JOURNAL OF MEDICAL LAW AND ETHICS; VOL. 1, NR. 2, 121-138, PARIS LEGAL PUBLISHERS © 2013

ARTICLE

Is there a Case for Criminalising Vertical Transmission of the Human Immunodeficiency Virus (HIV) from Mother to Child?

Rebecca Bennett*

Centre for Social Ethics and Policy, University of Manchester.

Abstract

Vertical transmission of HIV is transmission of the virus from an HIV infected woman to her foetus during pregnancy, birth, or breastfeeding. Recklessly transmitting HIV to another person via sexual contact is now considered to be a criminal offence in many jurisdictions and the wording of such criminal sanctions is such that it may well be possible to extend such prosecutions to vertical transmission of HIV. While there have been no attempts, thus far, to extend these criminal sanctions in this way, there have and continue to be attempts to compel pregnant women to act to protect their future children from harm and thus criminalisation of vertical transmission of HIV may well be considered.This article asks the question: 'Is it appropriate to allow the criminalisation of reckless vertical transmission of HIV?' I argue that any projected benefits of criminalisation of vertical transmission are at best tentative and the undesirable consequences of such a move are clear and may be disastrous for the rights of women.

Introduction

Vertical transmission of HIV is transmission of the virus from an HIV infected woman to her foetus during pregnancy, birth of breastfeeding. In the 1990s it was found that the use of antiretroviral medications during pregnancy, opting for birth by Caesarean section and avoiding breastfeeding could reduce the risk of transmitting HIV from mother to child from around

* DOI 10.7590/221354013X13823631596318

15-30%[1] to lower than 2%.[2] As a result it became possible for pregnant women who were aware that they were HIV positive to take steps to protect their future children from HIV infection, similarly to the way that safer sex practices can protect sexual partners.

Around the world the reckless transmission of HIV to another person via sexual contact has been considered a criminal offence and those found guilty of this offence have been imprisoned. The charge in these cases is not that the HIV-positive individual necessarily intended to infect his or her sexual partner (although such acts are also considered a criminal offence), but that the individual was aware of his or her infection and that his or her behaviour put sexual partners at risk of HIV infection. Putting others in danger of infection with HIV is viewed as so serious that criminal sanctions are deemed appropriate to send a message to individuals that this behaviour is not acceptable and to attempt to deter similar risky and reckless acts.

In some jurisdictions existing non-HIV specific laws have been applied to sexual HIV transmission. For instance, in England and Wales, there have been a number of cases since 2003 under section 20 of the Offences Against the Person Act (OAPA), which makes the infliction of grievous bodily harm an offence. Other jurisdictions have provided specific legislation on HIV transmission which, while clearly targeting sexual transmission of the virus, rarely explicitly excludes vertical transmission from its remit.

These criminal sanctions are worded in such a way that it may well be possible to extend prosecutions to other modes of HIV infection, particularly vertical transmission from mother to child during pregnancy. If it is deemed criminal behaviour to sexually transmit HIV by putting others at risk of infection unnecessarily (by not using condoms, for example), then it seems that this charge could be equally placed at the door of HIV-positive women who do not take steps to reduce the risk of vertical infection. While there have been no attempts, thus far, to extend these criminal sanctions in this way, there have and continue to be attempts to compel pregnant women to act to protect their future children from harm,[3] and these have recently extended to taking legal measures

---

1 M.L. Newell & C.S. Peckham, 'Risk Factors for Vertical Transmission and Early Markers of HIV-1 Infection in Children', *AIDS* 7 (1993): S591-597; E.M. Connor et al. (Pediatric AIDS Clinical Trials Groups Protocol 076 Study Group), 'Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment', *New England Journal of Medicine* 331 (1994): 1173-1180.

2 L. Mandelbrot et al., 'Lamivudine-Zidovudine Combination for Prevention of Maternal-Infant Transmission of HIV-1', *Journal of the American Medical Associaton* 285 (2001): 2129-2131; J.P. McGowan et al., 'Combination Antiretroviral Therapy in Human Immunodeficiency Virus-Infected Pregnant Women', *Obstetrics & Gynecology* 94 (1999): 641-646.

3 *Johnson v. State*, 578 So.2d 419, 420 (Fla. 5th DCA 1991); Heather Draper, 'Women, Forced Caesareans and Antenatal Responsibilities', *Journal of Medical Ethics*, 22 (1996): 327-333.

to try and enforce behaviour in pregnant women which it is hoped will reduce the risk of HIV infection of their foetus.[4]

The appropriateness of criminalising *sexual* HIV transmission and the legal possibility of extending these criminal sanctions to vertical transmission of HIV have both been examined in the literature.[5] This article seeks to focus on a different but related issue by addressing the question: 'Is it appropriate to allow the criminalisation of reckless *vertical* transmission of HIV?'. As a result it primarily asks moral rather than legal questions. It may well be that many jurisdictions allow this possibility, but this article seeks to address whether the use of the law in this way can be morally justified.

The Case for Criminalisation of Vertical HIV Transmission

One of the clear aims of criminalising reckless sexual transmission of HIV is to attempt to reduce infection rates. It is hoped that sending out a clear message that reckless transmission is not only morally unacceptable but also criminal will deter those infected with HIV from risky behaviour that may lead to their loss of liberty.

Reducing *vertical* transmission rates is also high on the agenda for policymakers. Since it was discovered in the 1990s that risk-reducing interventions could reduce the incidence of vertical transmission from mother to child there has been a general move towards attempting to identify as many HIV-positive pregnant women as possible to enable this risk reduction. As a result, most developed countries have introduced routine 'opt out' antenatal HIV screening in an attempt to test not just those who would have 'opted in' but also those who would not have actively chosen to be tested.[6]

---

4 Joanne Csete, Richard Pearshouse & Alison Symington, 'Vertical HIV Transmission Should be Excluded from Criminal Prosecution', *Reproductive Health Matters* 17, no. 34 (2009): 154-162.

5 Matthew, Weait, 'Criminal Law and the Sexual Transmission of HIV: *R v. Dica*', *The Modern Law Review* 68 no. 1 (2005): 121-134; J. Chalmers, 'The Criminalisation of HIV Transmission', *Journal of Medical Ethics* 28 (2002): 160-163; Rebecca Bennett, 'Should We Criminalize HIV Transmission?', in *The Criminal Justice System and Health Care*, ed. Charles Erin & Suzanne Ost (Oxford: Oxford University Press, 2007), 225-236; Joanne Csete, Richard Pearshouse & Alison Symington, 'Vertical HIV Transmission should be Excluded from Criminal Prosecution', *Reproductive Health Matters* 17, no. 34 (2009): 154-162.

6 W. Kiehl et al., 'AntenatalHIV Testing in Europe', *Eurosurveillance* 3 no. 34 (1999): 1346, www.eurosurveillance.org/ViewArticle.aspx?ArticleId=1346 Date of submission:; J.E. Banatvala & I.L. Chrystie, 'HIV Screening in Pregnancy: UK Lags', *Lancet* 343, no. 8906 (1994): 1113-1114; B.M. Branson et al., 'Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-care Settings', *MMWR Recommendations and Reports* 55 (September 2006) (RR-14): 1-17; Centers for Disease Control, Prevention (CDC), 'Recommendations of the US Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency Virus', *MMWR Recommendations and Reports* 43 (August

By introducing 'opt out' rather than 'opt in' antenatal testing for HIV, pressure is put on pregnant women not only to find out their HIV status but, arguably, to accept medication and Caesarean sections to protect their future children from infection.[7] It seems likely that women who test positive for HIV as the result of a routine antenatal screening will also feel under pressure to follow what might appear (however implicitly) the recommended path towards accepting these interventions. Thus a pandemic that had been characterised by a focus on voluntary 'opt in' testing and a strong adherence to respecting individual autonomy made an exception for pregnant women and justified this on the basis of harm reduction. There continue to be calls to take a further step and make HIV antenatal testing mandatory in order to identify as many HIV-positive women as possible and persuade them to accept this risk-reducing intervention.[8]

This shift in policy regarding HIV and pregnant women shows the desire on the part of policy-makers to use antenatal care as a means of attempting to reduce HIV transmission rates. Condom use by HIV-positive individuals cannot be enforced but it is possible to test all pregnant women seeking antenatal care for HIV, in an attempt to persuade them to take measures to protect their future children and thus advance these public health goals.

An Obligation to Protect our Future Children Explained

In this article I talk about a moral obligation to protect future children or foetuses we intend to bring to birth, or do bring to birth, from harm. According to this view pregnant women have a moral obligation not to harm their future children by inflicting harm or failing to prevent harm to these children in their foetal state. This is because harm caused to a foetus we intend to bring to birth will be likely to harm the welfare of the child we will cause to exist later. Such a moral obligation can be confusing and may mistakenly be

---

1994): 1–20, www.cdc.gov/mmwr/preview/mmwrhtml/00032271.htm, (RR-11); Centers for Disease Control, Prevention (CDC), 'US Public Health Service Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Women', *MMWR Recommendations & Reports* 44 (July 1995): 1-15, www.cdc.gov/mmwr/preview/mmwrhtml/00038277.htm.

7 Rebecca Bennett, 'Routine Antenatal HIV Testing and its Implications for Informed Consent', in *Midwifery and Ethics*, ed. Lucy Frith & Heather Draper (Edinburgh: Butterworth-Heinmann, 2004) 74-90; Rebecca Bennett, 'Routine Antenatal HIV Testing and Informed Consent: An Unworkable Marriage?', *Journal of Medical Ethics* 33, no. 8 (2007): 446-448.

8 J. Rovner, 'US Specialists Object to AMA's Call for Mandatory Testing', *The Lancet* 348, no. 9023 (1996): 330; Udo Schuklenk & Anita Kleinsmidt, 'Rethinking Mandatory HIV Testing During Pregnancy in Areas With High HIV Prevalence Rates: Ethical and Policy Issues', *American Journal of Public Health* 97, no. 7 (July 2007): 1179-1183.

interpreted as extending to a moral obligation to protect foetuses that perhaps could be turned into a legal obligation. A legal obligation to protect foetuses would revolutionise the way that we treat pregnancy and the interests of pregnant women, restricting women's access to abortion and curtailing women's rights to refuse treatment in pregnancy. However, such a moral obligation to prevent harm to our future children before they are born does not entail a moral obligation to protect all foetuses. The reason for this can be found in the rationale that usually justifies access to abortion in those jurisdictions where access to legal abortion is sanctioned.

Whether or not we personally agree with this stance, access to abortion is usually justified on the basis of the perceived moral status of the foetus. In the view of moral status that justifies legal abortion, the early foetus is considered to be a very different creature to the child he or she will become. The foetus is something that does not yet have the ability to value its existence. According to this view, while it is often heartbreaking for parents when early miscarriages occur, the tragedy is for these self-aware, grieving parents and not for the early foetus itself who cannot grieve for what it has not yet had or foreseen. Thus the justification used for abortion is that it does not involve the destruction of a self-conscious individual who can be aggrieved at this stage by the termination of its life and thus is morally acceptable.

However, once parents have made the decision to bring a foetus to birth, obligations become different. While this view of the moral status of the foetus may allow us to terminate its life at a very early stage, this stance does not sanction harm inflicted on the foetus if a decision to bring it to birth has been made. This is because once this decision has been made it becomes possible to harm, at the fetal stage, the self-conscious individual this foetus will become after birth. Harm inflicted on a foetus who will be brought to birth will harm someone, it will harm the child that the foetus will become. Thus, harm inflicted on the foetus is morally reprehensible if it will affect a self-conscious individual born at a later stage of development. However, there can be no justification for a legal obligation to protect the foetus from harm during pregnancy if the pregnant women carrying it intends to terminate the pregnancy, as harm done to the foetus will never affect the welfare of any individual if this termination takes place.

HIV, Pregnancy and Protecting Future Children from Harm

In countries where women have access to risk-reducing measures such as antiretroviral drugs, Caesarean section and alternatives to breastfeeding, HIV screening in pregnancy provides a convenient opportunity to attempt to persuade women to act to on a moral obligation to protect their future children. But persuading is one thing; criminalising those who do not

comply seems an entirely different step. However, this is a step that the law has, in some instances, already taken in relation to HIV and other harm prevention in pregnancy.

There have been many attempts by the law around the world to compel pregnant women to act to protect their future children from harm. For instance, women have been prosecuted for supplying drugs to a minor *in utero*,[9] women have been forced to submit to Caesarean sections against their will.[10] In line with these actions the law has stepped in regarding HIV in pregnancy. It has been reported,[11] for instance, that in 2008 a woman in Florida was charged with child neglect for failing to take action to prevent vertical HIV transmission to her child who was born HIV positive. An HIV-positive woman of Cameroonian origin was arrested in Maine for possessing false immigration documents. The judge in this case went beyond the prescribed sentence for the offence in an apparent attempt to keep her in prison for the duration of her pregnancy, in order to attempt to get her to accept interventions to protect her child from infection. In Canada in 2006 it was reported that an HIV-positive woman pleaded guilty to the charge of 'failing to provide the necessaries of life'[12] to her child who was HIV positive at birth. She was also charged with criminal negligence causing bodily harm, a charge previously levelled against cases of sexual HIV transmission.

A call to place criminal sanctions on women who refuse to accept treatments that dramatically reduce the risk of their future child being infected with HIV would undoubtedly be based on the laudable aim of attempting to prevent serious harm to future children. It also seems to be in line with the use of criminal prosecutions for sexual HIV transmission, as well as with other actions regarding previous prosecutions for drug and alcohol abuse and refusal of medical treatment in pregnancy and during childbirth that have led to harm to children born. However, while we may clearly understand a motivation to attempt to protect future children from harm *in utero* and during birth, it is not clear that enforcing a moral duty to protect our children is an appropriate use of the criminal law.

---

9 *Johnson v. State* (note 3).

10 Draper, 'Women, Forced Caesareans' (note 3).

11 Csete, 'Vertical HIV Transmission' (note 4).

12 J. Chan, 'Six-month Conditional Sentence for Mother who Hid HIV Status for Son's Birth', *HIV/AIDS Policy and Law Review* 11, no. 2/3 (2006): 45 cited by Csete, 'Vertical HIV Transmission' (note 4) 158-159.

Is the Criminalisation of Reckless HIV Transmission Appropriate?

The Goals of Criminalisation

As we have seen, the aim of criminalisation of reckless sexual transmission of HIV is a desire to prevent further infections by deterring similar behaviour. Any move to use existing legal sanctions to criminalise reckless vertical transmission would be motivated by the similar goal of prevention. Criminal sanctions are seen as an appropriate way of enabling this deterrent in the case of sexual transmission, as such behaviour is viewed as a serious moral wrong.

This assumption raises two fundamental questions both in the context of existing prosecutions for reckless sexual transmission of HIV and for possible future application of the criminal law to reckless vertical transmission of HIV. These questions are: 'Is criminalisation likely to reduce HIV transmission rates?' and 'Are we confident that reckless transmission of HIV via sex or from mother to child represents the sort of serious moral wrong that it is appropriate to punish in this way?'.

Is Criminalisation of Vertical HIV Infection Likely to Reduce Infection Rates?

It has been argued that the criminalisation of reckless sexual transmission of HIV may well turn out to be counterproductive in terms of public health goals, with individuals being less likely to seek out testing or to be honest about their high risk behaviours.[13] With this doubt about sexual transmission rates and criminalisation in mind, it is important to explore whether it is likely that criminalising reckless vertical HIV infection would be successful in reducing the incidence of vertical transmission of HIV.

13 Bennett, 'Should We Criminalize HIV Transmission?' (note 4).

Criminalisation and Mandatory Testing

In many countries antenatal HIV testing is routine and recommended in pregnancy. If avoiding HIV risk-reducing measures in pregnancy became a criminal offence, this would be likely to pave the way for a move towards mandatory antenatal HIV testing; there are already calls for this.[14] Those who argue for it argue that testing all pregnant women for HIV would allow more women to have access to antiretroviral drugs and to take measures to protect their future children. Mandatory testing of this kind might also help to normalise the test, reducing the stigma around it, and may allow women to protect their future sexual partners.

Unless antenatal HIV testing becomes mandatory, criminal sanctions in this area may be tricky. It might be that without compulsion some women would be deterred from being tested as a way of avoiding criminal prosecution, as they may not want to modify their behaviour in pregnancy. This of course would be contrary to any public health goals criminalisation of vertical HIV transmission may have.

However, would making antenatal HIV testing mandatory necessarily be a consequence of criminalising vertical HIV transmission? It may well be that refusing a routine antenatal test would not necessarily protect a woman from criminal sanctions. It might be argued that whether a woman who refuses the test is responsible for any consequent HIV infection of her child will depend on the risk factors that this woman has been exposed to – has she shared needles with anyone, had sex with anyone from a so-called high risk group, and so on? In other words, it might depend on how likely she feels it is that she is infected with HIV. In one English case of criminal prosecution for sexual HIV infection, the defendant had not been tested for HIV at the time of transmission but was charged on the basis that a doctor had warned him that 'his risky sexual lifestyle made it ''probable'' that he was HIV-positive'.[15] However, as a large proportion of new infections are from heterosexual sex, pregnant women, as individuals who in most cases will have had recent unprotected sex, are at risk of HIV infection.

While it may still be possible to convict for vertical HIV transmission without making HIV antenatal testing mandatory, it seems likely that criminal sanctions would give great weight to the move to making testing compulsory. If criminalisation of vertical transmission is viewed as an acceptable application of the

---

14 Rovner, 'US Specialists Object' (note 8); Schuklenk, 'Rethinking Mandatory HIV Testing' (note 8).

15 Colin Richardson, 'Proof Positive: Should the Reckless Transmission of HIV be a Crime?', *The Guardian*, 19 April 2006, www.guardian.co.uk/commentisfree/2006/apr/19/shouldthe recklesstransmissi.

law, this is because we feel that the moral wrong is serious enough to warrant this move. Thus the message sent out by criminalising vertical transmission of HIV would strongly support those who argue for the introduction of mandatory testing.

Is Mandatory Antenatal HIV Testing Necessarily a Bad Thing?

I have argued that criminalisation of vertical HIV transmission is likely to lead to the introduction of mandatory antenatal HIV screening and suggested that this might be an undesirable result of criminalisation. But why would such a move be undesirable? Surely if women have a moral duty to protect their future children from harm such testing enables them to fulfil this moral obligation, and also allows them to gain access to medication which may improve their own health.

However, mandatory testing is problematic. One of the main problems is that it is not clear that mandatory testing and criminalisation of vertical HIV transmission will be successful in terms of reducing transmission rates. Mandatory antenatal testing for HIV may not be as likely as less coercive measures to achieve its public health goals.

Mandatory Testing: Implications for Antenatal HIV Care and Treatment

It is not clear that using coercive mandatory testing is necessarily the best way to achieve the aim of reducing vertical transmission rates. There are a number of reasons for this.

Compliance

In order to reduce the risk of vertical transmission, pregnant women need to take antiretroviral drugs, give birth by Caesarean section and not breastfeed. These are all fairly invasive interventions which women may feel reluctant to accept. Caesarean section, for instance, poses a much greater

risk to women than vaginal delivery.[16] It has been suggested that 'compliance with medical care is likely to be greatest when the woman feels she has made an informed decision regarding HIV testing and has a relationship of respect and trust with her health care provider'.[17] Mandatory antenatal testing would remove women's choice in this matter and is likely to change their relationship with healthcare professionals.

Coercive Treatment?

While we may feel that it is justifiable to implement mandatory testing for HIV in pregnancy, we may not feel so comfortable about putting pressure on women to accept these invasive treatments. It is inevitable that criminalisation of vertical transmission of HIV with or without mandatory testing will put huge pressure on women to accept these treatments for the good of their babies. This would of course be the primary motivation for extending the criminal law in this way and is already the motivation behind current routine testing programmes for HIV in pregnancy.

Criminalisation of vertical transmission of HIV effectively makes these invasive medical interventions legally mandatory for infected women. With this in mind it is easy to see why, if accepting these risk-reducing interventions becomes legally mandated, some pregnant women may avoid antenatal care altogether either to avoid finding out their HIV status or to avoid being pressured into having treatment they are reluctant to have. It is clear that avoiding antenatal care can in itself put foetuses at great risk of harm, not just from HIV infection.

Coercive Testing and Treatment or Respecting Autonomy and Providing Information?

I have argued elsewhere[18] that it is not clear that coercively testing pregnant women for HIV and putting pressure on them to accept risk-reducing interventions will do a better job, in terms of preventing vertical

16 S.A. Stringer, D.J. Rouse & R.L. Goldenberg, 'Prophylactic Cesarean Delivery for the Prevention of Perinatal Human Immunodeficiency Virus Transmission: The Case for Restraint', *Journal of the American Medical Association* 281 (1999): 1946-1949.

17 L.M. Mofenson, The Committee on Pediatric AIDS, 'Technical Report: Perinatal Human Immunodeficiency Virus Testing and Prevention of Transmission', *Pediatrics* 106, no. 6 (2000): e88, 7.

18 Bennett, 'Routine Antenatal HIV Testing' (note 7); 'Routine Antenatal HIV Testing and Informed Consent' (note 7).

transmission, than a policy of mandatory antenatal HIV *counseling* with the offer of HIV testing as a truly voluntary 'opt in' option. Such a policy would allow women to receive balanced information about HIV, accurately informing them of the treatments available both for themselves and their future children. While it may be that this will result in a slightly lower uptake of testing, it could be that upholding women's autonomy and providing accurate information will encourage women to be tested for HIV and also mean that they are more likely to accept and comply with treatments offered, since the relationship between them and the healthcare professionals will not be damaged by coercion. Providing all pregnant women with information in this non-coercive way could also allow them to access counselling and information about high-risk behaviours, possibly helping to reduce sexual transmission rates.

A study in 1998 provided some evidence to support this claim that voluntary counselling and testing for HIV in pregnancy may well prove more effective in reducing HIV transmission rates. This study used a decision analysis model and concluded that the number of infants who would be spared HIV infection under a mandatory antenatal HIV testing regime would probably be lower than the number of perinatal deaths caused by women avoiding antenatal care in order to avoid mandatory HIV testing.[19]

Level of Moral Wrong

It seems that criminalisation of vertical transmission of HIV and the more coercive testing policies that it is likely to produce or at least support may not produce the hoped-for clear public health gains. However, there may be other reasons, apart from harm prevention, why criminalisation of vertical HIV transmission could be deemed appropriate.

The primary goal of the criminalisation of sexual transmission of HIV was to identify this behaviour as a serious moral wrong which should be punished, sending a strong message that such behaviour is morally repugnant behaviour. This is demonstrated by the English Crown Prosecution Service statement that:

> We wish to issue a clear statement that the intentional or reckless sexual transmission of infections that cause grievous bodily harm is not acceptable

19 Inaam A. Nakchbandi et al., 'A Decision Analysis of Mandatory Compared with Voluntary HIV Testing in Pregnant Women', *Annals of Internal Medicine* 128, no. 9 (1 May 1998): 760767.

and, where appropriate, will be prosecuted effectively through the criminal courts.[20]

Criminal sanctions seem wholly appropriate for the *intentional* transmission of HIV through a violent act or where there is a clear intent to harm another person. If such intent or violence can be shown, then it is clear that this is a serious moral harm that should be dealt with similarly to other violent and harmful acts. But where the criminal law is used to indicate moral repugnance regarding an act and to allow punishment of this act, this is usually only seen as appropriate where a *serious* moral wrong has been committed. We may commit all sorts of morally questionable or even wrong acts each day. However, it is only the very serious moral wrongs, usually involving not only serious harm but also some intention to harm, that face the full force of the criminal law. It is unclear that reckless transmission of HIV both via sex and from mother to child necessarily falls into this category of serious moral harm. Therefore, I argue that criminalisation may not be justified on the basis of indicating moral wrongs.

Reckless *Sexual* Transmission = A Serious Moral Wrong in All Circumstances?

It is often very difficult to establish that reckless transmission of HIV via sex, that is, transmission where there is no evidence of force or intention, is a serious moral harm or wrong on the same level as intentional HIV transmission to sexual partners. While a man who infects his wife with HIV after a string of affairs without giving her any reason to suppose he is other than monogamous may well have committed a serious moral wrong, what of the HIV positive gay man who has sex in saunas and the backrooms of clubs without disclosing his status as he assumes that his sexual partners will be aware of the risks involved, or the woman from a high risk group (e.g. an intravenous drug user) who has not been tested for HIV but is persuaded by a new partner, who is also aware of her high-risk affiliations, to have unprotected sex? Can all of these cases be classified as the same serious level of moral wrong as intentional HIV transmission? It is difficult to calculate accurately, particularly in a court of law, the level of moral wrong that might be done where a case involves the reckless sexual transmission of HIV.

---

20 Crown Prosecution Service, *Prosecuting Cases Involving the Sexual Transmission of Infections which Cause Grievous Bodily Harm: A Consultation Paper* (Crown Prosecution Service, 2006) 1, www.advisorybodies.doh.gov.uk/eaga/pdfs/cpsconsultation-nov2006.pdf.

Similarly, and perhaps even more contentiously, it is not clear that women who recklessly transmit HIV to their children via pregnancy and birth are committing such a level of moral wrong that imprisonment is a just punishment. It seems fairly uncontroversial to say that pregnant women, like other individuals in society, have a moral obligation to protect other people, including children they intend to bring to birth, from harm where possible. But it is not clear whether any instance of failing to do this can be classified as a moral wrong which it is appropriate to criminalise.

It is very unlikely that a woman who fails to take steps to protect her future child from HIV infection during pregnancy and birth does so with the intention to harm that child. It is likely that other things influence this behaviour. The woman may be scared of the repercussions of being tested for HIV in terms of her relationship or family support, or anxious that she will be pressured into accepting treatment she is worried about, or that her risky behaviour will be condemned by those caring for her. So women who refuse or avoid testing and treatment for HIV in pregnancy may do so as a result of fear and lack of power. Can this be seen as a serious moral wrong equivalent to using HIV as a weapon to harm others intentionally? If the criminal law is being used to punish morally repugnant crimes, do these women's actions really fall into this category?

Undermining of Women's Autonomy

Any claims that the criminalisation of vertical transmission of HIV might be justified on the basis of public health utility or in order to punish serious moral wrongs are at best without strong foundations. It is extremely hard to defend claims that criminalisation of vertical transmission is likely to reduce HIV transmission rates or that women who pass HIV to their children *in utero* should be criminally punished.

The problems with the possible criminalisation of vertical transmission of HIV do not end here. Extending criminal sanctions to the transmission of the virus may well have much wider consequences for pregnant women.

Wider Implications of Criminalising Vertical HIV Transmission

In many jurisdictions, including my own, although there have been attempts to use the law to take action against women who inflict harm on their foetus *in utero,* courts have ultimately refused to open the door to giving the foetus legal rights in this way and upheld a woman's right to choose to refuse treatment if she so wishes. Respect for individual autonomy and an individual's

choices about his or her life and body is usually seen as fundamental in modern healthcare ethics and law, and so far no general exception has been made in pregnancy. It may be clear that pregnant women who intend to bring a child to birth have moral obligations to protect that child from harm, but there are also very good reasons for the reluctance to turn this moral obligation into a legal one.

Obligation to Do Everything Possible to Protect One's Future Child?

As we have seen, by accepting risk-reducing interventions an HIV-positive pregnant woman can significantly reduce the risk of her child becoming infected with the virus. However, this is not as black and white as it may first appear. We know that without any interventions the transmission rate is around 15%–30%.[21] This means that women who are not aware of their positive status or refuse these treatments are likely to have a child who is *not* infected with HIV. Thus by criminalising the refusal of these interventions we are criminalising actions that might, but are not certain to, cause harm to the child who is born.

Once there is a legal obligation to protect the foetus not just from probable but also from possible harm, we will be moving to a radically different legal and social approach to pregnancy and childbearing.

There is a strong possibility that extending the criminal law to criminalise harm to a foetus would change the way that women are cared for by healthcare professionals during pregnancy. If healthcare professionals owe a legal obligation to the foetus as well as the woman, the way that antenatal care is provided must change. Criminalisation of vertical HIV transmission would provide a strong argument in favour of more mandatory testing in pregnancy, not just for HIV but for any condition that might negatively impact on the foetus if left undetected. This would include any genetic disorders where welfare can be improved by *in utero* diagnosis. Criminalisation of vertical HIV transmission would also provide a strong justification for overriding women's choices with regard to emergency Caesarean sections. If a legal duty to protect the foetus from possible harm is established by extending criminalisation of HIV transmission to transmission in pregnancy and childbirth, then women's decisions to refuse a medically indicated Caesarean section and put their children in danger could overridden much more easily by using a similar justification.

---

21 Newell, 'Risk Factors' (note 1).

Even outside the medical setting, things might change radically for pregnant women. We know that drinking alcohol in pregnancy, smoking, drug use and communicable diseases can be harmful to the foetus. But what of all the other factors that might cause it harm? Obesity, bad nutrition, risky activities, high blood pressure from overworking, living with a smoker, driving a car, eating soft cheese, having a cat, eating tuna, dyeing your hair, these are all things that midwives and pregnancy books warn pregnant women may damage their foetus. The same justification for criminalisation of vertical HIV transmission would allow criminal sanctions for pregnant women who ignore these warnings and end up bringing to birth a child who is harmed by their reckless actions during pregnancy. If there is no clear way of distinguishing the justification for criminalisation of HIV transmission from a justification that could be used in these other circumstances, then we must be ready for further prosecutions of women for the crime of excess tuna eating and reckless cat litter management.[22]

A legal obligation to protect your foetus from possible harm would seem to be hugely burdensome and also very difficult to police. As Brazier and Cave point out, as there is evidence that the foetus is particularly vulnerable in early pregnancy, a legal obligation to protect it from harm would be hugely onerous and unworkable.[23] They cite Sheila McLean, who argues that such a move would allow the law to demand that 'fertile, sexually active women of childbearing age should act at all times as if they were pregnant'.[24] If this legal obligation to protect our children in their foetal state was allowed to be established, then any woman who might be pregnant and who had any desire to bring a child to birth would have to live her life avoiding anything that might cause harm to that child to avoid legal sanctions.

Now it might be that women do owe a moral duty of care to any children they might bear and that this moral duty of care extends to protect those children as far as possible through lifestyle changes, even before pregnancy is confirmed. However, we all have many moral obligations that we would not necessarily recommend be translated into legal obligations with criminal sanctions. We may well have a moral obligation not to cheat on our spouse, or to donate blood or our organs, to give to charity, or even rescue people who are in physical danger. However, to make these moral obligations legal obligations with a criminal sanction would seem unnecessary, unworkable and in conflict with modern notions of respect for individual autonomy. If we do not generally place legal and criminal obligations on other individuals to make sacrifices in order

---

22 Toxoplasmosis can be picked up from cat faeces and in pregnant women may cause premature birth, low birth weight, fever, jaundice, abnormalities of the retina, mental retardation, abnormal head size and convulsions.

23 M. Brazier & E. Cave, *Medicine, Patients and the Law*, 3rd ed. (London: Penguin, 2011) 334.

24 S.A.M. McLean, *Old Law, New Medicine* (London: Pandora Press, 1999) 66, as cited in Brazier, *Medicine, Patients and the Law* (note 23) 334.

to protect third parties from harm, then singling out pregnant women for this treatment seems unjustified.

Incentive to Abort?

This laudable desire to protect future children from harm may have even more problematic implications. It seems that this obligation to protect the foetus could provide an incentive for some women to terminate their pregnancy, whereas without the threat of criminal sanctions they would have continued to carry the pregnancy to birth. This is because criminal sanctions would be avoided if a foetus harmed by HIV transmission, or any other possible harm, was aborted before he/she became a legal person at birth.

This may seem an odd stance at first glance. How can it be that we have a legal obligation to prevent harm to the foetus but that this does not cover killing it? How can the death of the foetus remove any culpability for harm caused before its death? If we understand the legal and moral justification used for legal access to abortion we can understand this distinction, as explained earlier in this article.

The justification for allowing access to legal abortion is usually that abortion is morally acceptable since the foetus is viewed as something that does not yet have the ability to value its existence. On this basis, abortion involves the destruction of a non-self-conscious individual which cannot be aggrieved by the termination of its life at this stage. However, once a decision has been made to bring the foetus to birth it is possible to harm, at the foetal stage, the self-conscious individual this foetus will become. So, according to this view, a pregnant woman who does not intend to bring her foetus to birth does not have an obligation to prevent harm to it. This moral underpinning justifies access to abortion and could also provide an incentive to abort a foetus, where a woman is worried she may have harmed it during pregnancy, in order to avoid any criminal repercussions.

Breaking a Fundamental Parental Bond?

The criminalisation of vertical HIV transmission is motivated by a desire to protect the welfare of future children. However, it is not clear that prosecuting and possibly incarcerating mothers would be good for the welfare of those children. As we have seen, the criminalisation of vertical HIV transmission may not only lead to the prosecution of HIV-positive women but also of other women who act or refuse to act in what is perceived to be the best interests of their future children. Is prosecuting women in this way a good use of the

criminal law? Is imprisoning women and possibly separating them from their young children a move that will be good for these children, who may already face more physical challenges than others?

Conclusion

In this article I have examined the case for extending the criminalisation of HIV transmission to cases of vertical transmission in pregnancy and childbirth and have argued that we should strongly resist such a move.

The case of reckless sexual transmission of HIV is problematic enough. This move to criminal prosecutions may well mean people are less willing to come forward and be tested for HIV and to be honest and frank with healthcare professionals about their risk factors and behaviour. Further, it may be clear when a vindictive individual deliberately sets out to infect others with HIV, particularly when this motive can be reasonably established, but in other cases this level of moral wrong, such that it warrants criminal sanction, will be difficult to establish with any confidence.

My arguments around criminalisation of vertical transmission of HIV lead me to similar conclusions. While it may well be a moral wrong to inflict harm on a foetus that will harm the child it will become, criminalising this behaviour is not the appropriate response to these actions for a number of reasons.

First it may well be that criminalisation will not reduce vertical transmission rates, at least not significantly enough to make such a radically different approach justifiable. Women could be deterred from being tested or from making use of antenatal care at all, which could have a greater detrimental effect on infant welfare.

Second, it is not clear that women who avoid taking measures to protect their future children from vertical HIV transmission are committing the sort of moral wrong that warrants criminal sanction. It is very unlikely that women will take this action or inaction with any intent to harm their future children, but for other reasons that may well be minimised by continuing to provide antenatal care based on a relationship of trust, openness and respecting women's choices.

Further, the wider implications of such prosecutions could be hugely detrimental to women's choices in pregnancy more generally. Opening the door to a criminal charge of harm to a foetus has the potential to change dramatically the way that women are treated in pregnancy and childbirth, singling this vulnerable group out for treatment that is not suggested for any other group in society, pitting their autonomy directly against the interests of the foetus they carry. This is a move that we should be very careful about making, even if there were strong evidence that it would have a significantly positive effect on the

welfare of newborns; the absence of such evidence makes this prospect even more frightening and unjustifiable.

It seems that in many jurisdictions the letter of the law may well leave the way open for prosecutions of women who refuse to accept interventions to protect their children from vertical HIV transmission. I have argued that we should strongly resist such a move; any benefits are at best tentative but the undesirable consequences are clear and may be disastrous for the rights of women.