can deter women from seeking maternal health services at hospitals.<sup>36</sup>

It is necessary to understand how opt-out testing implicates a broader range of issues arising from criminal law and how the criminalization of HIV transmission deters individuals from necessary hospital services. However, despite the increased attention on criminalization of HIV transmission, there is little to no effort on the part of public health entities to understand if and how opt-out testing will increase the likelihood that individuals will be prosecuted.

### *The Criminalization of Vertical Transmission*

Women are at risk for prosecution in the context of vertical transmission of HIV. A key public health intervention in the field of HIV has been focused on the prevention of mother-to-child transmission (PMTCT) of HIV. Currently, with appropriate treatment and safe alternatives to breastfeeding, there is less than a 2 percent chance

of vertical transmission.<sup>37</sup> Despite this low risk of transmission, HIV-positive women who are pregnant experience stigma and mistreatment at the hands of healthcare providers who feel that HIV-positive women should not have children. One of the most egregious examples of this is the recent documentation of forced and coerced sterilization of HIV-positive women in Namibia.<sup>38</sup> In developing countries where access to these drugs is difficult, existing stigma and discrimination of HIV-positive women is often exacerbated by the belief that HIV-positive women should not be having children.

Perhaps stemming from these discriminatory attitudes, laws criminalizing HIV transmission attempt to stop women from becoming pregnant or discourage adequate treatment and care by criminalizing HIV-positive mothers who transmit HIV to their children.<sup>39</sup> Even where laws do not explicitly criminalize mother-to-child transmission, general laws that criminalize HIV transmission are written so broadly that women could be prosecuted for transmitting HIV to their children either before, during, or after childbirth when breastfeeding. For example, a woman could be charged with knowingly transmitting HIV to her child if she does not seek out adequate treatment while breastfeeding, even when such treatment is unavailable to her. Laws that criminalize exposure to HIV (as opposed to transmission) make it nearly impossible for an HIV-positive woman to become pregnant without facing some risk of being prosecuted.<sup>40</sup> This is particularly true where laws criminalize only exposure to HIV and do not require transmission. The explicit focus on women serves to entrench the stigma against women as the “vectors” and “transmitters” of the epidemic. Criminalization of HIV transmission can undermine PMTCT programs because fear of prosecution will deter women from seeking care. Further, criminalization of vertical transmission increases blame on women for transmitting HIV to her child often in circumstances where women already face violence upon disclosure of HIV.<sup>41</sup>

PMTCT programs should be a place of safety and security for HIV-positive women who are pregnant and giving birth. Instead many have become a site of human rights violations.<sup>42</sup> Criminalization of HIV transmission from mother-to-child exacerbates the current stigmatization, neglect, and violence that occur in hospital settings against HIV-positive women.<sup>43</sup> In turn, criminalization serves to make PMTCT programs less effective in their goal of preventing transmission of HIV.

#### *New WHO Breastfeeding Guidelines*

In 2010, the WHO issued new breastfeeding guidelines for HIV-positive women. These guidelines recommend exclusive breastfeeding for HIV-positive women for the first six months even where women do not have access to anti-retroviral drugs, stating that when “ARVs are not available, mothers should be counseled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter unless environmental and social circumstances are safe for, and supportive of, replacement feeding.”<sup>44</sup> In cases where anti-retroviral drugs are available for both the mother and the child, there is a great reduction in the possibility of HIV transmission during breastfeeding. However, often even where drugs are available, the ability of some women to access ongoing treatment remains difficult due to a lack of available treatment and services, inability



to afford treatment and services, and ongoing discrimination of HIV-positive women in health care facilities.<sup>45</sup>

In some cases, breastfeeding remains the cause of HIV transmission even when reasonable attempts are made to mitigate the possibility of transmission. These reasonable attempts are subject to the judgment of the court: did a woman's lack of nutrition and related inability to breastfeed constitute unreasonable behavior? Did a woman make enough effort to seek out necessary medicines despite not having access to clinics to ensure that HIV was not transmitted via breast milk? While one can argue that this subjectivity on the part of the judge could benefit women, it is unclear that it will. In fact, history teaches us that women often suffer grave consequences in courts of law where judges exercise discretion over the fate of women's lives.<sup>46</sup>

There has been no concerted effort on the part of any public health body to assess the impact that encouraging women to breastfeed will have on the ability of the state to prosecute them for HIV transmission. While we have yet to see such cases, the very existence of criminal laws that make it possible to criminally prosecute women for following medical guidelines on breastfeeding serve to stigmatize HIV-positive women and discourage them from following the recommended public health guidelines.

### **How Have Courts Reacted to HIV-positive Mothers?**

In most jurisdictions there is no information on the actual numbers of prosecutions based on HIV transmission and exposure. In turn, it is difficult to track and monitor the prosecution of individuals living with HIV, making it difficult to predict how courts will address the prosecution of women for transmitting HIV to her child. In the United States, the few cases that are documented are instructive for the purposes of understanding how HIV-positive women will be understood and treated in courts. These U.S. cases can also suggest potential courtroom dynamics in other country contexts. Judges often adapt the reasoning of judges outside of their national jurisdiction and frequently draw on the reasoning of courts in the United States.<sup>47</sup> This diffusion of legal reasoning makes it relevant to assess how the courts have dealt with HIV-positive mothers in one jurisdiction, particularly in the United States, with the objective of understanding how HIV-positive mothers might be treated in courts outside of the United States.

#### *Reasoning of the Courts in the United States*

Several cases illustrate the reasoning of the court with regard to HIV-positive women in the United States. In 1998, the judgment of the Maine Supreme Court weighed the rights of the mother against those of the child. In this case, a mother of a four-year old boy, Nikolas, was recommended by the family physician to enroll Nikolas in a clinical trial focusing on children with HIV. The mother sought advice and guidance regarding the clinical trial from the physician who was running the trial who recommended that she place her son on treatment. Based on the mother's own experience with HIV, the death of her daughter from complications related to AIDS, and her distrust of drug therapy she declined to have her son participate. The physician in charge of the clinical

trial recommended to the state that they grant a “voluntary release of parental rights with residential custody for her,” which would have resulted in the mother losing all ability to make medical decisions on behalf of her child. The state asked Nikolas’ mother to consult a third physician. The third doctor reported no “irrationality” on the part of the mother and accepted her decision to forgo treatment for her son. During their conversations, it was established that there was no promise that Nikolas would survive longer due to his participation in this clinical trial. Despite this, the state filed for child custody and a child protection order so that he could receive treatment against his mother’s wishes. A guardian was appointed for her son. The mother responded by seeking to regain full custody of Nikolas.<sup>48</sup>

In their decision to determine guardianship, the Maine Supreme Court grappled with the issue of whether the mother’s decision to delay the drug therapy of her son was “rational and reasoned.” In the end, the court decided in favor of the mother given the uncertainty of treatment on children at that time. However, the court also noted that “if better treatment options should become available, that balance [between the benefits and risks of treatment against the benefits and risks of declining treatment] could shift in favor of treatment.”<sup>49</sup> By making this assertion, the court suggested that if the existing medicines had benefited Nikolas with more certainty and the mother continued to refuse treatment, she would have lost custodial rights over her son or at minimum lose the ability to determine his medical care. The court left open the possibility that as treatment options become more regimented for children, a mother could lose custody and be found guilty of serious child abuse or neglect. In 2008, the courts did just this when convicting an HIV-positive Florida woman for child neglect when her child did not receive appropriate HIV treatment.<sup>50</sup>

The 2009 case of Ms. T, a 28-year old woman from Cameroon, speaks to the paternalistic attitude of judges toward HIV-positive women.<sup>51</sup> Ms. T was arrested for falsified immigration documents in the United States. She was imprisoned for 114 days and should have been released under a “time served sentence.”<sup>52</sup> However, upon finding out that she was HIV-positive and pregnant, the court elongated her sentence stating concern that the woman would not have received the medication necessary for the protection of her “child,” likening the lack of receiving medications to “ongoing assault” from the mother onto the “unborn child.”<sup>53</sup> In fact, Ms. T had secured medical care outside of prison. Largely due to the activism and advocacy of HIV rights organizations, advocates, and experts, Ms. T was eventually released.<sup>54</sup>

These are some of the few available cases that illustrate the reasoning of courts with regard to HIV-positive women. Together they tell a story of distrusting HIV-positive women’s ability to make reasonable choices for the sake of her child and family. Despite the eventual results, they also tell a story of hardship: extended jail sentences, loss of child custody (following the death of a first child no less), fear of losing custody forever, and being accused of intentionally harming one’s child. This mistrust and invasive action on the part of the state creates a situation where HIV-positive women are ripe for prosecution and easy targets of a system seeking someone to blame for the ongoing transmission of HIV. In each country, it is the marginalized women – women

of color, migrants, poor women, sex workers, and drug users – who are most likely to be subject to unfair prosecution.

### **The Response to Criminalizing HIV Transmission**

Numerous health and human rights organizations, women’s rights organizations, UN agencies, and public health institutions have spoken out against criminalizing HIV transmission. Some of these attempts at legal reform have been successful.<sup>55</sup> The International Community of Women Living with HIV/AIDS, alongside other organizations, successfully advocated that the government of Sierra Leone remove language in their Prevention and Control Act of 2007 that specifically criminalized HIV-positive women for “knowingly” placing a fetus at “risk of becoming infected with HIV.”<sup>56</sup>

However, the high level of international attention on the challenges posed by criminalization of HIV transmission has not resulted in an aggressive approach of public health institutions to reconcile the potential impact of laws and policies that make women more vulnerable to prosecution. The resistance of public health institutions to do so often stems from the lack of arrest and prosecution records alongside an inability to consider the complicated realities that shape the implementation of public health policies. In the meantime, however, HIV-positive individuals and members of marginalized communities are being prosecuted.<sup>57</sup>

### **Conclusion**

It is necessary that there be a centralized effort to assess law and policy proposals pertaining to women’s health to ensure that women – HIV-positive women in particular – are not left in a quagmire of laws and policies that do nothing more than stigmatize and criminalize their very existence. Further, it is important to recognize how the criminalization of HIV transmission directly undermines the goals of evidence-based public health programs and how public health interventions leave women vulnerable to prosecution. UN Women has been tasked with supporting intergovernmental bodies to formulate policies, standards, and norms and assist member states in implementing these standards. Keeping with this mandate, UN Women can and should play a key role in ensuring that women’s lives and perspectives are kept central to the creation and development of HIV laws and policies. **Y**

– *Rayna Farnsworth and Hanna Azemati served as lead editors of this article.*

## **NOTES**

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<sup>2</sup> “Gender Inequalities and HIV,” World Health Organization, [http://www.who.int/gender/hiv\\_aids/en/](http://www.who.int/gender/hiv_aids/en/) (accessed November 22, 2010); Geeta Rao Gupta, “How Men’s Power Over Women Fuels the HIV Epidemic,” *British Medical Journal* 324 (2002): 183–4; Centers for Disease Control, “HIV/AIDS and Women,” <http://www.cdc.gov/hiv/topics/women/> (accessed at January 28, 2011).

<sup>3</sup> Ibid.

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