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BEYOND SURVIVAL: THE PROCREATIVE RIGHTS OF WOMEN WITH HIV

KATHRYN BOOCKVAR*

I. INTRODUCTION

Increasingly, women's autonomy over their bodies is being threatened as courts and legislatures play paternalistic roles. Women have been forced to have surgical procedures against their will, often to the detriment of their health.[1] They have been forced into temporary[2] or permanent[3] sterilization, and have been prosecuted for child abuse or neglect for having taken improper care during pregnancy.[4] Courts have even permitted women to be sued by their children for allegedly negligent actions during pregnancy.[5]

None of this is entirely surprising in light of the history of paternalistic attitudes toward women and especially toward women's birth-

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[1] These procedures are most often imposed in the name of protecting a fetus. Physicians and courts have ordered women to receive caesarian sections, blood transfusions and full life support systems, despite the objections of the women or their families. *See infra* note 137 and accompanying text.

[2] Recently, Norplant has been used as a means of temporarily sterilizing women considered to be incapable of effective parenting. *See infra* notes 29–36 and accompanying text.

[3] Compelled sterilizations to prevent reproduction by those considered unfit were prevalent earlier in the century, and are still performed today. *See infra* notes 20–28 and accompanying text.

[4] *See, e.g.*, People v. Stewart, No. M 508197 (San Diego Mun. Ct. 1987); GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 978 (1990) (describing the case of Pamela Rae Stewart, who was charged under California law with the "willful omission of 'necessary clothing, food, shelter or medical attendance'" from her fetus) (citations omitted). The state alleged that Ms. Stewart disregarded her doctor's advice by failing to maintain bedrest, participating in sexual intercourse, continuing to actively care for her other two children and not reporting to the hospital quickly enough after she experienced vaginal bleeding. These actions were alleged to have resulted in the death of her baby. *Id.*

[5] *See, e.g.*, Grodin v. Grodin, 301 N.W.2d 869, 871 (Mich. Ct. App. 1981) (recognizing a claim by a child against his mother for taking tetracycline during her pregnancy, allegedly causing the discoloration of the child's teeth). *But see* Stallman v. Youngquist, 531 N.E.2d 355, 356 (Ill. 1988) (refusing to allow a fetus to bring a legal action against its mother for negligent actions during pregnancy). *See generally* Dawn E. Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599, 605–07 (1986) (discussing the frightening consequences of the potential extension of tort liability to mothers for actions or inactions during pregnancy).

ing roles.[6] However, new avenues for potential control over women's bodies arise continually, and the AIDS crisis and its increasing impact on women have created a renewed fear.

Women are rapidly becoming the fastest growing population of people with HIV.[7] Inevitably, the number of infants with the disease is increasing as well.[8] These statistics and the intensity of society's negative perceptions of AIDS might provide adequate incentive for states to make women infected with HIV/AIDS their next "victims" of procreative control. No state has yet forbidden women with HIV/AIDS from bearing children or prosecuted them for doing so. This prospect does not seem unlikely, however, considering the history of state attempts to control reproduction by persons considered unfit or unable to make "appropriate" parenting decisions themselves.[9]

This is not a paranoid concern. Women have been screened for diseases such as syphilis, Tay-Sachs disease, and sickle-cell anemia before bearing a child.[10] Currently, several states have implemented pre-

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[6] For a comprehensive discussion of the treatment of women as birthing vessels, see GENA COREA, THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL WOMBS (1985).

[7] *See* Nan D. Hunter, *Complications of Gender: Women and HIV Disease, in* AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS 5, 5 (Nan D. Hunter & William B. Rubenstein eds., 1992) [hereinafter AIDS AGENDA] (citing estimates that HIV is currently spreading at a quicker rate among women than men, and that by 1994, each year more women than gay men will be diagnosed with AIDS) (citations omitted); *see also* CENTERS FOR DISEASE CONTROL, HIV/AIDS PREVENTION: FACTS ABOUT WOMEN AND HIV/AIDS (1993) (stating that in the United States, AIDS cases among women increased 17%, while cases among men increased 4% between 1990 and 1991).

[8] *See* Taunya L. Banks, *Women and AIDS—Racism, Sexism, and Classism*, 17 N.Y.U. REV. L. & SOC. CHANGE 351, 353 (1989–90) (citing estimates that about 80% of women with AIDS are of childbearing age, and that approximately 75% of pediatric AIDS cases occur as a result of perinatal exposure to HIV) (citations omitted).

[9] Several legal and medical commentators have discussed the potentially imminent threat to the right of women with HIV to bear children. *See, e.g.*, Hunter, *supra* note 7, at 16–30 (discussing the possible means by which states could control childbearing by women with HIV/AIDS); Scott H. Isaacman, *Are We Outlawing Motherhood for HIV-Infected Women?*, 22 LOY. U. CHI. L.J. 479 (1991) (arguing that Illinois' criminal HIV transmission statute could be used to prosecute women for perinatal transmission); Michael L. Closen & Scott H. Isaacman, *Criminally Pregnant: Are AIDS-Transmission Laws Encouraging Abortion?*, 76 A.B.A. J. 76 (December 1990) (questioning whether state criminal HIV transmission statutes encourage abortions by HIV-infected women, and whether this deterrent to childbearing violates these women's constitutional rights).

[10] *See* Katherine L. Acuff & Ruth F. Faden, *A History of Prenatal and Newborn Screening Programs: Lessons for the Future, in* AIDS, WOMEN AND THE NEXT GENERATION: TOWARDS A MUTUALLY ACCEPTABLE PUBLIC POLICY FOR HIV TESTING OF PREGNANT WOMEN AND NEWBORNS 59, 59–93 (Ruth R. Faden et al. eds., 1991) [hereinafter NEXT GENERATION] (describing numerous state screening programs implemented during the last century); *see also infra* notes 134–62 and accompanying text.

natal screening programs for HIV.[11] If states are prosecuting pregnant women for fetus abuse or the "delivery" of drugs to their infants,[12] might they not also prosecute women for exposing their fetuses or newborns to the AIDS virus, which could also result in serious problems for the infant?[13] If states are prosecuting people with HIV for reckless endangerment, attempted murder, or transmission of HIV to another individual,[14] who can say that states will not institute such prosecutions against women who expose a fetus or newborn to HIV?

As mentioned above, no provisions *explicitly* preventing women with HIV/AIDS from bearing children have yet been enacted. There are many ways, however, by which society might eventually attempt to legally prevent women with HIV from procreating.

Part II of this Article discusses women's lack of control over their bodies and their procreative ability. It first addresses society's control over women's reproduction from a preventative perspective, with a focus on compelled sterilizations to preclude childbearing ability altogether. It then discusses the current trend in the law toward after-the-fact punishment, intended to deter particular women from deciding to bear children. Finally, it addresses two aspects of a potential, but unwelcome, future: first, the extension of child abuse/neglect statutes to prosecute women with HIV/AIDS for becoming pregnant; and second, the possible application of criminal HIV transmission statutes to prosecute the perinatal exposure or transfer of HIV.[15]

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[11] *See* Banks, *supra* note 8, at 358 (reporting that Delaware and Tennessee require prenatal HIV tests, and that several other states employ testing under particular circumstances) (citations omitted).

[12] *See infra* notes 41–53 and accompanying text.

[13] Of babies born infected with HIV, approximately 75% will exhibit symptoms by the time they are two years old. Nancy E. Kass, *Reproductive Decision Making in the Context of HIV: The Case for Nondirective Counseling, in* NEXT GENERATION, *supra* note 10, at 308, 310. These symptoms may include growth failure, various bacterial infections, neurologic abnormalities, certain pneumonias, and organ abnormalities. John Modlin & Alfred Saah, *Public Health and Clinical Aspects of HIV Infection and Disease in Women and Children in the United States, in* NEXT GENERATION, *supra* note 10, at 29, 43–47.

Fetuses and children exposed to drugs such as cocaine or heroin *in utero* may be spontaneously aborted, or may exhibit addiction, strokes, low birth weight, small size, low IQ scores, moodiness, urological malformations, less mother-child bonding, brain lesions, and learning disabilities. Julia Elizabeth Jones, Comment, *State Intervention in Pregnancy*, 52 LA. L. REV. 1159, 1161–62 (1992); *see also In re* Dustin T., 614 A.2d 999, 1002 (Md. 1992).

On the other hand, whereas approximately 350,000 to 739,000 infants are exposed to at least one illegal drug *in utero* each year, Jones, *supra*, at 1160–61, as of December 1991, there had been a total of 3471 cases of AIDS reported in children under 13 years old. CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE: YEAR-END EDITION (1992).

[14] *See infra* notes 55–79 and accompanying text.

[15] This Article will discuss the exposure to and transmission of HIV from a woman to her

Part III of this Article explains why women should not and must not be screened, prosecuted, or punished for perinatal HIV exposure under any of the above-mentioned statutes. It explains the ways in which these statutes violate women's constitutional rights of liberty and privacy, and work against practical public policy. Part III concludes by offering more appropriate and less restrictive means for accomplishing the governmental goals espoused.

II. Women's Historical Lack of Control Over Their Procreation

Conception takes place in the woman's body. Any potential life develops within the woman's body. It is the woman's body that determines when that potential life will enter the world. Yet, society has historically devised and implemented means to deprive a woman of control over her reproductive operations, and our laws and customs continue to do this. The following subparts discuss medical and legal practices used to punish or restrict individuals considered to be unfit or undesirable parents. Also specifically addressed are child abuse and neglect statutes and HIV transmission and exposure statutes, and how they might be applied to women of childbearing age with HIV/AIDS.

A. *The Goal of Preventing "Imperfect" Offspring*

> *Given the present power structure, the real question is: Should the machine (the woman) be the one to decide whether, or how often, or with what materials, it goes into production? Obviously not.*[16]

Women have long been viewed and treated as breeding machines—vessels or containers for a fetus which then goes on to become a baby, and with any luck a quality product.[17] Numerous statesmen, geneticists, biologists, and others have contended that women should not have an automatic right to have a child; rather, consideration should be given to the mother's genetic makeup and social desirability.[18] Some have even questioned whether women are the best vessels

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fetus. The expressions "perinatal," "vertical," and "*in utero*" transmission or exposure will be used to describe the circumstances surrounding the movement of HIV between mother and infant during pregnancy or childbirth.

[16] Corea, *supra* note 6, at 27.

[17] *See id.* at 17, 28, 250, 299 (discussing the treatment of women's parenting role as a procedure directed by men, by which women's bodies are used to contain and deliver the fetus for the purpose of creating desirable human beings).

[18] *See id.* at 19, 25, 28–29 (quoting many eugenicists, including reform school administrator

for better babies, or whether glass containers might provide a safer haven.[19]

United States law has sometimes reflected and sometimes rejected these positions in its evolving stance on forced sterilizations.[20] In the first half of this century, it is estimated that as many as 45,000 Americans were legally compelled to be sterilized.[21] These sterilizations were performed primarily on the poor, the mentally ill, the disabled, and on criminals.[22] They had the greatest impact on people of color.[23]

In order to serve the above-mentioned goals of reproductive "quality," the medical industry has attempted to exert control by performing operations resulting in reduced sexuality and sexual drive or full sterilization, often without the informed consent of the patient. Doctors have removed women's ovaries, breasts, and clitorides in the name of

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Moya Woodside; optometrist and author Robert K. Graham; Nobel prize winner Dr. William Shockley; one of the discoverers of DNA's structure, Francis Crick; and biochemist Norman W. Pirie). To facilitate this "appropriate mother" selection process, various means have been hypothesized, including parent licensing schemes, taxing strategies and mandatory temporary sterilizations to be reversed only upon government approval. *Id.* at 28–29.

The basic aims of these theories reflect many of the same ideals of German Nazism: to improve the human race and produce "better" human beings through reproductive control, which often means weeding out those "inferior" by race, class, and physical and mental condition. *Id.* at 17.

[19] COREA, *supra* note 6, at 250–53.

> Fetuses may someday be safer in an artificial womb than in a woman's body, which does not sufficiently protect them from teratogens—agents that could cause defects. . . . Labor is dangerous for babies. Some contractions of the womb can be too hard and long and can actually "batter" the baby. Some argue that the artificial womb would eliminate birth trauma.

Id. (citations omitted).

[20] *See, e.g.*, Buck v. Bell, 274 U.S. 200, 207 (1927) (holding that a statute authorizing the sterilization of "mental defectives" was permissible, because "[t]hree generations of imbeciles are enough"); Estate of C.W., No. 2970, 1993 Pa. Super. LEXIS 857, at *10–11 (Sup. Ct. Pa. Mar. 17, 1993), *vacated and petition for reargument granted. But see* Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) (holding that a statute authorizing the sterilization of certain criminals violates Equal Protection Clause, and that such legislation triggers strict scrutiny because it involves the fundamental right of procreation. The majority in *Skinner* stated that "[t]he power to sterilize, if exercised, may have subtle, far-reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear." *Id.*; *see also Estate of C.W.*, 1993 Pa. Super. LEXIS at *8–12 (stating that the United States has a "long history of eugenic sterilization of the mentally retarded," and holding that mentally disabled people have a fundamental right to privacy and procreation requiring that any contraceptive measures sought be the least restrictive possible).

[21] In the 1920s, most states permitted forced sterilization "to control population among 'socially unfit' people." Editorial, *Don't Use Norplant Against Welfare Mothers*, USA TODAY, February 16, 1993, at 10A; Barbara Kantrowitz & Pat Wingert, *The Norplant Debate*, NEWSWEEK, February 15, 1993, at 36 (citing Dr. Allan Rosenfield, Dean of Columbia University School of Public Health).

[22] Editorial, *supra* note 21; Kantrowitz & Wingert, *supra* note 21.

[23] Editorial, *supra* note 21; Kantrowitz & Wingert, *supra* note 21.

healing certain neuroses, cancers,[24] nymphomania, "troublesomeness, menstrual cramps, attempted suicide, cussedness and erotic tendencies."[25]

Sterilization is performed most often on women of color, particularly those who are poor.[26] Many women are not asked for consent at all, or are pressured by their doctors to consent to these operations. Between 1971 and 1974, Mexican-American women in Los Angeles sued a public hospital, alleging that their doctors had compelled their consent to sterilization while they were in active labor, by "(1) withholding medication, (2) not informing women that the procedure was permanent, or (3) pressuring some husbands to sign consent forms after their wives refused."[27]

As a more recent demonstration of coerced sterilization, several years ago a Latina woman with AIDS was offered a free abortion (which she wanted but could not afford), but only on the condition that she consent to a tubal ligation.[28] In addition, the arrival and availability of Norplant[29] have created similar sterilization issues. There have been numerous accounts of women being compelled to have Norplant inserted as a condition of plea bargains or probation.[30] Furthermore, in

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[24] Potential cancers are often cited as a reason for hysterectomies (removal of the uterus), oophorectomies (removal of the ovary) and mastectomies (removal of the breast). Yet statistics indicate that the risk of death is higher for hysterectomy operations than it is for uterine cancer. COREA, *supra* note 6, at 308 n.8 (citation omitted). Furthermore, some doctors have asserted that "if prophylactic hysterectomies were performed on one million women, the average gain in life expectancy would be about two months, 'or about the time it takes to go through the operation and convalescence.'" *Id.* (citations omitted).

[25] *Id.* at 307–10 (citations omitted).

[26] *See* Banks, *supra* note 8, at 362 (stating that 43% of federally funded sterilizations are conducted on African-American women). Banks also reports that in 1981, a study found that 65% of Puerto Rican women in Hartford, Connecticut and 55% percent of Latina women in Springfield, Massachusetts had been sterilized. *Id.* at 362 (citations omitted).

[27] *Id.* at 362–63 (citing Carlos G. Velez-Ibanez, *The Nonconsenting Sterilization of Mexican Women in Los Angeles, in* TWICE A MINORITY: MEXICAN-AMERICAN WOMEN 235, 240, 242 (Margarita B. Melville ed., 1980)). The federal court judge found in favor of the defendant hospital and physicians, holding that the language barriers between the doctors and the women led the doctors to believe the women were consenting. *Id.* (citing Madrigal v. Quilligan, No. CV 75–2057 JWC, slip op. at 6 (C.D. Cal. June 30, 1978)).

[28] Banks, *supra* note 8, at 363 (citing Abraham, *Pregnant Women Face AIDS Dilemma*, AM. MED. NEWS, July 22, 1988, at 35).

[29] Norplant is a contraceptive designed to prevent pregnancy for up to five years. It is made of a synthetic hormone which is implanted into the woman's arm, allowing small amounts of the hormone to be released slowly. Kantrowitz & Wingert, *supra* note 21. Norplant was approved by the FDA in 1990. *Id.*

[30] *See, e.g., ACLU Challenges Norplant Order*, UPI, March 8, 1993, *available in* LEXIS, Nexis Library, UPI File (reporting that a county judge in McLean, Illinois, sentenced 22-year-old Lisa Smith to have five-year Norplant implanted as part of a plea bargain resulting from her admitted abuse of her son); *Birth Control Implant Order is Appealed*, L.A. TIMES, February 2, 1991, at B18

the last two years, thirteen states have proposed Norplant-related legislation.[31]

The law is not acting alone in its move to coerce the use of Norplant; the medical and pharmaceutical industries are acting with much of the same compulsion toward reproductive control. It is sometimes not divulged to potential recipients that Norplant removal, as well as insertion, will result in some financial expense to them.[32] Many women have complained that they were urged to try Norplant despite their reservations, that they were not fully informed about potential side effects, and that their doctors discouraged them or refused to perform the procedure for removal of the implant when requested.[33]

As is usually the case with compelled sterilization, the impact of coerced Norplant insertion has been overwhelmingly felt by women of color, and has raised questions of racial eugenics and social control. For example, numerous complaints have been made by Native American women asserting that clinicians have coerced them to have Norplant inserted, or to keep it in once it was already implanted.[34] Many Hispanic women have felt the same pressures and have reported that some health clinics distribute Norplant pamphlets in Spanish only, with none in English.[35] Numerous African Americans have analogized the

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(noting that a superior court judge in Tulare, California included Norplant implantation as a condition of probation for 27-year-old Darlene Johnson, a convicted child abuser).

Other courts have ordered women to refrain from becoming pregnant as a condition of probation, although they have often been overruled on appeal. *See, e.g.*, Kansas v. Mosburg, 768 P.2d 313, 315 (Kan. 1989) (prohibiting the sentencing judge's use of this probation requirement because the condition "unduly intrude[d]" on the defendant's constitutional right to privacy) (citing People v. Pointer, 199 Cal. Rptr. 357, 364 (Cal. Ct. App. 1984); Rodriguez v. State, 378 So. 2d 7, 10 (Fla. Dist. Ct. App. 1979); State v. Livingston, 372 N.E.2d 1335, 1337 (Ohio Ct. App. 1976)).

[31] Kantrowitz & Wingert, *supra* note 21 (citing information compiled by the Alan Guttmacher Institute). Several of these legislative efforts have included requiring or providing financial encouragement to women on governmental support to be implanted with Norplant. *Id.* (describing bills proposed in Tennessee and Mississippi as examples).

[32] Norplant costs about $365, plus approximately $200 to have it inserted. Kantrowitz & Wingert, *supra* note 21. It costs at least $100 to $150 to have the implant removed. *Id.*; Sally Jacobs, *Norplant Draws Concerns Over Risks, Coercion*, BOSTON GLOBE, Dec. 21, 1992, at 1. Although Medicaid does cover costs for Norplant insertion, it will not pay for its removal, even if the woman experiences negative side effects. Darrell Dawsey, *Norplant Just a Way to Control*, DETROIT NEWS, GANNETT NEWS SERVICE, Apr. 5, 1993.

[33] *See, e.g.*, Jacobs, *supra* note 32 (reporting disturbing stories of women's experiences with Norplant).

[34] Jacobs, *supra* note 32 (citing information given by Charon Asetoyer, Director of the Native American Women's Health Education Resource Center in South Dakota).

[35] *Id.* (citing statements made by Luz Alvarez Martinez, Director of the National Latina Health Organization in Oakland, California).

effects of compelled Norplant insertion (via public assistance, inner-city clinics, and schools) to attempted genocide.[36]

B. *After-the-Fact Punishment: Application of Child Abuse and HIV Transmission Statutes to Perinatal Transfer of HIV*

There are two recent movements in the law which threaten to add yet another avenue for constraining the childbearing autonomy of women, particularly women with HIV/AIDS. This subpart first discusses the trend of applying child abuse and neglect statutes to pregnant women and their fetuses. Although no state has yet prosecuted a woman for child abuse or neglect for perinatally exposing a child to HIV, states have employed these abuse and neglect statutes to prosecute women who use illicit drugs during pregnancy. Because of the similar perceptions of blame and disgust attached to drug dependency and AIDS, numerous medical and legal workers fear that these abuse and neglect statutes will be extended to cover the transmission of HIV from mother to child.

The second section of this subpart will address the numerous criminal HIV transmission statutes enacted by states in the last decade. Although no states have yet applied these statutes to pregnant women and their fetuses, many of the statutes are broadly drawn, leaving room for the possibility of prosecution and punishment of women for the perinatal transfer of HIV.

1. Prosecution for Child Abuse, Neglect, or Delivery of Drugs

The war on drugs has injured many more than it has helped, and most of the wounded have been poor women of color. One of the harshest battles has been fought on the procreation front, where drug-using women have been branded unfit to mother. Rather than working to help these women conquer their addiction, giving them education in parenting, or trying to instill hope and motivation to break cycles of addiction, society has deemed punishment to be the best response.[37]

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[36] Kantrowitz & Wingert, *supra* note 21 (quoting Melvin Tuggle, a black Baltimore minister: "One third of us are in jail and another third is killing us and now they're taking away the babies. . . . If the community, the churches and our white brothers don't stand up for us, there won't be any of us left."); Dawsey, *supra* note 32 ("Once again, it's on, black America. The United States is stepping up its war on poor people of color—in particular, low-income sisters. The latest bullet aimed at poor black women is Norplant . . . .").

[37] The United States General Accounting Office has determined that pregnant women with drug and alcohol problems encounter many barriers in trying to access basic health care services. CENTER FOR REPRODUCTIVE LAW & POLICY, PUNISHING WOMEN FOR THEIR BEHAVIOR DURING

Rather than increasing the resources and efforts available to expand substance abuse treatment and prevention, states have focused on prosecuting and penalizing these women under the rubric of fetal abuse and neglect, and "delivery" of controlled substances to their newborns.[38]

Many professionals in the medical, legal, and scientific fields believe that women who use illicit drugs, sexual partners of drug users, and others with the potential to bear or raise "defective" offspring, should not have an automatic right to bear children.[39] This conviction is generally grounded in blame constructs and disdainful beliefs, and it prevents these women from being viewed with compassion and support. The current trend of prosecuting drug-using women reflects these perceptions of blame and disgust, as many courts order children

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PREGNANCY: A PUBLIC HEALTH DISASTER 2 (1993) (citing UNITED SATES GENERAL ACCOUNTING OFFICE: REPORT TO THE CHAIRMAN, COMMITTEE ON FINANCE, U.S. SENATE, DRUG-EXPOSED INFANTS, A GENERATION AT RISK (1990)).

Women, and especially pregnant women, have also had difficulty accessing appropriate substance abuse programs where they have been able to access such programs at all. *See id.* at 2–3 (describing a study finding that approximately 54% of New York City substance abuse programs refuse to treat pregnant women, 67% did not accept pregnant women on Medicaid, and 87% refused to treat crack-addicted pregnant women) (citing Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUB. HEALTH 483, 483–87 (1990)); OFFICE OF NATIONAL DRUG CONTROL POLICY, BREAKING THE CYCLE OF DRUG ABUSE: 1993 INTERIM NATIONAL DRUG CONTROL STRATEGY 8 (1993) (only 10% of pregnant woman in need of substance abuse treatment actually receive such treatment).

[38] *See, e.g., In re* Dustin T., 614 A.2d 999, 1001 (Md. Ct. Spec. App. 1992), *cert. denied*, 620 A.2d 350 (Md. 1993) (affirming finding of child abuse because of mother's drug use before and during pregnancy); *In re* Valerie D., 613 A.2d 748, 758–69 (Conn. 1992) (reversing judgment of neglect based on prenatal cocaine use); Johnson v. State, 602 So. 2d 1288, 1296 (Fla. 1992) (reversing conviction for drug delivery to a minor of a mother who took cocaine shortly before childbirth); State v. Gray, 584 N.E.2d 710, 713 (Ohio 1992) (dismissing child endangerment charges against woman addicted to cocaine during pregnancy); Welch v. Commonwealth, No. 90-CA-1189-MR (Ky. Ct. App. Feb. 7, 1992) (reversing child abuse conviction of woman who allegedly used drugs during pregnancy), *aff'd* 1993 Ky. LEXIS 128 (Sept. 30, 1993); People v. Hardy, 469 N.W.2d 50, 53 (Mich. Ct. App. 1991) (drug delivery statute does not apply to woman using drugs during pregnancy), *appeal denied*, 437 Mich. 1046 (1991), *amended*, 471 N.W.2d 619; *In re* Troy D., 263 Cal. Rptr. 869, 872 (Cal. Ct. App. 1989) (finding neglect for the prenatal drug use of the mother); State v. Bremer, No. 90–32227-FH (Mich. Cir. Ct. Jan. 31, 1991) (dismissing drug delivery charges against mother for ingestion of cocaine during pregnancy); Department of Soc. Servs. v. Felicia B., 543 N.Y.S.2d 637, 638 (N.Y. Fam. Ct. 1989) (if child is born with a positive toxicology for illicit drugs, mother may be found guilty of neglect); *In re* Ruiz, 500 N.E.2d 935, 939 (1986) (holding that abuse may be based on prenatal conduct by the mother).

[39] Banks, *supra* note 8, at 361; *see also id.* at 372–73 (comparing beliefs of certain geneticists and others that women with the potential to give birth to "genetically defective" babies should not be granted reproductive autonomy); COREA, *supra* note 6, at 28–29 (discussing beliefs that social desirability and gene pools should be taken into account to determine a woman's right to bear children).

to be placed in the custody of foster parents rather than in the arms of their natural mothers.[40]

In the cases utilizing child abuse and neglect statutes to prosecute drug-using women, courts have often focused on the past, giving little in the way of second chances.[41] Even when mothers have tried to recover from drug addiction and resume care for their children, courts have denied custody based on past conduct.[42] Indeed, at least one court has held that so long as the mother has at some point "merely *placed* [the child] *at risk* of significant harm," the court may find neglect or abuse.[43] If this standard is upheld, a court could decide that a woman with HIV/AIDS places a child "at risk of significant harm" simply by becoming pregnant, considering that an estimated 7 to 40% of infants born to HIV-infected women develop their own seropositivity.[44] Further, in light of the courts' emphases on the past, if a woman with HIV/AIDS has ever used drugs or participated in other "disapproved" behaviors, the likelihood of her prosecution may be even greater.

In making judgments to take children away from women who use illicit drugs, states have also employed statutes proscribing the delivery of drugs to minors. *Johnson v. State*,[45] is probably the best known opinion on this matter. *Johnson* held that Florida's statute criminalizing "deliver[y of] any controlled substance to a person under the age of 18 years"[46] applied to the transmission of cocaine from a mother to her

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[40] *See, e.g., Dustin T.*, 614 A.2d at 1001 (denying appeal by a former drug-using mother to regain custody of her child); *In re* Stephen W., 271 Cal. Rptr. 319, 320 (Cal. Ct. App. 1990) (placing child in foster care because of its positive test for drugs at birth); *Troy D.*, 263 Cal. Rptr. at 874 (holding that an infant should be in foster care because mother's drug use was indicative of probability of future neglect); *Ruiz*, 500 N.E.2d at 938 (allowing the state to take custody of a child judged to have been neglected *in utero*).

[41] *See, e.g., Dustin T.*, 614 A.2d at 1003 ("[W]e believe that the [Montgomery County Department of Social Services] has a right—and indeed a duty—to look at the track record, the past, of [the mother] in order to predict what her future treatment of the child may be").

[42] *See, e.g., id.* at 1003–04 (affirming placement of a child in foster care, even though the mother had not taken drugs for a month and was desperately trying to remain drug-free); *see also In re* William B., 533 A.2d 16, 19 (Md. Ct. Spec. App. 1987) (parent's treatment of one child may be used to evaluate how another child will be treated), *cert. denied*, 537 A.2d 272 (Md. 1988).

[43] *Dustin T.*, 614 A.2d at 1003.

[44] *See* J.C. Melchor et al., *Vertical Transmission of HIV*, 5 J. AIDS 529, 534 (1992) (reporting research finding approximately 13% are infected, and suggesting that because many infants are born seropositive but later seroconvert, an eighteen-month waiting period be followed before children are determined to be HIV infected); Modlin & Saah, *supra* note 13, at 41 n.56 (citing statistics of 7 to 33%); C.G. Prober & A.A. Gershon, *Medical Management of Newborns and Infants Born to Human Immunodeficiency Virus-Seropositive Mothers*, 10 J. PEDIATRIC INFECTIOUS DISEASE 684 (1991) (quoting the transmission figure as 15 to 30%); M.L. Stuber, *Children, Adolescents, and AIDS*, 9 PSYCHIATRIC MED. 441 (1991) (estimating 25 to 40%).

[45] 578 So. 2d 419, 420 (Fla. Dist. Ct. App. 1991), *rev'd*, 602 So. 2d 1288 (Fla. 1992).

[46] FLA. STAT. ANN. § 893.13(1)(c) (West 1989).

newborn after birth and before the cutting of the umbilical cord.[47] The court focused on its interpretation of the statutory language to the exclusion of legislative intent.[48] The majority stated that logic compelled them to find that the statute clearly applied to the defendant's situation:

> Appellant voluntarily took cocaine into her body, knowing it would pass to her fetus and knowing (or should have known) [sic] that birth was imminent. She is deemed to know that an infant at birth is a person, and a minor, and that delivery of cocaine to the infant is illegal. We can reach no other conclusion logically.[49]

This interpretation was chosen even though the legislature had discussed previously whether it wished to criminalize the perinatal transmission of illegal drugs, and had explicitly decided not to do so.[50]

More enlightened courts have recently overturned convictions of drug-using women because of a lack of legislative intent to apply such statutes in these circumstances or evidence of contrary intent.[51] These cases have held that child abuse or neglect statutes, and statutes prohibiting drug delivery to a minor, were not intended to cover the transmission of drugs from a mother to her fetus or newborn. Courts should also take this approach to legislative omissions should cases arise that invite the application of these statutes to perinatal HIV transmission.

As states all over the country have instigated these prosecutions, however, some commentators have expressed apprehension about the potential scope of the reasoning used. There is concern that states will decide explicitly that drug users and other women are unfit parents, and will look for ways to deny the right of these women to bear

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[47] *Johnson*, 578 So. 2d at 419.

[48] *Id.*

[49] *Id.* at 420.

[50] *Id.* at 423–24 (Sharp, J., dissenting).

[51] *See, e.g.*, Johnson v. State, 602 So. 2d 1288, 1297 (Fla. 1992) (drug delivery statute not intended to apply to time between a child's birth and cutting of umbilical cord, or to *in utero* transmission), *rev'g* 578 So. 2d 419 (Fla. Dist. Ct. App. 1991); State v. Gray, 584 N.E.2d 710, 713 (Ohio 1992) (child endangerment statute does not apply before the child was born); Welch v. Commonwealth, No. 90-CA-1189-MR (Ky. Ct. App. Feb. 7, 1992) (criminal abuse statute does not cover drug use during pregnancy); State v. Gethers, 585 So. 2d 1140, 1142 (Fla. Dist. Ct. App. 1991) (child abuse statute does not apply to fetuses); People v. Morabito, 580 N.Y.S.2d 843, 847 (N.Y. City Ct. 1992) (welfare endangerment statute does not apply to unborn child).

children.[52] The prosecution of these women for fetal abuse or neglect would essentially preclude them from being able to procreate. Because of the threat that any children born would be removed,[53] women would be forced to refrain from childbearing.

The trend of punishing society-designated unfitness could be extended to women with HIV/AIDS, especially in light of society's unsympathetic perception of AIDS. AIDS is viewed as a disease involving fault, guilt, and irresponsibility. A substantial portion of the public regards HIV infection as a stigma—a mark of disgrace and shame.[54] Because of this societal prejudice, and because AIDS is perceived as a "death sentence," most people would not be sympathetic to the desires of women with HIV/AIDS to have children. As will be discussed below, however, the right to have children is a fundamental right, and it cannot be denied merely because of societal disapproval.

2. Prosecution for HIV Transmission or Exposure

States have generally prosecuted individuals for HIV transmission or exposure in two ways: they have tried to fit such actions under traditional criminal statutes, and they have created statutes specifically for that purpose.

a. *Use of traditional criminal statutes*

Soon after the appearance of AIDS, states began to employ already-existing criminal statutes to prosecute individuals for criminal exposure to or transmission of HIV.[55] Individuals have been prosecuted for numerous criminal offenses, including reckless endangerment,

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[52] Presumably, states could amend their child abuse and neglect statutes to express their intentions of reaching fetal abuse via illegal drugs or HIV transmission. Such statutes, however, would be unconstitutional violations of women's rights of liberty and privacy. *See supra* notes 109–208 and accompanying text.

[53] Many child abuse and neglect statutes provide for temporary or permanent removal of such children from the custody of parents committing the alleged abuse or neglect. *See infra* note 127; *see also* Jones, *supra* note 13, at 1164; Note, *Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325, 1330 (1990).

[54] *See, e.g.*, Charles E. Rosenberg, *Disease and Social Order in America: Perceptions and Expectations, in* AIDS: THE BURDENS OF HISTORY 12, 28 (Elizabeth Fee et al. eds., 1988) ("The social response to AIDS . . . reminds us that we live in a fragmented society. To a substantial minority of Americans . . . [AIDS is] a deserved punishment for the sexual transgressor; the unchecked growth of deviance was a symptom of a more fundamental social disorder."); Allen M. Brandt, *AIDS: From Social History to Social Policy, in* AIDS: THE BURDENS OF HISTORY, *supra*, at 147, 155 (1988) ("Some have seen the AIDS epidemic in a purely 'moral' light: AIDS is a disease that occurs among those who violate the moral order.").

[55] *See* Michael I. Leonard, *Combatting AIDS's Acoustic Shadow: Illinois Addresses the Problems of Criminal Transfer of HIV*, 22 LOYOLA U. CHI. L.J. 497, 500 (1991) (discussing the traditional approaches to criminalizing HIV transfer).

assault, battery, murder, manslaughter, and attempts to carry out these crimes.[56]

These criminal frameworks have not been easily applied to HIV transfer because of the peculiar nature of HIV-related prosecutions.[57] The HIV-related prosecutions are unique because without the disease, the actions at issue could never satisfy the elements of the statutory crimes. As a result, prosecutors have sometimes had difficulty obtaining convictions because of the inability to prove mens rea, or criminal intent, as required by many of these criminal statutes.[58]

This proof difficulty might be especially amplified in the context of a woman giving birth. Many HIV-infected individuals prosecuted under traditional criminal statutes are in situations where criminal intent or the desire to hurt their victims may be readily inferred.[59] It would be unlikely and difficult to prove, however, that a woman would elect to carry a baby for nine months and deliver it for reasons of harmful intent. Studies have been conducted on women's decisions to have children despite their seropositivity, and neither animosity nor the motive either to inflict harm or communicate the disease has been reported.[60]

Individuals must also have some degree of knowledge of their HIV infection, or at least of the substantial likelihood of infection, before they could be accused of intent to cause harm by means of transfer to

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[56] *See, e.g.*, United States v. Moore, 846 F.2d 1163, 1167–68 (8th Cir. 1988) (affirming conviction of HIV-infected defendant for assault with deadly and dangerous weapon for biting two officers); State v. Smith, 621 A.2d 493, 502 (N.J. Super. Ct. App. Div. 1993) (affirming HIV-infected defendant's conviction for attempted murder and aggravated assault for biting an officer); Scroggins v. State, 401 S.E.2d 13, 18–19 (Ga. Ct. App. 1990) (affirming conviction for aggravated assault with intent to murder of defendant who bit a police officer); Brock v. State, 555 So. 2d 285, 288 (Ala. Crim. App. 1989) (overturning first-degree assault conviction of defendant who bit prison officer); State v. Sherouse, 536 So. 2d 1194, 1195 (Fla. Dist. Ct. App. 1989) (dismissing attempted manslaughter charge against prostitute for offering to have sex with men despite her knowledge that she was HIV infected). *See generally* Mark H. Jackson, *The Criminalization of HIV, in* AIDS AGENDA, *supra* note 7, at 239.

[57] Leonard, *supra* note 55, at 500.

[58] For example, in at least one case, it was observed that a HIV-infected woman's offer of prostitution was not adequate to prove specific intent to kill. *Sherouse*, 536 So. 2d at 1194 (Cobb, J., concurring).

[59] *See, e.g.*, State v. Haines, 545 N.E.2d 834, 835 (Ind. Ct. App. 1989) (defendant screamed he had AIDS and would kill anyone who tried to prevent him from committing suicide).

[60] *See* R.T. Henrion et al., *HIV-Infected Women's Decision to Continue or Terminate Pregnancy*, 20 PRESSE MED 896–98 (May 18, 1991) ("Motivations for continuing pregnancy included a visceral desire to have a child, a means of transcending one's mortality, a gift to the partner, a means of rehabilitation, a denial of the pathologic state or the conviction that the infant will be unaffected."); Peter A. Selwyn et al., *Knowledge of HIV Antibody Status and Decisions to Continue or Terminate Pregnancy Among Intravenous Drug Users*, 261 JAMA 3567, 3567 (June 23–30, 1989) ("Women who were HIV positive and chose to continue their pregnancies cited the desire for a child, religious beliefs, and family pressure as the most important factors in their decisions.").

another.[61] Further, there is some indication that a woman would need to have knowledge that HIV could be transmitted perinatally to her baby before she could be convicted of the action under traditional criminal statutes.[62]

b. *The creation of HIV transfer statutes*

In the last five to ten years, states have attempted to circumvent these problems with traditional criminal statutes by enacting specific HIV transfer statutes. By creating a new, particularized crime, states have made obtaining convictions easier. Currently, approximately twenty-five states have at least some form of an HIV transmission or exposure statute.[63] This Article will focus on eleven state statutes, which either specifically address perinatal transmission[64] or are most likely to evoke concern about their potential applicability to perinatal transmission.[65]

The majority of these criminal HIV transfer statutes include one or more of the following elements in various combinations:

1. Some knowledge of HIV status;[66]
2. An intent to infect;[67]

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[61] *See, e.g.*, State v. Smith, 621 A.2d 493, 502 (N.J. Super. Ct. App. Div. 1993) (defendant's conviction for attempted murder reasonable in light of proof that defendant knew he was HIV infected and subjectively believed his bite could kill someone); State v. Scroggins, 401 S.E.2d 13, 18–19 (Ga. Ct. App. 1990) (jury could infer malicious intent from defendant's knowledge that he was HIV infected and deliberately bit police officer).

[62] *See, e.g.*, Brock v. State, 555 So. 2d 285, 288 (overturning attempted murder conviction for lack of evidence that defendant knew human bite could transmit HIV).

[63] These states include: Alabama, Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nevada, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and Washington. AIDS POLICY CENTER, INTERGOVERNMENTAL HEALTH POLICY PROJECT, THE GEORGE WASHINGTON UNIVERSITY, *Criminal Penalties for Knowingly Transmitting/Exposing Another to HIV Infection* (Oct. 1992).

[64] OKLA. STAT. tit. 21, § 1192.1 (1991); TEX. PENAL CODE ANN. § 22.012 (West 1993).

[65] ARK. CODE ANN. § 5–14–123 (Michie 1992); DEL. CODE ANN. tit. 16, § 1201 (1992); GA. CODE ANN. § 16–5–60 (Michie 1992); IDAHO CODE § 39–608 (1992); ILL. REV. STAT. ch. 38, para. 12–16.2 (1991); IND. CODE ANN. § 35–42–1–7 (Burns 1991); MD. HEALTH-GEN. CODE ANN. § 18–601.1 (1992); MO. REV. STAT. § 191.677 (1991); S.C. CODE ANN. § 44–29–60 (Law. Co-op. 1991); *see also* 42 U.S.C. § 300ff-47 (1992).

[66] In other words, the accused must have some degree of awareness that she is infected with HIV/AIDS. ARK. CODE ANN. § 5–14–123(b); GA. CODE ANN. § 16–5–60(c); IDAHO CODE § 39–608(1) (1992); ILL. REV. STAT. ch. 38, para. 12–16.2; IND. CODE ANN. § 35–42–1–7(b); MD. HEALTH-GEN. CODE ANN. § 18–601.1(a); MO. REV. STAT. § 191.677(1); OKLA. STAT. tit. 21, § 1192.1(A); S.C. CODE ANN. § 44–29–60; TEX. PENAL CODE ANN. § 22.012(a); *see also* 42 U.S.C. § 300ff-47(a)(1) (1992).

[67] IDAHO CODE § 39–608(1); IND. CODE ANN. § 35–42–1–7(b); OKLA. STAT. tit. 21,

3. Some description of particular conduct, such as "exposure,"[68] "intimate conduct,"[69] "conduct reasonably likely to result in transfer,"[70] "creat[ing] a grave and unjustifiable risk of infecting,"[71] "sexual conduct,"[72] "parenteral transfer,"[73] or a variation of delivering, transferring, donating, providing, or selling;[74]

4. Fluid or product that is being transferred or exposed;[75]

5. A recipient of the transfer or exposure;[76]

6. Exemptions and qualifications;[77] and

7. A criminal label and punishment.[78]

Only two of these statutes explicitly exempt *in utero* transmission from the offense.[79] None explicitly includes perinatal transfer. At least nine of the others could arguably be extended to reach a woman for transmitting HIV to her fetus. The next subparts discuss these arguments and explain why these prosecutions should not be undertaken.

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§ 1192.1(A); TEX. PENAL CODE ANN. § 22.012(a); WASH. REV. CODE § 9A.36.021(d), (e) (1991); *see also* 42 U.S.C. § 300ff-47(a)(1) (1992).

[68] ARK. CODE ANN. § 5-14-123(b); IDAHO CODE § 39-608(1); S.C. CODE ANN. § 44-29-60; WASH. REV. CODE § 9A.36.021(1)(e).

[69] ILL. REV. STAT. ch. 38, par. 12-16.2(a)(1), (b).

[70] OKLA. STAT. tit. 21, § 1192.1(A); TEX. PENAL CODE ANN. § 22.012(a); *see also* DEL. CODE ANN. tit. 16, § 1201 ("manner known to transmit HIV").

[71] MO. REV. STAT. § 191.677(1).

[72] ARK. CODE ANN. § 5-14-123(b); GA. CODE ANN. § 16-5-60(c)(1), (3), (4); MO. REV. STAT. § 191.677(1); *see also* 42 U.S.C. § 300ff-47(a)(2) (1992).

[73] ARK. CODE ANN. § 5-14-123(b); DEL. CODE ANN. tit. 16, § 1201(9).

[74] GA. CODE ANN. § 16-5-60(c)(5); IDAHO CODE § 39-608(1), (2)(b); ILL. REV. STAT. ch. 38, para. 12-16.2(a)(2); IND. CODE ANN. § 35-42-1-7(b); MD. HEALTH-GEN. CODE ANN. § 18-601.1(a); MO. REV. STAT. § 191.677(1); *see also* 42 U.S.C. § 300ff-47(a)(1) (1992).

[75] ARK. CODE ANN. § 5-14-123(b); DEL. CODE ANN. tit. 16, § 1201(9); GA. CODE ANN. § 16-5-60(c)(5); IDAHO CODE § 39-608(1), (2); ILL. REV. STAT. ch. 38, para. 12-16.2(a)(2); IND. CODE ANN. § 35-42-1-7(b); MO. REV. STAT. § 191.677(1); OKLA. STAT. tit. 21, § 1192.1(A); TEX. PENAL CODE ANN. § 22.012(a); *see also* 42 U.S.C. § 300ff-47(a)(1) (1992).

[76] ARK. CODE ANN. § 5-14-123(b); GA. CODE ANN. § 16-5-60(c); IDAHO CODE § 39-608(1), (2); ILL. REV. STAT. ch. 38, para. 12-16.2(a), (b); IND. CODE ANN. § 35-42-1-7(c); MD. HEALTH-GEN. CODE ANN. § 18-601.1(a); MO. REV. STAT. § 191.677(2); OKLA. STAT. tit. 21, § 1192.1(A); S.C. CODE ANN. § 44-29-60; TEX. PENAL CODE ANN. § 22.012(a); WASH. REV. CODE § 9A.36.021(1)(d), (e); *see also* 42 U.S.C. § 300ff-47(a) (1992).

[77] IDAHO CODE § 39-608(3); ILL. REV. STAT. ch. 38, para. 12-16.2(d); IND. CODE ANN. § 35-42-1-7(d); OKLA. STAT. tit. 21, § 1192.1(A); TEX. PENAL CODE ANN. § 22.012(a); *see also* 42 U.S.C. § 300ff-47(b) (1992).

[78] ARK. CODE ANN. § 5-14-123(d); GA. CODE ANN. § 16-5-60(c); IDAHO CODE § 39-608(1); ILL. REV. STAT. ch. 38, para. 12-16.2(e); IND. CODE ANN. § 35-42-1-7(b), (c); MD. HEALTH-GEN. CODE ANN. § 18-601.1(b); MO. REV. STAT. § 191.677(2); OKLA. STAT. tit. 21, § 1192.1(A); S.C. CODE ANN. § 44-29-60; TEX. PENAL CODE ANN. § 22.012(c); WASH. REV. CODE § 9A.36.021(2).

[79] OKLA. STAT. tit. 21, § 1192.1(A); TEX. PENAL CODE ANN. § 22.012(a).

3. The Application of HIV Transmission Statutes to Women of Childbearing Age

As described above, there are numerous elements that play a role in the determination of criminality under HIV transfer statutes. The interpretation given to these elements determines whether the statutes could apply to childbearing women. Assuming that a woman knows she is HIV infected, the most significant elements in determining whether the statutes could apply are (a) the defined criminal conduct, (b) the defined fluid or product being passed and the defined recipient of the fluid or product, and (c) possible statutory defenses, including explicit exemption of *in utero* transmission, and lack of harmful intent or knowledge of the means of HIV transmission.

a. *The defined conduct*

The language used to define criminalized transfer actions is pivotal in assessing the applicability of a statute to mother-fetus HIV transmission. In the above-mentioned statutes, the designated transfer actions most threatening to women's childbearing autonomy are "expos[ure],"[80] "intimate conduct,"[81] "conduct reasonably likely to result in transfer,"[82] and "creat[ing] a grave and unjustifiable risk of infecti[on]."[83]

"Expose" is defined as "to place in a position where the object spoken of is open to danger, or where it is near or accessible to anything which may affect it detrimentally; as, to 'expose' a child . . . or another to a contagious disease. . . ."[84] The mechanics and timing of perinatal HIV transmission are not well known.[85] Studies have indi-

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[80] IDAHO CODE § 39–608(1); S.C. CODE ANN. § 44–29–60; WASH. REV. CODE § 9A.36.021(e).

[81] ILL. REV. STAT. ch. 38, para. 12–16.2(a)(1).

For a comprehensive discussion of Illinois's criminal HIV transmission statute and its application to pregnant women, see Isaacman, *supra* note 9. Isaacman reports that evidently, none of the drafters of Illinois's statute solicited any input from health professionals. *Id.* at 485 n.43, 486 (citations omitted). Further, the legislative history does not indicate that there was any discussion of perinatal transmission at all. *Id.* at 485 n.43. This omission makes one wonder whether Illinois and other states unintentionally created HIV statutes which could be applied to pregnant women simply because they did not adequately perceive the repercussions of their statutory language.

[82] OKLA. STAT. tit. 21, § 1192.1(A); TEX. PENAL CODE ANN. § 22.012(a); *see also* DEL. CODE ANN. tit. 16, § 1201(9) ("manner known to transmit HIV").

[83] MO. REV. STAT. § 191.677(1).

[84] BLACK'S LAW DICTIONARY 579 (6th ed. 1990). The Washington Court of Appeals has, for example, interpreted a statute's use of the term "expose" to mean "engaging in conduct that can cause another person to become infected with the virus." State v. Stark, 832 P.2d 109, 116 (Wash. Ct. App. 1992).

[85] Modlin & Saah, *supra* note 13, at 40.

cated that the HIV transfer often occurs very late in pregnancy or during delivery.[86] Regardless of when the transmission occurs, however, under the definition cited above, an HIV-infected woman is likely to "expose" either her fetus or her infant (before the umbilical cord is cut) to HIV.[87]

The definition of "intimate conduct" poses a similar problem. Because that term has been defined as "the exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of HIV,"[88] a similar argument could be used to explain the statute's application to pregnant seropositive women.

It is also probable that perinatal exposure would be considered to constitute a "reasonable likelihood" of exposure, or to involve "knowledge" of transmitting HIV, given the estimated 7 to 40% chance that a seropositive woman will bear an infected child.[89] On the other hand, the application of the standard of "creat[ing] a grave and unjustifiable risk of infecting" to pregnant women depends on the determination of what risks are "grave and unjustifiable." Exposing a fetus to HIV arguably bestows a "grave" risk of illness and death that cannot be justified. Others have pointed out, however, that once a mother is pregnant, opting for abortion gives the fetus a 100% chance of death, whereas continuing pregnancy gives the fetus at least a 60% chance for healthy life.[90]

Use of the term "parenteral" transfer in HIV transmission statutes may also be a threat to HIV-infected women's ability to procreate.[91] "Parenteral," by definition, does not exclude perinatal transfer. It is defined as a transfer "by some other means than through the gastro-

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[86] *See, e.g.*, James J. Goedert et al., *High Risk of HIV-1 Infection for First-Born Twins*, 338 LANCET 1471, 1473 (Dec. 1991) (reporting results of a study indicating that while some infants may become infected before delivery, a substantial proportion of HIV transfer occurs during labor); A. Ehrnst et al., *HIV in Pregnant Women and Their Offspring: Evidence for Late Transmission*, 338 LANCET 203, 206 (July 1991) (finding that in most infants HIV transfer occurs "close to or at delivery").

[87] For a discussion of the definition of the recipient of the exposure—i.e., whether the legislatures intended "person" or "another" to apply to a fetus or a newborn—see *infra* notes 99–104 and accompanying text.

[88] ILL. REV. STAT. ch. 38, para. 12–16.2(b). A recent Illinois case has held that by participating in certain conduct recognized as allowing transmission of HIV, a defendant "clearly exposed the body of another to his bodily fluid in a manner that could result in the transmission of HIV." People v. Dempsey, 610 N.E.2d 208, 223 (Ill. App. Ct. 1993).

[89] *See supra* note 44.

[90] Isaacman, *supra* note 9, at 491; Jones, *supra* note 13, at 1173. This forms the basis for a strong public policy argument against coerced prenatal HIV testing and punitive measures, which are likely to create incentives for abortion. *See infra* notes 173–77 and accompanying text.

[91] *See* ARK. CODE ANN. § 5–14–123 (parenteral transfer of blood); DEL. CODE ANN. tit. 16, § 1201 (parenteral exposure to blood).

intestinal tract or lungs; referring particularly to the introduction of substances into an organism . . . ."[92] The fluids and nutrients that the mother circulates to her fetus do not enter through the fetus's gastrointestinal tract or lungs. Instead, maternal blood circulates nutrients and other substances that are filtered through her placenta into the umbilical cord and into the fetus's bloodstream.[93] Thus, perinatal transfer or exposure is arguably within the meaning of "parenteral" transfer or exposure as used in this context. On the other hand, this application to pregnant women might be more elusive than it seems, because despite its strict definition, the general medical use of the term is in reference to "intravenous, subcutaneous, intramuscular, or intramedullary injection," and not generally to perinatal transfer.[94]

Moreover, HIV transfer statutes using the expressions "donation" or "transfer" could also arguably include the flow of blood and other fluids from a pregnant woman to her fetus or newborn.[95] "Donate" is defined as "to present as a gift, grant, or contribution . . . ."[96] "Transfer" means "to convey or remove from one place, person, etc., to another . . . ."[97] Under these definitions, a pregnant mother arguably donates, and more convincingly transfers, blood and other fluids into the body of her fetus and newborn infant, and thus could be prosecuted under these statutes. Generally, however, these statutes seem directed toward those who give blood to an individual or an institution for medical or scientific reasons, and not to a mother who naturally passes blood to her fetus.

None of these definitions strictly precludes applicability to vertical transmission. On the other hand, there also seems to be a decided lack of legislative intent to include perinatal transfer. Until clear evidence of statutory intent is expressed one way or another, it is vital to examine the other elements of criminalized HIV transmission to defend against the removal of childbearing rights of women with HIV/AIDS.

b. *The fluid or product passed and the recipient*

The defined statutory substances transmitted and the specified recipients of those substances are also relevant considerations in de-

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[92] STEDMAN'S MEDICAL DICTIONARY 1031 (24th ed. 1982).

[93] *See* WILLIAMS OBSTETRICS 58–61 (F. Gary Cunningham, M.D. et al. eds., 18th ed. 1989).

[94] STEDMAN'S MEDICAL DICTIONARY 1031 (24th ed. 1982).

[95] *See* GA. CODE ANN. § 16–5–60 ("donates"); IND. CODE ANN. § 35–42–1–7 ("donates or transfers"); MD. HEALTH-GEN. CODE ANN., § 18–601.1 (transfer or attempt to transfer); *see also* 42 U.S.C. § 300ff-47 (1992) (makes a donation).

[96] RANDOM HOUSE DICTIONARY OF THE ENGLISH LANGUAGE 582 (2d ed. unabridged 1987).

[97] *Id.* at 2009; *see also* BLACK'S LAW DICTIONARY 1497 (6th ed. 1990).

termining whether a statute applies to a pregnant woman. These statutes define blood, blood products, and other potentially infectious body fluids as criminal substances.[98] These definitions are important because a pregnant woman invariably transfers blood and other bodily fluids to her fetus and newborn infant before the umbilical cord is cut.

In the statutes that define the recipient of the transferred substance, that recipient is usually referred to as a "person"[99] or simply as "another."[100] The Supreme Court has held that a fetus is not a person under the Fourteenth Amendment.[101] Many state courts have also held that the unborn fetus is not considered a "person" or "human being" under criminal or civil law.[102] Under this interpretation, any statutes criminalizing exposure or transfer to a "person" would not apply to the mother-fetus transfer. It is unclear whether this interpretation would be applicable to statutes that refer to transmission to "another."

Further, if it can be shown that HIV transfer occurs after delivery but before the umbilical cord is cut, proponents of perinatal HIV prosecutions might argue that a newborn baby is sufficiently a "person" or "another" under the Constitution to justify state protection. On the other hand, this argument has been attempted by advocates of prosecutions under statutes proscribing drug delivery to minors, but has generally been rejected by the courts.[103] Instead, these courts have

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[98] *See* 42 U.S.C. § 300ff-47(a)(1) (1992); ARK. CODE ANN. § 5–14–123(b); DEL. CODE ANN. tit. 16, § 1201(9); GA. CODE ANN. § 16–5–60(c)(5); IDAHO CODE § 39–608(1), (2); ILL. REV. STAT. ch. 38, para. 12–16.2(a)(2), (b); IND. CODE ANN. § 35–42–1–7(b); MO. REV. STAT. § 191.677(1); OKLA. STAT. tit. 21, § 1192.1(A); TEX. PENAL CODE ANN. § 22.012(a).

[99] *See* ARK. CODE ANN. § 5–14–123(b); GA. CODE ANN. § 16–5–60(c); IDAHO CODE § 39–608; ILL. REV. STAT. ch. 38, para. 12–16.2(b); IND. CODE ANN. § 35–42–1–7(c); MD. HEALTH-GEN. CODE ANN. § 18–601.1(a); TEX. PENAL CODE ANN. § 22.012(a).

[100] *See* 42 U.S.C. § 300ff-47(a)(1) (1992); IDAHO CODE § 39–608(a); ILL. REV. STAT. ch. 38, para. 12–16.2(a); MO. REV. STAT. § 191.677(1); OKLA. STAT. tit. 21, § 1192.1(A); S.C. CODE ANN. § 44–29–60; TEX. PENAL CODE ANN. § 22.012(a); WASH. REV. CODE § 9A.36.021(d).

[101] Roe v. Wade, 410 U.S. 113, 156–57 (1973); Planned Parenthood v. Casey, 112 S. Ct. 2791, 2839 (1992) (Stevens, J., dissenting).

[102] *See, e.g.*, Egger v. State, 817 S.W.2d 183, 186 (Tex. Ct. App. 1991) ("Even though the life of the unborn may have some value, the United States Supreme Court has determined that it is the mother of the unborn who must ascribe that value and not the consciences of those who oppose abortion."); State v. Harbert, 758 P.2d 826, 827–28 (Okla. Crim. App. 1988) (state penal statutes do not specify the inclusion of fetus in the definition of person, and that "words not found in the text of a criminal statute will not be read into it for the purpose of extending it . . . ."); Billingsley v. State, 360 S.E.2d 451, 452 (Ga. Ct. App. 1987) (common law did not consider unborn fetus to be a "person" or "human being"); Meadows v. State, 722 S.W.2d 584, 585 (Ark. 1987) (unborn fetus was not included as a person or a human being within meaning of statute, and court should not create new common law claims). *But see* State v. Knapp, No. WD 44098 (Mo. App. Dec. 3, 1991) (finding that viable fetuses were intended to be included under the definition of person in particular circumstances).

[103] *See supra* notes 45–51 and accompanying text.

found that legislators did not intend the statutes to cover the short period of time after a baby is born and before the umbilical cord is cut.[104]

c. *Possible defenses*

As mentioned above, several HIV criminalization statutes contain clauses that exempt perinatal transmission. Other statutes contain defense clauses that, although less explicit, would also probably exempt most pregnant women. For example, several states require that an element of harmful intent be present before an individual may be convicted for HIV transfer. Washington's provision, for example, would likely preclude the prosecution of nearly all pregnant women, because it requires an "intent to inflict bodily harm."[105] The situation is somewhat less clear in statutes requiring only an intent to infect or an intent to transfer HIV-infected blood or other fluids.[106] It is not clear whether a woman's awareness of her own seropositivity would be sufficient to show such intent, or whether more specific intent to cause harm would be necessary.

Other statutory defenses rely on an individual's knowledge of the nature of HIV infection and transmission. Missouri's statute would require a pregnant woman to understand that by allowing herself to become or remain pregnant, she is creating a "grave and unjustifiable risk of infecting . . ." her fetus.[107] This implies that women who do not have this understanding could not be convicted under this statute. Other state statutes are more ambiguous and require that an individual with HIV not "knowingly transfer or attempt to transfer" or "knowingly expose" another to HIV.[108] It is not clear whether these statutes are referring to knowing one's HIV status, knowingly engaging in particular conduct, or knowing that this conduct can infect another.

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[104] *See, e.g.*, Johnson v. State, 602 So. 2d 1288, 1290 (Fla. 1992) ("We find that the legislative history does not show a manifest intent to use the word 'delivery' [of a controlled substance] in the context of criminally prosecuting mothers for delivery . . . by way of the umbilical cord.").

[105] WASH. REV. CODE § 9A.36.021(d), (e). It would be unlikely and very difficult to prove that a seropositive woman would become or remain pregnant in order to inflict harm upon a child. *See supra* notes 58–62 and accompanying text.

[106] *See* IDAHO CODE § 39–608(1) ("intent to infect"); IND. CODE ANN. § 35–42–1–7(b) ("recklessly, knowingly, or intentionally donates, sells, or transfers blood"); 42 U.S.C. § 300ff-47(a)(1) (1992) ("intends to expose").

[107] *See* MO. REV. STAT. § 191.677(2).

[108] *See* IND. CODE ANN. § 35–42–1–7(b) (Burns 1991) ("knowingly . . . donates, sells, or transfers"); MD. HEALTH-GEN. CODE ANN. § 18–601.1(a) ("knowingly transfer or attempt to transfer"); S.C. CODE ANN. § 44–29–60 ("knowingly expose").

The degree of knowledge required in these states may determine whether a woman is convicted or acquitted. Case law sufficient for the elucidation of firm standards has not yet developed. It can be inferred from the statutory language, however, that it would be very difficult to convict a woman who did not know she was seropositive when she became pregnant. Further, if a state is unable to prove that the woman knew that HIV could be transferred to a fetus or newborn, it would also be hard put to prove "knowing transfer" or exposure. Where a certain degree of deliberation is required, women who did not intentionally become pregnant may also find an affirmative defense to conviction.

III. Women Must Not Be Screened, Prosecuted, or Punished for Perinatal Transfer of HIV

Part II of this Article discussed how child abuse or neglect statutes and HIV transmission statutes could be extended to apply to HIV transfer from a pregnant woman to her fetus. This Part explains why screening, prosecution, and punishment would violate women's constitutional rights of liberty and privacy, and why these statutes would work against sensible public policies rather than accomplishing legitimate state goals.

A. *Fundamental Constitutional Rights*

What makes a right fundamental for the purposes of substantive due process? Justice Cardozo described such a right as "a principle of justice . . . rooted in the traditions and conscience of our people . . . ."[109] An individual's right to have a child, and not to have this right unduly interfered with, is one such principle of justice.[110] Indeed, American "traditions and conscience" have long protected decisions relating to and furthering the family,[111] as well as decisions involving bodily integrity and choice.[112] A state cannot interfere with such fundamental rights unless that interference is demonstrated to promote a compelling state interest, and the means used by the state are narrowly tailored to serve those compelling interests.[113]

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[109] Palko v. Connecticut, 302 U.S. 319, 325 (1937) (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934)).

[110] *See* Loving v. Virginia, 388 U.S. 1 (1967).

[111] *See* Prince v. Massachusetts, 321 U.S. 158 (1944).

[112] *See* Roe v. Wade, 410 U.S. 113 (1973).

[113] *See* Roe v. Wade, 410 U.S. 113, 155–56 (1973) ("[R]egulations imposing a burden on [a fundamental right] may be justified only by compelling state interests, and must be narrowly

1. Liberty and Reproductive Autonomy

The decision to have a child has long been regarded as a fundamental right.[114] The discussion of this right has involved two aspects of the issue: the right not to have a child or to terminate a pregnancy, and the affirmative entitlement to choose to bear offspring.[115] While both of these rights have been accorded constitutional protection,[116] greater attention has been paid to the former right, probably because of the issues of life and death that are involved in the termination of a pregnancy. However, the right of a woman with HIV/AIDS to conceive and give birth to a child without being punished for it involves the latter right. This positive right to procreate is fundamental to American constitutional ideals and principles.[117]

The affirmative right to reproduce may be particularly important to defend because it promotes life and life-giving, and the creation of family and progeny.[118]

> Reproduction is a basic instinct that supplies societies with the members who maintain and perpetuate the social order and who provide services for others. Reproduction also satisfies an individual's natural drive for sex and his or her

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drawn to express only those interests."); San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 16–17 (1973) ("[S]trict scrutiny means that . . . the State must demonstrate that [the offending statute] has been structured with 'precision,' and is 'tailored' narrowly to serve legitimate objectives and that it has selected the 'less drastic means' for effectuating its objectives . . . .").

[114] Reproductive autonomy is rooted in the concept of federal substantive due process rights, which are applied to the states through the Fourteenth Amendment. *See, e.g.*, Carey v. Population Servs. Int'l, 431 U.S. 678, 686 (1977) (holding that the ability to decide whether or not to "bear or beget" a child is a fundamental right); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639–40 (1974) ("This court has long recognized that freedom of personal choice in matters of marriage and family life is one of the liberties protected by the due process clause of the Fourteenth Amendment."); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."); Stanley v. Illinois, 405 U.S. 645, 651 (1972) ("The rights to conceive and raise one's children have been deemed 'essential,' . . . 'basic civil rights of man,' . . . and 'rights far more precious . . . than property rights' . . . ."); Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) (striking down a sterilization statute on the basis that "[m]arriage and procreation are fundamental to the very existence and survival of the race."); Meyer v. Nebraska, 262 U.S. 390, 399 (1923) (stating that under the Fourteenth Amendment's concept of liberty, individuals have "the right . . . to marry, establish a home and bring up children . . . .").

[115] *See* John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 406 (1983) (discussing the differences between the right to avoid and the right to exercise childbirth).

[116] *Roe*, 410 U.S. at 153; *Skinner*, 316 U.S. at 541.

[117] *See* Loving v. Virginia, 388 U.S. 1 (1967).

[118] Robertson, *supra* note 115, at 408–10.

> continuity with nature and future generations. It fulfills cultural norms and individual goals about a good or fulfilled life, and many consider it the most important thing a person does with his or her life.[119]

Furthermore, many consider the passing on of one's genes to be a mark of immortality, self-worth, and contribution to the world.[120]

> Decisions about how we will use our reproductive powers are decisions about our own future and about our own contribution to the future of the human community, about how one's life is to count, and how far its influence is to extend. . . . [T]he very dignity and identity of the person as a moral being is at stake in any decision to use compulsion in controlling reproductive behavior.[121]

Many of these rationales are reflected in the reasons women have given for deciding to have children even after the women discovered they were HIV infected. When asked why they continue their pregnancies, women with HIV/AIDS emphasize their "visceral desire" to bear children, their religious beliefs, and their perception of procreation as "a means of transcending one's mortality" and a way to achieve some kind of rehabilitation.[122]

Extending child abuse and neglect statutes and criminal HIV transmission statutes to the prosecution of perinatal HIV transfer interferes with HIV-infected women's reproductive autonomy. Although these women may physically have the ability to conceive and bear a child, the threat of punishment in effect precludes procreation by these women.[123]

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[119] *Id.* at 408.

Numerous others have noted that fertility, childbearing, and motherhood may be especially important to African-American women. *See, e.g.*, Kass, *supra* note 13, at 318. Yet, African-American women are disproportionately victimized by AIDS, and are thus most vulnerable to having procreative choice taken away. *See infra* notes 182–85 and accompanying text.

[120] Robertson, *supra* note 115, at 409 n.12.

[121] *Id.* at 409 n.12 (quoting Arthur J. Dyck, *Population Policies and Ethical Acceptability*, in NATIONAL ACADEMY OF SCIENCES, 2 RAPID POPULATION GROWTH: CONSEQUENCES AND POLICY IMPLICATIONS 618, 625–26, 628–29 (1971)) (other citations omitted).

[122] Henrion et al., *supra* note 60, at 896–98; Selwyn et al., *supra* note 60, at 3567–71.

[123] *See* Isaacman, *supra* note 9, at 489 (asserting that forcing HIV-infected women to forgo childbearing under these conditions is "in effect, involuntary sterilization"). Because there is no cure for HIV/AIDS at this point, this effective sterilization is permanent, making the harshness of these penalties even more clear.

Statutes which in effect preclude women with HIV/AIDS from bearing children may violate the constitutional ban against bills of attainder, or bills of pains and penalties. *See* U.S. CONST. art. I, §§ 9, 10. A bill of pain and penalty is a statute that singles out and inflicts sanctions (other

As discussed above, at least nine states attach criminal labels and punishments to HIV transmission statutes that could be applied to perinatal HIV transfer.[124] The majority of these statutes classify HIV transmission as a felony, which could result in lengthy prison sentences or severe fines.[125] There are similar penalties for statutes forbidding drug delivery to minors.[126] Furthermore, conviction under child abuse or neglect statutes can temporarily or permanently divest a mother of custody of her child.[127]

If these statutes were successfully applied to women with HIV, these women would have to choose either to refrain from procreation or to break the law.[128] When the consequences could include years of imprisonment, costly fines (which the woman might not be able to afford), or having a child taken away, this choice is no choice at all. Such an impermissible interference with an individual's fundamental

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than death) upon a particular individual or group without a judicial determination or hearing. United States v. Brown, 381 U.S. 437, 447–49 (1965); United States v. Lovett, 328 U.S. 303, 315 (1946). Although the conviction of a woman for perinatal HIV transmission would require a trial, the trial would be of little consequence, because once a woman is HIV infected she will inevitably be "guilty" if she becomes pregnant. She is being punished—effectively sterilized—for her status as an HIV-infected woman. If she wants to avoid other punishment, she must refrain from getting pregnant, amounting to compulsory sterilization.

This penalty is effectively the same as legislature-imposed punishment, which is exactly what the Article I ban sought to prevent. *See* Davis v. Berry, 216 F. 413 (D. Iowa 1914) (holding that a statute commanding vasectomies for all men twice convicted of a felony was unconstitutional because it was in effect a bill of attainder), *rev'd on other grounds*, 242 U.S. 468 (1917). The *Davis* court also emphasized the cruelty of the penalty in making its decision:

> [T]o destroy the power of procreation . . . is, of course, to follow the man during the balance of his life. The physical suffering may not be so great, but that is not the only test of cruel punishment; the humiliation, the degradation, the mental suffering are always present and known by all the public, and will follow him wheresoever he may go. This belongs to the Dark Ages.

Id. at 416. Similar arguments can be made against criminalizing pregnancy for HIV-infected women.

[124] *See supra* notes 55–108 and accompanying text.

[125] *See, e.g.*, IDAHO CODE § 39–608 (up to 15 years in jail, up to $5,000 fine, or combination of both); OKLA. STAT. tit. 21, § 1192.1 (up to five years in jail). *See also* MD. HEALTH-GEN. CODE ANN. § 18–601.1 (labeled a misdemeanor but punishable by up to 3 years in jail, a fine of up to $2,500 or both).

[126] *See, e.g.*, ARIZ. REV. STAT. ANN. § 13–3409 (1993) (imprisonment for "sentence imposed by court" and fine of $2000 or three times value of substance, whichever is greater); CAL. HEALTH & SAFETY CODE § 11353 (West 1993) (imprisonment for three to nine years); MISS. CODE ANN. § 41–29–139 (1993) (not more than one year imprisonment, fine of not more than $1000, or both); NEV. REV. STAT. § 453.334 (1991) (prison for one to ten years and fine of not more than $10,000 for first offense; life sentence and fine up to $20,000 for second offense).

[127] *See supra* notes 37–53 and accompanying text; *see also* MASS. GEN. L. ch. 119, § 24 (1993); OKLA STAT. tit. 10, § 1130 (1993); W. VA. CODE § 49–6–5 (1993).

[128] Isaacman, *supra* note 9, at 489.

right to reproduce cannot be justified unless it survives strict scrutiny, and is narrowly tailored to a compelling state interest.[129]

2. The Fundamental Right to Privacy

Implementing prosecutions for perinatal transmission of HIV inevitably involves extensive HIV testing of mothers and infants. Such testing evokes additional constitutional analysis of issues involving an individual's right to privacy.

Personal privacy is considered a fundamental right under the Constitution.[130] This privacy right has been interpreted to protect an individual's bodily integrity and choice.[131] An HIV testing program would raise numerous questions relating to the issue of bodily integrity and privacy: what population would be tested and at what stages, whether testing would be mandatory or voluntary, and what the consequences of testing positive would be.

If a state wished to extensively enforce a criminal perinatal HIV transfer statute, it would likely demand mandatory testing of all pregnant women, with consistent penalties assigned.[132] Mandatory HIV

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[129] *See id.* at 492 (stating that extending HIV transmission statutes to perinatal transfer violates women's fundamental liberty rights, and thus, that strict scrutiny must be applied) (citing Zablocki v. Redhail, 434 U.S. 374, 383 (1978); Stanley v. Illinois, 405 U.S. 645, 651 (1972); Shelton v. Tucker, 364 U.S. 479, 488–89 (1960); Meyer v. Nebraska, 262 U.S. 390, 399–400 (1923)).

> Since a fundamental right is implicated in the decision to impose sterilization upon an individual, the state must demonstrate a compelling state interest before it may constitutionally deprive an individual of that right. If a less restrictive alternative is available that can achieve the same stated goal without depriving an individual of a fundamental right, it must be utilized.

Estate of C.W., 1993 Pa. Super. LEXIS 857, at *9 (citations omitted).

[130] *See, e.g.*, Roe v. Wade, 410 U.S. 113, 152 (1973) ("[T]he Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution."); Griswold v. Connecticut, 381 U.S. 479, 495 (1965) (Goldberg, J., concurring) ("Various guarantees [in the Bill of Rights] create zones of privacy.").

[131] *See* Anita Allen, *Legal Issues in Nonvoluntary Prenatal HIV Screening, in* NEXT GENERATION, *supra* note 10, at 178–79 (discussing the association between the constitutional right to privacy and the right to bodily integrity); *see also* Bartling v. Superior Court, 209 Cal. Rptr. 220, 225 (Cal. Ct. App. 1984) (holding that the right to privacy "guarantees to the individual the freedom to choose to reject, or refuse to consent to, intrusion of his bodily integrity"); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1979) (Massachusetts law acknowledges an individual's "strong interest in being free from nonconsensual invasion of his bodily integrity").

[132] I begin with this assumption in light of the equal protection implications that would be involved were states to screen only high-risk groups. *See infra* text accompanying notes 181–91. The equal protection issues involved here are numerous, and a comprehensive discussion of them is beyond the scope of this article. I give only a brief overview for explanatory purposes.

Since HIV occurs so disproportionately in poor women of color, *see infra* text accompanying notes 181–87, poor women of color would predominantly be tested, prosecuted, and penalized

testing would require the taking of blood from a woman even without her consent. This unwelcome bodily invasion arguably violates an individual's bodily integrity and fundamental right to privacy.[133] As mentioned above, such a violation cannot be justified unless the government can prove that the practice serves a compelling interest, and is the least restrictive means for doing so.

Although this strict scrutiny test offers some protection, courts have often held that a state's interest in protecting public health and welfare supersedes nearly all personal rights.[134] This justification has been used to permit widespread screening for diseases such as syphilis, hepatitis B, sickle-cell anemia, cystic fibrosis, Tay-Sachs disease, and phenylketonuria (PKU).[135] Public health and welfare arguments have also justified mandatory vaccinations, medical examinations, and even certain quarantines.[136] Courts have been especially willing to interfere

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as members of high-risk groups. Because of the history of eugenic selectivity, because the government has not previously devoted much energy to the promotion of the health of babies of color, and because the government has often refrained from initiating mandatory testing programs for diseases prevalent in Caucasians, the motive for mandatory HIV screening would be suspect and subject to challenge. *See supra* text accompanying notes 16–36 (describing the history of eugenic selectivity); *infra* text accompanying note 191 (noting that there has been no drive for mandatory testing for cystic fibrosis, a disease primarily affecting Caucasians); *see also* Hunter, *supra* note 7, at 17 (stating that the government has demonstrated "no great zeal" towards protecting the health of African-American and Latino babies, and that in fact the infant mortality rates in these communities are not substantially different from infant mortality rates in impoverished countries).

Even if mandatory testing of *all* pregnant women were instituted, there would likely be equal protection challenges based on gender inequality. The success of such challenges would depend on whether courts determined men and women to be "similarly situated" with regard to posing a risk of vertical transmission. Hunter, *supra* note 7, at 21. It is likely that courts would not decide that they were so situated, because a father's HIV infection is not sufficient to cause a fetus to become infected; the mother must be infected herself to create the risk of vertical transmission. *Id.* Thus, an equal protection claim is likely to fail. *Id.* at 22.

[133] Allen, *supra* note 131, at 179.

[134] *See, e.g.*, Barnes v. Glen Theatre, Inc., 111 S. Ct. 2456 (1991) (Rehnquist, C.J., concurring) (state public heath and safety powers may override free speech interests of nude dancers); Michigan Dep't of State Police v. Sitz, 496 U.S. 444 (1990) (sobriety checkpoint program justified on public health and safety grounds does not violate Fourth Amendment rights of drivers); Jones v. United States, 463 U.S. 354 (1983) (insane person may be confined without consent if dangerous to society).

[135] *See* Acuff & Faden, *supra* note 10, at 59–80 (discussing history of governmental screening programs); Kass, *supra* note 13, at 310–12 (describing differences between HIV and other diseases which have been screened).

[136] Allen, *supra* note 131, at 168; Susan J. Levy, *The Constitutional Implications of Mandatory Testing For Acquired Immunodeficiency Syndrome—AIDS*, 37 EMORY L.J. 217, 218 (1988). *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11 (1905) (affirming a state's practice of compulsory smallpox vaccinations); Compagnie Française v. State Board of Health, 186 U.S. 380 (1902) (upholding quarantine statute for persons suspected of having an infectious disease); Reynolds v. McNichols, 488 F.2d 1378 (10th Cir. 1973) (upholding statute authorizing detention, examination, and

with women's personal rights when they are pregnant in order to further fetal health.[137]

There are many factors, however, that distinguish HIV from other diseases for which women have been screened, and that demonstrate why compulsory screening for HIV should not be conducted. Several commentators have compared and contrasted particular characteristics and consequences of HIV/AIDS with those of these other diseases.[138] They have attempted to weigh the importance of several factors in deciding the balance between women's constitutional rights and public health needs. These factors include the availability of effective treatment, prevalence of the disorder, rates of transmission, and severity of the illness.[139]

Considering these factors, the situation for HIV-infected women of childbearing age is distinguishable from the above-mentioned diseases. Other mandatory testing programs have been implemented for treatment and prevention purposes and not for punitive reasons. For

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treatment of any individual "reasonably suspected of having a venereal disease"); Hanzel v. Arter, 625 F. Supp. 1259 (S.D. Ohio 1985) (school requirement of immunization does not violate right to privacy). *But see* Jew Ho v. Williamson, 103 F. 10 (C.C.N.D. Cal. 1900) (overturning a quarantine for individuals with bubonic plague, because of unnecessary intrusion on liberty and privacy interests).

[137] *See, e.g., In re* A.C., 533 A.2d 611 (D.C. App. 1987), *rev'd*, 573 A.2d 1235 (D.C. Cir. 1990) (ordering a caesarian section to be performed on a woman in an attempt to save her 25-week fetus, which had a 50 to 60% chance of survival). The *A.C.* court made this order despite physician acknowledgement that the surgery would accelerate the death of the mother, who had cancer. This decision was overturned by the Court of Appeals for the District of Columbia, long after it could do the mother any good. *In re* A.C., 573 A.2d 1235 (D.C. Cir. 1990). *See also* Jefferson v. Griffin Spalding County Hosp., 274 S.E.2d 457, 460 (Ga. 1981) (forcing a woman to have a caesarian section procedure despite her refusal on religious grounds); Raleigh Fifkin-Paul Memorial Hosp. v. Anderson, 201 A.2d 537, 538 (N.J. 1964) (per curiam) (ordering pregnant woman to submit to blood transfusion despite her religious objections), *cert. denied*, 377 U.S. 985 (1964). *But see* Taft v. Taft, 446 N.E.2d 395, 396 (Mass. 1983) (reversing order to have a woman's cervix sutured "to hold her pregnancy" because of the woman's religious objections); Tamar Lewin, *Courts Acting to Force Care of the Unborn*, N.Y. TIMES, Nov. 23, 1987, at A1 (reporting court's refusal to order a woman to undergo caesarian section, holding that pregnant women also have the right to choose whether or not to have surgery).

Courts have even ordered that brain-dead pregnant women be kept alive on machines for months in order to allow their pregnancies to continue to term. *See, e.g.*, Marc Fisher, *Germany's Fetal Position; If a Mother Dies, Should Her Pregnancy Continue?*, WASH. POST, Oct. 29, 1992, at C1 (reporting brain-dead 18-year-old woman kept alive on machines to continue her twelve-week-old fetus to term). *See generally* ANNAS ET AL., *supra* note 4, at 978–88.

[138] *See, e.g.*, Acuff & Faden, *supra* note 10, at 59–80 (comparing AIDS to syphilis, PKU, sickle-cell anemia, Tay-Sachs disease, neural tube defects, and hepatitis-B); Kass, *supra* note 13, at 309–12 (discussing distinctions between HIV and syphilis, hepatitis-B, homozygous recessive traits, sickle-cell anemia, cystic fibrosis, and Tay-Sachs disease). For statistics comparing HIV to drug dependence, see *supra* note 13 and accompanying text, *infra* note 159.

[139] Acuff & Faden, *supra* note 10; Kass, *supra* note 13, at 309–10.

example, compulsory screening programs for congenital syphilis were set in motion after the United States Public Health Service emphasized that "prenatal syphilis is a preventable disease; its prevention depends upon the routine, early and repeated use of the serologic test for syphilis and adequate, early and continuous treatment of the mother up to the termination of the pregnancy."[140] Furthermore, women could refuse the syphilis test for "conscientious, religious, or other" reasons.[141]

Similar goals were present between 1963 and 1973, when forty-three states enacted legislation, most of it mandatory, for screening for PKU.[142] PKU is regarded as a disease well suited for screening programs in that it "has a known prevalence; the test is simple, safe and accurate; the cost of the test is low; and an effective treatment is available."[143] In addition, these screening programs did not mandate punishment for parents who declined to be tested.[144]

In contrast, there are no cures, vaccines, or treatments for AIDS that do more than slow the progression of the disease,[145] so any mandatory testing program would result primarily in punishing the mother and consequently the child. Mandatory testing programs for diseases lacking cures or vaccines have been much less effective in attaining public health goals than widespread education and voluntary screening programs.

A demonstrative example arises out of the different approaches to screening for sickle-cell anemia and Tay-Sachs disease that were taken in the early 1970s. No treatment was available at the time for either of these diseases, yet two very different strategies ensued. At first, sickle-cell anemia was attacked through mandatory screening programs, which were often poorly directed, inadequate and had little positive effect.[146] Because of the lack of treatment available, the medical community emphasized the consequences of two carriers having a child together, so as to prevent the birth of infected newborns.[147] The disproportionate numbers of African Americans affected by the disease

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[140] Acuff & Faden, *supra* note 10, at 63 (citations omitted). Compulsory screening programs of pregnant women for congenital syphilis began with New York's "Baby Health Bill" in 1938, and by 1945, 36 states and the federal government had passed prenatal syphilis screening laws. *Id.* at 62–63.

[141] *Id.* at 62.

[142] *Id.* at 65.

[143] *Id.*

[144] *Id.*

[145] Hunter, *supra* note 7, at 28.

[146] Acuff & Faden, *supra* note 10, at 68–69.

[147] *Id.* at 68–69, 71.

fueled opposition to the compulsory nature of the programs, in light of the eugenic implications of counseling against childbirth. Eventually, sickle-cell screenings were amended to be voluntary.[148]

In contrast, large-scale, voluntary, community-based screening programs for Tay-Sachs carriers were set up in seventy-three cities and thirteen countries by 1980.[149] Like sickle-cell counseling, Tay-Sachs counseling involved the dissemination of information regarding the consequences of childbearing by two carriers of the disease. In the noncompulsory, community-supportive context, however, the programs were effective. These voluntary screenings, combined with educational and counseling efforts, served to decrease the incidence of Tay-Sachs in Jewish infants by an estimated 60 to 85%.[150]

A second reason that HIV/AIDS should not be treated in the same manner as other screened diseases stems from the perinatal incidence of HIV as compared to those other diseases. Although HIV prevalence and rate of perinatal transmission are not yet fully known, the estimated figures indicate a lower occurrence of perinatal HIV than other diseases which have been targeted for compulsory screening. For example, syphilis was far more rampant earlier in the century than AIDS is now, affecting approximately 20% of the population of the United States.[151] Since the perinatal transmission rate of syphilis is as high as 70 to 100%,[152] the incidence of infected babies was enormous. It was estimated in 1940 that each year women with syphilis were transmitting the disease to at least 85,000 fetuses.[153]

In contrast, there were a total of 36,325 cases of AIDS in women reported to the Centers for Disease Control (CDC) as of June 1993.[154] Also reported as of that date were a total of 4121 cases of pediatric AIDS related to a mother with or at risk of HIV infection.[155] The figures for seroprevalence are much more difficult to determine, but the CDC estimates that between 1989 and 1990, 0.15% of childbearing women nationwide were HIV positive.[156] When women with HIV/AIDS bear

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[148] *Id.* at 69.

[149] *Id.* at 72.

[150] *Id.*

[151] Acuff & Faden, *supra* note 10, at 61 n.11.

[152] Kass, *supra* note 13, at 310.

[153] Acuff & Faden, *supra* note 10, at 61. These figures were even more drastic considering that the United States' population was only 130 million at the time. *Id.*

[154] CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE: SECOND QUARTER EDITION (July 1993).

[155] *Id.*

[156] CENTERS FOR DISEASE CONTROL, AIDS INFORMATION: HIV SEROPREVALENCE SURVEYS (Jan. 1993).

children, between 7 and 40% of those children will develop their own seropositivity.[157] Overall, it is estimated that approximately five to seventy seropositive infants are born per ten thousand births.[158] In other words, approximately 0.05 to 0.7% of all babies born to all women will become HIV infected.[159]

These statistical differences play an important role in determining the balance between public health needs and women's privacy. There is some justification for testing for an infectious disease, especially when that disease is widespread and threatens to infect a large number of people. Such screening would only be justified, however, if there is evidence that it would help prevent the spread of the disease.

AIDS is much less widespread[160] and less easily transmitted[161] than other diseases for which screenings have been conducted. Even though AIDS is a devastating disease, there is little evidence that screening would help to control its spread in light of the current lack of effective treatments or vaccines. In fact, AIDS has been less responsive to treatment than nearly any disease for which screenings have been conducted.[162] Since the public health protection arguments are weak, more weight should be given to women's privacy rights.

On account of these factors, mandatory prenatal screening programs for HIV are unjustified invasions of women's right to privacy and cannot be permitted unless the programs satisfy a strict scrutiny analysis.

3. Strict Scrutiny is not Satisfied

As mentioned above, in order to uphold a statute interfering with a woman's fundamental right to liberty and privacy, a court must find that the statute furthers a compelling state interest and utilizes the least restrictive means of accomplishing that purpose.

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[157] *See supra* note 44.

[158] Kass, *supra* note 13, at 311.

[159] As another example, contrast these pediatric HIV figures with the number of children born drug dependent each year. Approximately 350,000 to 739,200 infants born annually have been exposed to at least one illegal drug *in utero*. Jones, *supra* note 13, at 1160–61. These figures represent approximately 10 to 20% of all babies born. *See* Anastasia Toufexis, *Innocent Victims*, TIME, May 13, 1991, at 56 (citing National Association for Perinatal Addiction Research and Education (NAPARE) statistics).

[160] *See supra* text accompanying notes 151–59.

[161] AIDS is considered a communicable disease, but it is not easily transmitted. *See* Richard Green, *The Transmission of AIDS*, *in* AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 28, 28 (Harlon L. Dalton ed., 1987) (noting that AIDS cannot be spread by casual contact).

[162] Kass, *supra* note 13, at 310.

a. *Compelling state interests are not furthered*

A state may offer many laudable motives for screening for HIV/AIDS and prosecuting HIV-infected women who become pregnant. These motives would likely include halting the spread of AIDS,[163] preserving fetal and family health[164]and cutting costs and saving resources.[165]

Although all of these reasons may be compelling governmental interests, there is little evidence that prosecuting women with HIV/AIDS for having children will further any of them, or that prosecutions would accomplish the goals less restrictively than other possible means. First, these prosecutions would not have much effect on curtailing AIDS because there is still no way to prevent the transfer of HIV perinatally; women already pregnant cannot help but expose their fetuses to HIV.[166] Therefore, unless abortion is encouraged or re-

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[163] *See* Banks, *supra* note 8, at 377 ("[T]he state arguably has a compelling interest in preventing the spread of a mildly contagious, but often fatal, disease, HIV, especially when the possible target of infection is a newborn child."); Isaacman, *supra* note 9, at 490 ("Combating a public health problem is a legitimate health and welfare power of the state, and AIDS is a public health problem of monumental concern and proportion.") (citation omitted).

[164] *See, e.g.*, Nancy Hutton & Lawrence S. Wissow, *Maternal and Newborn HIV Screening: Implications for Children and Families*, *in* NEXT GENERATION, *supra* note 10, at 105, 116 ("Early diagnosis of HIV infection permits more prompt and focused management of the immunodeficient child, including specific antiretroviral therapy, and thus holds the promise of both extending and improving the child's quality of life."); *see also* Isaacman, *supra* note 9, at 490 (analyzing whether Illinois's HIV transmission statute, as applied to pregnant women with HIV, promotes family health); *cf.* Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse,"* 101 HARV. L. REV. 994, 1003–05 (1988) (discussing the state's interest in protecting fetuses from the risk of miscarriage, stillbirth, birth defects, and other fetal injuries, as a result of "fetal abuse").

A state's interest in protecting "family health" may also include a desire to prevent children's having to grow up without their mothers (who will presumably die of AIDS). *See* Hutton & Wissow, *supra*, at 114 (reporting estimates that by 1995, in New York City alone, approximately 20,000 children will be orphaned because of parents dying of AIDS).

[165] Some argue that the medical and foster care costs of HIV-infected children are likely to approach or even exceed that of drug-addicted infants, unless the birth rate of children with HIV/AIDS is checked. Others have expressed concern that infants exposed to HIV and infants exposed to drugs might end up "competing" for the same resources. Hutton & Wissow, *supra* note 164, at 114. Some commentators believe that these costs are a strong reason why women with HIV should be discouraged from having children.

The possibility of a drain on available resources is also a concern, as state welfare agencies wonder how they will handle an expected flood of infants, many of whom will be without parents or with terminal illnesses. *See, e.g.*, Cheryl Laird, *The New Orphans: When AIDS Claims Parents, What Happens to the Children?*, HOUSTON CHRON., October 4, 1992, at 1 (discussing the already overburdened child welfare systems in many states, and the tremendous costs that AIDS will precipitate in the coming years).

[166] Ruth R. Faden & Judith Areen, *Screening Newborns for HIV: Ethical and Legal Aspects*, *in* NEXT GENERATION, *supra* note 10, at 259, 267. As mentioned above, however, not all babies will

quired,[167] HIV transfer will still occur.[168] It may be argued that these prosecutions serve a deterrent purpose: that these women and others like them will try harder to avoid pregnancy in the future. It is more likely, however, that the prosecutions will deter women from seeking care and treatment before, during, and after childbirth in order to avoid the punishment.[169]

Second, it is unlikely that fetal and family health would be furthered much, if at all, by prosecuting parenting women with HIV/AIDS. As mentioned above, the threat of prosecution likely will deter pregnant women from seeking prenatal care, and may cause them to deliver their babies at home to prevent discovery.[170] Further, many of the particulars of perinatal HIV transmission are unknown, including when the transmission takes place, why some infants form their own seropositivity while most do not, and what effects the pregnancy will have on the mother's health.[171] What is known is that at the moment, there are no cures or long-term effective treatments for HIV/AIDS.[172] Although voluntary educational, testing, and treatment

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remain infected: somewhere from 60 to 93% of babies born to women with HIV/AIDS will develop in full health. *See supra* note 44.

[167] *See, e.g., infra* note 174.

[168] It may be worth noting that "[t]ransmission of the infection from infants to others has rarely been demonstrated." Faden & Areen, *supra* note 166, at 267. Thus, even if a small percentage of babies becomes HIV infected, AIDS will not be spread beyond those infants.

[169] Banks, *supra* note 8, at 370–72 & n.98 (citing Patton, *Resistance and the Erotic: Reclaiming History, Setting Strategy as We Face AIDS*, RADICAL AM., 68, 78 (Nov.-Dec. 1986) (stating that former Surgeon General C. Everett Koop does not advocate mandatory prenatal HIV screening because he fears it would discourage prenatal care)); *cf.* Johnson v. State, 602 So. 2d 1288 (1992) (refusing to apply statute proscribing delivery of drugs to minors to woman who passed drugs through her umbilical cord to her newborn, because of the fear that it would dissuade women from seeking prenatal care). The court in *Johnson* noted that:

> [P]rosecuting women for using drugs and "delivering" them to their newborns appears to be the least effective response to this crisis. Rather than face the possibility of prosecution, pregnant women who are substance abusers may simply avoid prenatal or medical care for fear of being detected. Yet the newborns of these women are, as a group, the most fragile and sick, and most in need of hospital neonatal care. A decision to deliver these babies "at-home" will have tragic and serious consequences.

Id. (adopting the dissenting opinion of the court below). This view has also been asserted by the American Medical Association Board of Trustees, the California Medical Association, and numerous others in the medical community. *Id.*

[170] *See* CENTER FOR REPRODUCTIVE LAW AND POLICY, *supra* note 37, at 3 (also stating that public health groups and policy makers are in wide agreement that punitive measures do not improve the health of women or their children).

[171] Modlin & Saah, *supra* note 13, at 39–40; John T. Repke & Timothy R.B. Johnson, *HIV Infection and Obstetric Care, in* NEXT GENERATION, *supra* note 10, at 94, 94–98; Kass, *supra* note 13, at 311.

[172] Allen, *supra* note 131, at 187–88.

programs should be made widely available, a compulsory testing program is not appropriate until advances are made in "test specificity, presymptomatic treatment, and social safeguards."[173]

Prosecutions of HIV-infected women are more likely to encourage fetal death in the form of abortions than to further any governmental interest in protecting fetal health.[174] In addition to antiabortionists' traditional objections to such encouragement of abortion,[175] there is also a question as to the legal and moral authority of a court or state to favor death over disability. For example, courts have refused to recognize parents' "wrongful life" claims against doctors for inadequately performing sterilizations that resulted in unplanned pregnancies and children born with disabilities.[176] Courts have based these refusals on the assertion that there is no foundation in the law that enables judges to decide that "it is better to have never been born at all rather than to have been born with serious . . . defects . . . ."[177]

Yet, in the case of perinatal HIV transfer prosecutions, the legislatures and courts would be saying just that: it is better not to have a child at all than to have a child who may develop AIDS. In addition to the lack of legal support for preferring death to disability, the lack of moral authority should also prevent a state from making this choice:

> Preventing the birth of a child who would have an illness or a disability is morally different from preventing illness or disability in persons already living. . . . [Treating them as the same] involves a morally unacceptable view of the social worth of such persons. A public policy aimed at discouraging persons with inheritable disabilities or illnesses from having children embodies highly objectionable social affirmations of

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[173] Hutton & Wissow, *supra* note 164, at 116; Faden et al., *HIV Infection, Pregnant Women, and Newborns; A Policy Proposal for Information and Testing, in* NEXT GENERATION, *supra* note 10, at 331, *also published in* 264 JAMA 2416 (1990).

[174] If a pregnant woman knows or suspects she is seropositive or has AIDS/ARC, she may seek an abortion in order to avoid being discovered and prosecuted. Thus, the government would in effect encourage certain death for an infant rather than a 60 to 93 percent chance of healthy life. *See* Isaacman, *supra* note 9, at 491 (asserting that Illinois's HIV transmission statute encourages abortion because it is the only way for the pregnant seropositive woman to avoid breaking the law); *see also* Note, *supra* note 164, at 1003 n.55 (arguing that perhaps the governmental "interest in prohibiting abortions is greater than the state's interest in preventing fetal abuse because nonexistence may be a greater harm than mere injury").

[175] For example, that abortion is murder, the killing of potential life.

[176] Curlender v. Bio-Science Laboratories, 165 Cal. Rptr. 477, 485 (Cal. Ct. App. 1980); Elliott v. Brown, 361 So. 2d 546, 548 (Ala. 1978).

[177] *Curlender*, 165 Cal. Rptr at 485; *see also Elliott*, 361 So. 2d at 548 ("Upon what legal foundation is the court to determine that it is better not to have been born than to be born with deformities?").

> individual inequality. First, it denies that such persons have an equal right to participate in a highly valued aspect of the human experience—the begetting and raising of children. Second, it says to disabled and ill persons generally that the lives of some are not worth living, and hence that these persons are not entitled to a share of the social resources necessary for human flourishing. Third, it conveys the message that persons with a disability or an illness are to be understood as only an economic and social drain on society and never as a source of enrichment for the lives of others.[178]

Perinatal HIV prosecutions do not encourage family health. As mentioned above, it is not healthy for a mother to avoid care and treatment relating to her pregnancy (or to her HIV/AIDS), which she is likely to do if she fears detection and prosecution. Further, these prosecutions could lead to the imprisonment of mothers or placement of children in temporary or permanent foster care, both of which remove an infant from a presumably caring and able parent. Punitive fines will also only result in hurting members of the family, who probably are already hard-pressed to cope with their illnesses.

Lastly, there is also no proof that the statutory prosecution of childbearing women with HIV/AIDS will prevent rising foster care and welfare costs. As mentioned above, it is unclear that these statutes will actually discourage HIV-infected women from having children; AIDS-related costs may therefore remain the same. In addition, the prosecutions themselves and their associated court expenses will require additional funds, as will any imprisonment or supplemental foster care costs.

b. *The application of these statutes in this situation is not the least restrictive means for achieving governmental objectives*

Compounding the constitutional problems stemming from the lack of evidence that compelling state interests will be furthered, the terms of these measures are unnecessarily broad. The extension of child abuse, child neglect and HIV transmission statutes to perinatal HIV transmission is likely to impact decisions made by women in three settings: decisions by all women whether or not to be tested for HIV/AIDS; decisions by HIV-infected women or women in higher risk groups whether or not to become pregnant; and decisions made by

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[178] Faden et al., *supra* note 173, at 338–39.

pregnant HIV-infected women or women in higher-risk groups after becoming pregnant whether to carry the pregnancy to term.[179] Although only a very small percentage of women are HIV infected, millions would be affected by prenatal screenings.[180] Furthermore, the potential screenings and prosecutions would affect countless other women in deciding whether to be tested for HIV (if knowledge of HIV status was an element of the offense) and whether to become pregnant.

Some people have argued that screening for HIV/AIDS should be targeted so that it is required only of high-risk groups. This suggestion has elicited concerns of genocide and racism similar to those evoked by the mandatory screening for sickle-cell anemia two decades ago[181] because of the disproportionate effect AIDS has had on women of color.[182] Seventy-five percent of women with AIDS are African American or Latina.[183] Furthermore, 69% of women with AIDS are either injection drug users or sex partners of injection drug users,[184] and about

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[179] *See* Kass, *supra* note 13, at 308–24 (recommending appropriate nondirective counseling for women in these three stages). The decisionmaking issue inevitably involves questions about the type of counseling prescribed (i.e., directive or nondirective). There is a good deal of disagreement over the role of the doctor, clinician or counselor: should he or she advise or encourage patients to follow a particular course of action (i.e., an abortion following positive HIV tests), or should he or she simply inform and educate patients to enable them to make their own decisions in light of their particular circumstances?

This issue is beyond the scope of this article. For a comprehensive discussion of the numerous factors involved in screening and counseling, see NEXT GENERATION, *supra* note 10, *passim*; Banks, *supra* note 8, *passim*; *see also* Faden et al., *supra* note 173, at 331 (discussing the countless moral, legal, and policy issues involved in screening and counseling, and advocating widespread education and voluntary testing rather than mandatory screening and directive counseling).

[180] The number of births recorded in the United States in 1989 was 4,040,958. WOMEN'S HEALTH DATA BOOK 1 (Jacqueline A. Horton ed., 1992). For a discussion of the overbreadth of coercive prenatal HIV testing, see Allen, *supra* note 131, at 172.

> For the most part, pregnant women are not HIV infected, do not have AIDS or ARC, and do not fit into any high-risk category. To impose testing nonetheless on all pregnant women would appear to be irrational in economic cost-benefit terms and would "burden some who are not similarly situated with regard to the purposes" of HIV testing. The governmentally imposed burden of these women would involve more than a needle puncture. It would include lost autonomy, false positives, false negatives and consequent stigma, personal turmoil, or unnecessary abortion.

Id. (quoting from LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1450 (2d ed. 1988)).

[181] *See supra* notes 146–48 and accompanying text.

[182] *See, e.g.*, Banks, *supra* note 8, at 354 ("Given the racial composition of the women currently thought to be at risk, HIV screening and counseling proposals designed to somehow prevent perinatal transmission have genocidal overtones.").

[183] E.G. Bing & T.A. Soto, *Treatment Issues for African Americans and Hispanics with AIDS*, 9 PSYCHIATRIC MED. 455 (1991). As of June 1993, there were 19,544 cases of African-American women with AIDS and 7451 cases of Hispanic-American women with AIDS, out of a total of 36,960 American women with AIDS. CENTERS FOR DISEASE CONTROL, *supra* note 154, at 8. These figures add up to approximately 74%.

[184] CENTERS FOR DISEASE CONTROL, *supra* note 154, at 8.

78% of these women are also African American or Latina.[185] These disproportionate statistics are not caused by biological differences among ethnicities; they reflect only sociodemographic differences.[186] Directed screening based on such sociodemographic criteria would be "invidiously discriminatory on its face."[187]

Even if all pregnant women are tested for HIV, mandatory programs will still be subject to questions of racial genocide and eugenics because of the dramatically disproportionate impact such testing will have on families of color.[188] There have been few legislative attempts to proscribe pregnancy among women with particular diseases, especially when the disease has affected nonminority populations.[189] This makes the reproductive control of women with HIV susceptible to charges of racial animus because many diseases are more prevalent than HIV/AIDS.[190] An example is cystic fibrosis, a disease that primarily affects nonminorities. Though more prevalent than HIV/AIDS, cystic fibrosis has not incited a drive for mandatory screening or punitive measures for bearing affected children.[191]

The application of these criminal statutes to all HIV-infected women would also be overbroad because of the lack of knowledge of the likelihood and means of vertical HIV infection.[192] On the other hand, it makes little sense to prosecute only those women whose babies happen to be infected if states wished to punish those who even take the risk. The issues involving knowledge and intent, discussed above, complicate attempts to enact a logical, uniformly applied statute.[193]

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[185] *Id.*

[186] Faden et al., *supra* note 173, at 343–44.

[187] *Id.* at 343.

[188] *See, e.g.*, Kass, *supra* note 13, at 320 ("If some people believe that these [minority] women should not be having babies or more babies anyway, HIV poses the perfect excuse for legitimately encouraging them not to do so.").

[189] *Id.* at 320.

[190] *Id.*

[191] *Id.*

[192] Although most babies born to mothers with HIV/AIDS will initially test seropositive, the majority of these babies will "lose" their seropositivity over the first two years of life. As noted, studies have shown that somewhere between 7 and 40% of these babies will retain their HIV-positive status. *See supra* note 44. It is not known why some babies retain the infection and others do not. However, several researchers who have found incidence on the lower end of the spectrum have emphasized the importance of not making HIV status judgments before the baby is at least eighteen months old. *See* Melchor et al., *supra* note 44, at 534. According to these studies, many babies exhibit seropositivity before the 18-month point but later "lose" that status. *Id.*

[193] For example, what would be the response to women who do not intend or want to get pregnant, who become seropositive after becoming pregnant, or who did not know they were HIV infected when they became pregnant? Further, what is the appropriate measure for a woman who knew she was HIV infected and became pregnant intentionally but miscarried her baby? Should she be prosecuted because she *might* have borne an infant with HIV?

Until more is known about the incidence of perinatal transmission, no far-reaching measures should be taken against pregnant women.

In addition, the argument that children should not have to be born to mothers who are going to die soon is paternalistic and facile. Many people with HIV have remained healthy for a decade or longer before becoming ill with AIDS.[194] There is even recent evidence that 5% of seropositive individuals may have some type of natural immunity to AIDS.[195] It seems logical that in order to justify the taking of an individual's reproductive control, a state would need to prove that the individual lacked some requisite degree of capacity or ability to parent.[196] A probability of death within ten or more years does not represent such an inability or incapacity per se. If it did, countless people, including the older population and others afflicted with illness, might also be stripped of their reproductive rights.

As demonstrated, statutes aimed at the screening, prosecution, and punishment of childbearing women with HIV/AIDS do not meet the requirements of strict scrutiny. These statutes would not promote compelling state interests in the least restrictive manner. As a result, women's fundamental rights must be guarded, and women must not be screened, prosecuted, or punished for the perinatal transfer of HIV.

B. *The Fourth Amendment Right to Bodily Integrity*

The need for HIV testing in order to accomplish the above-mentioned statutory goals also invokes the Fourth Amendment, which grants individuals "[t]he right to be secure in their persons. . . ."[197] This right has been interpreted as preventing unjustifiable invasions of the body or person.[198] The question then arises whether a compulsory

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[194] *See, e.g.*, Laurie Garrett, *Why Some Survive*, NEWSDAY, June 15, 1993, at 59 (recounting a study by Dr. Renate Baumgarten of Ulm University Hospital in Germany of 25 gay men and 20 intravenous drug users who had all lived with HIV infection for more than 12 years without becoming ill); Erik Kirschbaum, *Scientists Drawn to Mystery of Long Survival with AIDS Virus*, REUTER LIBR. REP., June 7, 1993 (citing studies of a group of 593 men with HIV, indicating that 12% exhibited full-blown AIDS within 5 years, 51% within 10 years, and 68% within 13.8 years).

[195] *See* Christine Gorman, *Are Some People Immune to AIDS?*, TIME, March 22, 1993, at 49 (reporting that there are at least 70 documented cases of individuals who have lived for 14 or more years with an HIV-positive diagnosis, without experiencing any symptoms of AIDS).

[196] There is currently much discussion concerning the guardianship rights of parents with HIV/AIDS and their ability to plan immediate guardianship placements for their children upon the parents' incapacity. *See infra* notes 214–17 and accompanying text.

[197] U.S. CONST. amend. IV.

[198] This doctrine has for the most part grown out of decisions involving searches and seizures in the criminal context, and has been extended to situations involving personal privacy. *See, e.g.*, Mapp v. Ohio, 367 U.S. 643, 660 (1961) ("[T]he right to be secure against rude invasions of privacy by state officers is . . . constitutional in origin."); Boyd v. United States, 116 U.S. 616, 630–32 (1886) ("[I]t is not the breaking of his doors, and the rummaging of his drawers, that

blood test for pregnant women is an unjustifiable invasion by the state.[199]

The general rule utilized to determine whether the Fourth Amendment is triggered was developed in *Katz v. United States*[200] and its progeny. It involves two questions: does the individual at issue have an expectation of privacy in this context, and is that expectation of privacy reasonable?[201] Clearly, a woman has an expectation of privacy in her body. This leaves the question of whether her expectation is reasonable in the context of pregnancy and her HIV infection.

As mentioned above, the government has on many occasions justified invasions of the body on the basis of protecting public health.[202] Perinatal HIV transmission, however, carries less risk than other diseases for which compulsory programs have been designed, and additional justification is therefore needed before Fourth Amendment interests can be infringed upon.

The Supreme Court has on several occasions confronted the question of whether forced blood tests were violative of the Fourth Amendment. In *Schmerber v. California*[203] and *Breithaupt v. Abram*,[204] the Supreme Court held that blood alcohol tests performed without a warrant or consent did not violate the Fourth Amendment.[205] In each

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constitutes the essence of the offence; but it is the invasion of his indefeasible right of personal security, personal liberty and private property . . . [that] is contrary to the principles of a free government . . . [and] is abhorrent to the instincts of an American. . . .").

Justice Brandeis's famous dissent in Olmstead v. United States underscores this point:

> The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man.

277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), *quoted in* Stanley v. Georgia, 394 U.S. 557, 564 (1969).

[199] A comprehensive discussion of the conflict between HIV testing and the Fourth Amendment right to privacy is beyond the scope of this article. I include here a only a short discussion of the issues involved.

For a decision indicating that nonconsensual HIV tests may not be justified without a warrant or exigent circumstances, see Barlow v. Ground, 943 F.2d 1132, 1137 (9th Cir. 1991).

[200] 389 U.S. 347 (1967).

[201] *Id.* at 361–62 (1967) (Harlan, J., concurring).

[202] *See supra* note 136 and accompanying text.

[203] 384 U.S. 757 (1966).

[204] 352 U.S. 432 (1957).

[205] *See Schmerber*, 384 U.S. at 767–68 (holding that a blood alcohol test constituted a search, but that it was permissible under the circumstances); *Breithaupt*, 352 U.S. at 439 (finding that a blood alcohol test of an unconscious person admitted to the hospital reeking of alcohol was acceptable and admissible).

of those cases, however, the Court recognized that there was some form of probable cause or exigent circumstances that justified the invasion.[206] This requirement for individualized suspicion or cause was buttressed by the holding in *Amalgamated Transit Union v. Suscy*.[207] The court in *Suscy* held that bus drivers had no reasonable expectation of privacy in their blood or urine, because drug and alcohol-related tests were performed only if the specific individual had been involved in an accident or if the Transit Authority suspected that the specific individual was under the influence of drugs or alcohol during work.[208]

There is no probable cause, individualized suspicion, or exigent circumstance that justifies testing every pregnant woman for HIV. Furthermore, as mentioned above, although the risks associated with perinatal HIV transmission are terrible, they are currently incurable, and thus cannot justify the invasion of a woman's right to privacy. Mandatory screening of all pregnant women for HIV would therefore violate women's Fourth Amendment rights and cannot be supported.

C. *Alternatives to Punitive Measures*

There are other means by which states could protect their interests in preventing the spread of AIDS, promoting family and fetal health, and diminishing the costs of AIDS. These means would not only be less restrictive of fundamental rights, but would also be more effective in accomplishing those goals. First, widespread voluntary educational, testing, and support systems should be set up so that women could learn more about HIV/AIDS and could be tested if they chose. Women testing positive should be informed about and assisted with the possible consequences of being infected with HIV. There is no proof that voluntary systems have been less effective than compulsory ones; in

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[206] *See Schmerber*, 384 U.S. at 769–70 (holding that when there is probable cause and exigent circumstances (as is the case with blood alcohol levels, which decrease over time), an invasion such as a blood alcohol test may be performed without a search warrant); *Breithaupt*, 352 U.S. at 439 (holding that the blood alcohol test on the unconscious defendant was not unreasonable because there was probable cause: officers noticed that the defendant's breath reeked of alcohol after he was involved in an automobile crash).

[207] 538 F.2d 1264 (7th Cir.), *cert. denied*, 429 U.S. 1029 (1976).

[208] *Suscy*, 538 F.2d at 1267. *But see* Shoemaker v. Handel, 795 F.2d 1136, 1143 (3d Cir.), *cert. denied*, 479 U.S. 986 (1986) (holding that *random* breathalyzer and urine tests performed by the New Jersey Racing Commission on jockeys were permissible, despite the fact that they constituted searches). The *Shoemaker* court held, however, that for random searches to be justified, there must be a "strong state interest in conducting an unannounced search," and "the pervasive regulation of the industry must have reduced the justifiable privacy expectation of the subject of the search." *Shoemaker*, 795 F.2d at 1142. Because these conditions are not satisfied in the case of HIV tests for all pregnant women, testing is not justified.

fact, looking back on lessons learned from Tay-Sachs disease and sickle-cell anemia, voluntary programs may be more effective under these circumstances. With preventative education and knowledge of the possibilities of transmission to a child, a woman with HIV/AIDS can weigh her options and decide whether the risks are too great.[209] With adequate support, a woman would seek care and treatment for herself and her child, rather than isolating herself out of fear that discovery of her condition would bring harmful legal or medical consequences.

The concern that a mother with HIV/AIDS might not be able to care for her children or might become unable to do so because of her own illness is also remediable in a less restrictive way. Before a state can deny an individual's reproductive autonomy, the state should have a clear sense of the minimum physical and mental capacity that an individual should have in order to parent.[210] Onora O'Neill has stated that an appropriate minimum standard for procreative autonomy may be "the ability to take care of the child *or to transfer the obligation to one who can fulfill it.*"[211] It seems apparent that not all women with HIV/AIDS would be found to lack that capacity.

> Under [Onora O'Neill's] formulation, a person utterly incapable of fulfilling rearing responsibilities would still have a right to bear and beget as long as there were a reasonable likelihood that he or she could transfer parental obligations to one who was fit to rear the child.[212]

Under this standard, the state could insure that a child would not be left without any care,[213] but a woman's right to procreate would remain intact.

Several states are legislating or considering means by which parents with HIV/AIDS could remain parents while capable, but ensure

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[209] The issue of whether federal funding should be made available to women who would choose to abort their fetus, but cannot afford to, is beyond the scope of this article.

[210] Robertson, *supra* note 115, at 411. Further, "[l]ack of physical capacity alone should not disqualify a person from exercising procreative choice." *Id.*

[211] *Id.* at 411 (citing Onora O'Neill, *Begetting, Bearing and Rearing, in* HAVING CHILDREN: PHILOSOPHICAL AND LEGAL REFLECTIONS ON PARENTHOOD 25 (1979)) (emphasis added).

[212] *Id.* at 412.

[213] Professor Robertson has also asserted that under O'Neill's formulation, even persons incapable of specifically designating other caretakers retain the right to reproduce. *Id.* He relies on the fact that the United States has in place social mechanisms for transferring parental responsibilities when a child is in need (i.e., guardian and foster care systems). *Id.* Robertson states that these social arrangements fulfill O'Neill's second condition of reasonable likelihood of transferring parental responsibilities. *Id.*

that their children would have appropriate guardians immediately upon their incapacity.[214] Under most current laws, parents can leave guardianship provisions in their wills, but these appointments are subject to lengthy review processes.[215] Children might therefore be left for several weeks or months without a guardian trusted and desired by the natural parent. Under standby guardianship provisions, parents with HIV/AIDS can nominate a guardian for their children and proceed with the approval process while they are still capable.[216] If a standby guardian is approved, the parent with HIV/AIDS may care for her children while she is able, while ensuring that her children will not be left alone upon her death or incapacity.[217]

IV. CONCLUSION

For too long, women have been subject to procedures and punishments in the name of protecting the potential for life within them. Decisions about whether to conceive, and whether to carry a pregnancy to term, can and should be left to the mother whenever possible. Such a conclusion only makes sense, considering that any action taken in the name of the fetus invariably involves the mother.

Women with HIV/AIDS are especially vulnerable to state reproductive control because they have the potential to bear "defective" offspring. As demonstrated, however, women's constitutional rights of liberty and privacy protect them from compulsory screening and prosecution for perinatal transmission of HIV. Such prosecutions would neither accomplish any legitimate governmental goals nor effectuate any rational public policy. In fact, these programs would result in clear harms and little, if any, benefit. For these reasons, states should not attempt to screen pregnant women for HIV, or extend child abuse,

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[214] *See In re* Estate of Two Minors, No. 1-93-1067, 1993 Ill. App. LEXIS 1498, at *7 (Ill. App. Ct. Sept. 30, 1993) (reversing refusal to grant standby guardianship and remanding for consideration in light of Illinois legislature's amendment of Probate Act to establish standby guardianship measures); *see also* Laura Duncan, *Standby-Guardian Ruling is Source of Hope for Parents, Advocates*, CHI. DAILY LAW BULL., Sept. 27, 1993, at 1. New York and Florida also permit standby guardian appointments. David Bailey, *Appeal of Standby Guardian Ruling Mooted*, CHI. DAILY LAW BULL., Feb. 2, 1993, at 1.

[215] *See* Laura Duncan, *Court Urged to Approve Standby Guardians for Children of AIDS*, CHI. DAILY LAW BULL., May 10, 1993, at 1 (discussing the current state of probate law in Illinois). Under the current system, parents with HIV/AIDS can also appoint a guardian for their children while they are still alive. *Id.* However, if the guardianship is granted, the parents must relinquish their own guardianship rights immediately, even if they are still capable. *Id.*

[216] Bailey, *supra* note 214.

[217] Duncan, *supra* note 214.

child neglect, or HIV transmission statutes to pregnant seropositive women. Instead, the government should work to accomplish the goals of fighting AIDS and promoting fetal and family health by offering voluntary educational, screening, and support programs; conducting more outreach into overlooked communities; and devoting more funds to the development of effective AIDS drugs and vaccines.