

When law and science part ways: the criminalization of breastfeeding by women living with HIV

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Abstract: Stigma and discrimination are a constant reality for the 37.7 million people living with human immunodeficiency virus (HIV) around the globe. Fear over vertical transmission has fuelled HIV criminalization: laws that target people living with HIV for acts deemed to be a transmission risk. Research has now shown that many of these behaviours, including breastfeeding, pose an extremely low risk of transmission when people have proper medical care, access to treatment and open relationships with medical professionals. Yet, we are witnessing a wave of criminal cases against women living with HIV for breastfeeding, an act which is actively promoted worldwide as the best infant feeding strategy. In this review, we will place the criminalization of breastfeeding within the context of current medical recommendations and cultural views of breastfeeding. We will highlight the criminal cases against women living with HIV for breastfeeding around the globe and the criteria for justifiable criminalization. Finally, we will provide recommendations for moving towards decriminalization, removing this barrier to HIV prevention, treatment and care.

Keywords: breastfeeding, criminalization, law, women living with HIV

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Introduction

Since the beginning of the HIV epidemic, the association of infection with sex and drugs has driven discrimination, stigma and even criminal prosecutions.^{1–5} Many HIV-specific laws and general criminal laws applied against people living with HIV allow prosecution of individuals living with HIV for acts that constitute no or very low transmission risk, including sex with condoms, and spitting at or biting another person.⁶ Since the first reported prosecution in 1986, HIV-related criminal cases have taken place in 81 countries.⁴ These laws have been discredited as a public health approach and are considered counterproductive in the efforts to mitigate the HIV epidemic.⁷

HIV criminalization has been used against women living with HIV who have breastfed or comfort nursed a child. Breastfeeding is actively promoted around the world as the best infant feeding strategy for both mothers and babies. As early as 1985,

it was confirmed that HIV could be transmitted through breastmilk.⁸ As a result, parents living with HIV experience a moral dilemma: reconciling the widespread message that breastfeeding is optimal for a child's development with the possibility of viral transmission through breastmilk.⁹ Women living with HIV experience surveillance, judgement and limitations on autonomy and decision-making in relation to childbearing and infant feeding.^{10–12} At least 12 women living with HIV have faced criminal prosecution in relation to breastfeeding or comfort nursing. Nine of these cases have taken place in Africa. In addition, women living with HIV have been threatened with punitive public health processes and child protection interventions for breastfeeding their children in multiple countries.¹³

There is limited awareness of the surveillance, judgement, punishment and criminal prosecution that women living with HIV experience postnatal.

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This article aims to draw attention to the criminalization of breastfeeding in the context of HIV infection. Here, we will review the literature on transmission risks during breastfeeding and the impact of antiretroviral treatment (ART) on mitigating that risk. We will present a global review of criminal cases against women living with HIV for breastfeeding and the national policies, which enable these prosecutions. We will evaluate whether breastfeeding by people living with HIV meets the criteria for justifiable criminalization. Finally, this article will propose actions required to reverse this wave of criminalization.

Global attitudes towards breastfeeding

Breastfeeding is actively promoted around the world as the best infant feeding approach for both mothers and babies. There is a wealth of data demonstrating that breastfeeding is a significant protector against infectious disease and provides better nutritional outcomes than the alternatives.^{14–19} UNICEF and WHO officially recommend exclusive breastfeeding for 6 months, followed by complementary foods with continued breastfeeding for up to 2 years of age or beyond.²⁰ Globally, 95% of babies will receive breastmilk²⁰ and 41% of infants are exclusively breastfed for the first 6 months of life.²¹ The highest rates of exclusive breastfeeding were found in Rwanda (86.9%), Burundi (82.3%), Sri Lanka (82%), Solomon Islands (76.2%) and Vanuatu (72.6%).²²

The decision to breastfeed is influenced by various factors: personal choice, health considerations, cultural expectations and socioeconomic status. In low-income countries, where poverty, food scarcity and poorer sanitation amplify infant mortality and morbidity risks, we see greater advocacy for breastfeeding. In low- and middle-income countries, just 4% of infants are never breastfed, as compared with 21% in high-income countries.²⁰ Those who do not breastfeed are for the most part from wealthier households.²⁰ In addition, the length of time for which a mother continues to breastfeed varies substantially by the wealth status of the household. In low- and middle-income countries, among the poorest families, almost 64% of babies are still breastfed at age two, compared with only 41% among the richest families.²⁰

It is important to note that although most of the relevant policy guidelines and literature are

focused on mothers and their biological children, mothers are not the only people who breastfeed. Transgender men and non-binary parents may ‘chestfeed’ their infants.²³ Non-biological parents can initiate lactation.²⁴ Moreover, wet-nurses, relatives and other care providers can breastfeed or provide expressed breastmilk to non-biological infants/children (sometimes referred to as ‘third party breastfeeding’ or ‘cross-feeding’), with or without the knowledge of the parents.²⁵ Breastmilk banks are increasingly available where donated breastmilk can be distributed to parents in need. Furthermore, not all infant-breast latching results in the provision of breastmilk: parents and caregivers may engage in comfort nursing whereby the child is put to the breast for the purpose of soothing, as opposed to for feeding.

International organizations promote exclusive breastfeeding broadly. The message most mothers receive is resoundingly clear: breast is best.

HIV transmission via breastmilk

The choice to breastfeed is more complicated for parents living with HIV. It is estimated that 1.3 million women with HIV become pregnant each year.²⁶ Vertical transmission of HIV can occur during pregnancy, labour, delivery or breastfeeding. The first recorded incidence of transmission via breastmilk occurred in 1985.^{27,28} It was later shown that the risk of HIV transmission through breastfeeding was approximately 15%.^{29,30}

Vertical transmission of HIV has drastically decreased with the use of ART. ART is used to manage HIV in people living with HIV and prevents onward transmission of the virus.³¹ The preventive benefit of treatment was documented first with respect to transmission during pregnancy, labour and delivery.³² A systematic review found that, in the presence of maternal ART, the pooled rate of postnatal HIV transmission was 1.1% by 6 months of age and 3.0% at 12 months.³³ The PROMISE study, conducted in Africa and India, reported that ART reduced the postnatal HIV transmission rate to 0.57%.³⁴ More recently, a Tanzanian study found no vertical HIV transmission through breastfeeding among women who were engaged in care and had a suppressed viral load.³⁵ No large-scale studies have been conducted in high-income countries to determine the risk of transmission through breastfeeding.

The scientific literature provides strong evidence that, in the presence of ART, the risk of transmission of HIV through breastmilk is very low. Parents living with HIV who want to breastfeed could reasonably decide that the health benefits of breastmilk outweigh the risk.³⁶ In line with this, the official WHO guidelines on HIV and infant feeding recommend that mothers living with HIV should exclusively breastfeed for the first 6 months of life and may continue breastfeeding for up to 24 months or longer while being fully supported for ART adherence, or exclusively formula feed where there is safe access to formula. It is increasingly acknowledged that some parents living with HIV choose to breastfeed, even where formula is available.^{37–41}

History of HIV criminalization

Myths and misconceptions about HIV transmission have fuelled HIV criminalization in all regions of the world.⁴² In 48 countries, non-HIV-specific laws (e.g. sexual assault, bodily harm, attempted murder and public health orders) have been applied to people based on their HIV-positive status⁴² while 82 countries currently have HIV-specific laws in place. Since the first reported prosecution in 1986, HIV-related criminal cases have taken place in 81 countries.⁴ Many HIV criminalization laws allow prosecution for acts that constitute no or very little actual risk including vaginal-penile sex while wearing a condom,⁶ oral sex,⁶ a single act of breastfeeding,⁴³ spitting at another person⁶ or biting another person.⁶

Criminalizing not revealing one's HIV-positive status to a sexual partner (i.e. non-disclosure), HIV exposure and HIV transmission has been discredited as a public health approach.⁷ At the international level, ending HIV criminalization has been recognized as critical to an effective HIV response. *Global AIDS Strategy (2021–2026)* aims to have less than 10% of countries with HIV-related criminal laws by 2025.⁴⁴ In the 2021 *Political Declaration on HIV and AIDS*, governments committed to reviewing and reforming laws related to HIV non-disclosure, exposure and transmission to meet the Strategy target.⁴⁴

Criminalization of breastfeeding by HIV-positive women

Given the history of HIV criminalization, it is unsurprising that women living with HIV have

faced prosecution for breastfeeding. We have conducted a global review of court judgements using the Global HIV Criminalization Database, Lexis Library, Westlaw, JustisOne, BAILII, CanLII, AustLII, SAFLII and CommonLII. Using these data, in conjunction with the authors' global institutional, civil and academic partners as information sources, we present an overview of the 12 known cases where women living with HIV were criminally prosecuted for breastfeeding or comfort nursing. Nine of these cases took place in East or Southern Africa and, at the time of this publication, at least three cases are still ongoing.

1. *Canada, 2005*. A mother faced criminal charges for not disclosing her HIV-positive status to hospital staff when she gave birth. She was originally charged with aggravated assault and ultimately convicted of failure to provide the necessities of life (*Criminal Code*, Section 215). The charges were justified on the grounds that the child could not receive antiretroviral therapy immediately (which may have prevented the seroconversion) and they may have been exposed to HIV through breastfeeding. Canada does not have an HIV-specific law but has applied various criminal provisions of general application to HIV non-disclosure or exposure-related offences, or both.
2. *Austria, 2010*. A woman described as an HIV denialist was convicted for not following medical advice regarding the delivery, medication and feeding of her infant.⁴⁵ She was given a 10-month suspended sentence, which she appealed.
3. *Botswana, 2013*. A 39-year-old woman was arrested on charges of common nuisance for allegedly breastfeeding a neighbour's 14-month-old baby without the parent's consent.^{46,47} The mother alleged that the neighbour snatched the child and took it to her rented room. The child's initial HIV test came back negative. A second test was to be done, and it was reported that if it came back positive, charges would be raised to 'deliberately infecting another person with HIV'.

This woman would have been charged under the Botswana *Public Health Act*. Under Section 116, legal action can be taken against a person who is aware of their HIV status and fails to 'take all

reasonable measures and precautions to prevent the transmission of HIV to others' or places 'another person at risk of becoming infected with HIV'. Section 58 of the Act also criminalizes 'wilful exposure of another to a communicable disease without taking proper precautions against spreading the disease'. 'Proper precautions' are not defined.

4. *Malawi, 2016*. A woman living with HIV had attended a village meeting with her youngest child who was then 11 months old. Another woman asked her to hold a young child. It was alleged that the child latched on briefly. The mother went to the police, and the woman was arrested. She was sentenced to 9 months' imprisonment with hard labour.⁴³ She was convicted of negligently and recklessly doing an act 'likely to spread the infection of any disease which is dangerous to life' under Section 192 of the *Penal Code*. Malawi is one of the few countries in sub-Saharan Africa without an HIV-specific criminal law.⁴⁸ Justice Zione Ntamba overturned the conviction, noting that the woman did not know or believe that breastfeeding was likely to transmit HIV, the breastfeeding of another's child was accidental, and the child did not contract HIV.
5. *Uganda, 2018*. A 20-year-old domestic worker was charged for allegedly breastfeeding her employer's 9-month-old baby, knowing that she was living with HIV. She was remanded to prison while awaiting trial. She was charged under Uganda's *HIV and AIDS Prevention and Control Act of 2014* which includes two HIV criminalization provisions: Section 41, 'attempted transmission of HIV', and Section 43, 'intentional transmission of HIV'. Section 41 states that a person who attempts to transmit HIV is guilty of an offence punishable by a fine or 5 years' imprisonment, or both.⁴⁹

The Uganda Network on Law, Ethics and HIV/AIDS (UGANET), on behalf of a coalition of 50 civil society organizations, is challenging the Act which they allege is discriminatory and an impediment to the fight against HIV. As of the time of publication, the case remains before the court.⁵⁰

6. *Kenya, 2018*. A 29-year-old woman was charged for allegedly transmitting HIV to the 9-month-old in her care. The woman was a friend of the mother. The mother was not aware of the caregiver's HIV-positive status. Media reported that the baby's preliminary test results indicated that they had contracted HIV. The caregiver was charged under Kenya's *Sexual Offences Act* which includes sections on disease transmission which specifically name HIV 'and other life threatening sexually transmitted disease', making it illegal for a person who knows they have HIV to intentionally, knowingly and wilfully do anything, or permit anything to be done, which they should reasonably know is likely to transmit HIV [Section 26(1)].⁵¹ This section, erroneously titled 'deliberate transmission of HIV or any other life threatening sexually transmitted disease', does not require HIV transmission or for an accused to have an intention to transmit HIV.

In March 2018, the Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN), alongside six petitioners, is challenging the constitutionality of Section 26 of the *Sexual Offences Act*. As of the time of publication, the case remains before the court.⁵¹

7. *Kenya, 2019*. A woman living with HIV was investigated for allegedly breastfeeding the child she was employed to care for while the child's mother was away for work. There were CCTV cameras in the house that were connected to the mother's phone. The mother said that while at work she checked her phone and was surprised to see the caregiver breastfeeding her child. The caregiver was charged under Kenya's *Sexual Offences Act*.⁵¹
8. *Zambia, 2019*. Police arrested a 29-year-old domestic worker for allegedly breastfeeding her employer's 1-month-old baby, charging her with performing a negligent act likely to spread infection. Reportedly, she tested HIV-positive, and the infant tested negative.^{43,52} In Zambia, people living with HIV can be prosecuted through laws contained in the *Penal Code Act* and the *Anti-Gender-Based Violence Act, 2010*, as well as the *Public Health Act*.⁵³

9. *Russia, 2019.* A 44-year-old woman living with HIV gave birth in Russia. According to the mother, she had been diagnosed with HIV years earlier, but received no pre- or post-test counselling, HIV-related support or treatment. During the more recent pregnancy, she was not counselled on the risk of HIV transmission to the child. The baby was taken from the maternity hospital to an orphanage by the guardianship authorities, she was deprived of her parental rights, and she was charged under Article 122 of the *Criminal Code* – ‘knowingly placing another person in danger of contracting HIV infection’ – for breastfeeding the infant.⁵⁴ Social and psychological support was provided to the mother by a local women’s organization and she began ART. The criminal case against her was dropped, at least in part due to expert psychological evidence that she had been in denial of her HIV diagnosis.⁵⁵ Her parental rights were restored.
10. *Uganda, 2019.* A 23-year-old woman was charged for breastfeeding a relative’s child. She contended that she was not fully dressed and the child reached for her breast. She had never had a child herself. She was charged under Uganda’s *HIV and AIDS Prevention and Control Act of 2014*.⁵⁶
11. *Kenya, 2020.* A 20-year-old domestic worker was prosecuted for allegedly exposing her employer’s 2-year-old son to HIV through breastfeeding.⁵⁷ She was charged with deliberately infecting the child with HIV under Kenya’s *Sexual Offences Act*.
12. *Zimbabwe, 2020.* A 23-year-old woman was accused of deliberately infecting her friend’s 10-month-old son after breastfeeding the baby when he cried. The woman was caring for the baby while the mother was away. She was initially charged with ill-treatment of a minor under the *Children’s Act*. The court dismissed the charges against her. Zimbabwe had an HIV-specific criminal law, included in the *Sexual Offences Act of 2001*,⁵⁸ amended in 2006 and then repealed in 2022. Section 79 prohibited any act that includes ‘a real risk or possibility’ of transmitting HIV. It could be applied to anyone who knows they have HIV or who realizes ‘there is a real risk or possibility’ they might have HIV.

Section 79 was repealed in March 2022 decriminalizing HIV exposure and transmission.⁵⁹

Mixed messages

People living with HIV are receiving mixed messages. On the one hand, the medical and scientific experts indicate that, with ART and reduced viral loads, the risk of HIV transmission via breastmilk is low. WHO and other agencies actively encourage breastfeeding for most women. Yet, the act of breastfeeding can lead to criminal prosecution.

Adding to the confusion, breastfeeding recommendations with respect to HIV vary by country. For example, in higher-income countries where infant formula is available and safe, parents living with HIV are counselled to avoid breastfeeding. In contrast, where infant formula may not be accessible or safe (e.g. due to unsafe drinking water for preparation or lack of refrigeration for storage), exclusive breastfeeding is recommended. These disparities are due to the need to balance the risk of HIV transmission against other causes of child mortality, such as diarrhoea, pneumonia and malnutrition. Some parents living with HIV have reported that the differing guidelines throughout the world are confusing and anxiety-producing, especially if they migrate to a country with different guidelines than those of their country of origin. Women also report fearing violence or rejection from family for not breastfeeding in cultures where breastfeeding is the norm and considered indicative of good mothering. In some contexts, bottle feeding may signal that a woman is living with HIV, which may also invite violence or rejection, or both, due to HIV-related stigma.^{10,38,60}

It is notable that the prosecutions that have taken place in Africa have all been against women living with HIV who allegedly breastfed or comfort nursed an infant that was not their own child. Another mixed message. Here, we have women who have been counselled by healthcare professionals that breastfeeding is the best choice for their own infants, in contexts where third party breastfeeding is not unheard of. Then, they face criminal prosecution for these same acts. This suggests that it is HIV-related stigma in combination with misinformation or irrational fear that motivates the legal intervention.

Criteria for valid criminalization

To determine whether breastfeeding in the context of HIV can legitimately constitute a criminal offence, we must consider the generally accepted criteria for criminality. Criminal legal systems are designed to provide redress for specific injuries, deter future harms, and punish and/or rehabilitate offenders, but a state's power to criminalize is not unlimited. There are long-standing international legal principles that govern appropriate criminalization.

The overarching principle of criminal law enforcement is that criminalization is the strongest expression of a state's power over its population and, as such, it should be the last resort.⁶¹ In addition, human rights law states that criminalization must meet specific criteria^{62,63}:

- (a) Legitimate aim or purpose – restrictions on liberty and other rights must be for a legitimate aim or purpose.
- (b) Legality – crimes must be defined by law in a manner that is accessible to the population.
- (c) Necessity – restriction of a person's human rights can only be justified when other less restrictive responses would be inadequate to achieve the legitimate purpose or aim.
- (d) Proportionality – restrictions must be proportionate to the legitimate aim.
- (e) Non-discrimination – criminal laws must be applied equally to everyone, without discrimination.

Breastfeeding by people living with HIV does not meet the criteria for criminalization

In advocating for law reform to eliminate unjust prosecutions of women living with HIV for breastfeeding or comfort nursing, stakeholders have a strong case because breastfeeding criminalization does not meet these international legal standards.

Legitimate aim or purpose

HIV transmission is viewed as an offence against a child's health and their future. The purpose of criminalizing breastfeeding by people living with HIV would be to reduce transmission through breastmilk. Yet as we have seen, for those who receive ART and adherence support, and maintain an undetectable viral load, the actual risk of

HIV transmission through breastfeeding is negligible. Furthermore, when we consider the whole health of the child and the many protective effects of breastfeeding on childhood morbidity and mortality, the question of risk becomes relative. Thus, HIV status alone cannot justify criminalization.

Moreover, fear of surveillance, disapproval and reporting may deter parents living with HIV from communicating honestly with their service providers (including nurses, social workers, doctors, midwives, pharmacists, peer support workers and counsellors), potentially putting their child at increased risk of acquiring HIV (e.g. due to mastitis, gut problems or viral load variation) or suffering other health problems. Contrary to the aim, criminalisation may increase transmission risk.

Legality

As we have seen in the cases discussed above, information regarding criminalization of breastfeeding in the context of HIV is not accessible nor widely understood. Most HIV-related laws are vague, failing to clearly communicate which behaviours are prohibited for those living with HIV. It is peculiar to apply provisions generally aimed at sexual behaviours to infant feeding.

In many cases, the information provided by medical professionals does not align with the language of criminal laws (e.g. doing something *likely* to transmit a disease) and guidelines vary between countries, further reducing understanding and accessibility. Contextualized knowledge of the factors relevant to HIV transmission risk through breastfeeding is not widespread.

Necessity

Education, access to ART and support for women living with HIV are effective means to reduce, even eliminate, HIV in infants, which negates the notion of necessity. From a 'last resort' perspective, the criminalization of breastfeeding is not justified. The aims can be achieved by more effective, less restrictive means.

It is difficult to assert that a prohibition is of necessity when it does not apply equally. Clinical guidelines differ depending on local circumstances and some healthcare providers support parents living with HIV who decide to breastfeed while others do not.

Proportionality

Any restrictions placed on personal liberty must be proportional to the risk of harm or to actual harm caused. The intent of the accused is also relevant to measuring the proportionality of the response (i.e. punishment is more justifiable if there is an intent to cause harm). Incarceration, the stigma of being criminalized and possible denial of parental rights are not proportionate responses to a single act of breastfeeding or comfort nursing by a person living with HIV. Arguably, even for long-duration breastfeeding, the risk of harm is too low to be proportional to applying the state's ultimate power.

Justification of a criminal prosecution would require a thorough assessment of relative risk. Factors including any counselling the accused had been given about HIV and breastfeeding, access to ART, viral load, duration of feeding, and any exacerbating factors such as breast and gut inflammation would need to be considered. Regional socioeconomic and cultural contexts, the availability and quality of health services, maternal and child nutrition, and infant and child mortality rates would also be relevant to the assessment of risk.

Non-discrimination

Those living with HIV already face significant stigma and persecution. Criminalization for breastfeeding fuels discrimination and reinforces stigma. Without a significant risk of harm, criminalization represents discrimination on the basis of HIV-positive status. Furthermore, criminalization would discriminate against those who lack access to alternative infant feeding strategies or to clean water and refrigeration to make formula-feeding a viable option. Victims of criminalization may already be in positions of significant vulnerability to an employer, spouse or extended family.

From a human rights perspective, respect for autonomy and for the sexual and reproductive rights of people living with HIV is fundamental. Placing unjustifiable limits on personal and parenting decisions of people living with HIV could violate international and domestic law.

What is being done to curb criminalization

It is clear that, in most cases, the criminalization of breastfeeding for women living with HIV is

unjustified. In response to ongoing prosecutions and the stigma, misinformation, and anxiety these laws produce, community groups are mobilizing in various parts of the world to stop prosecutions and convictions, and to repeal the criminal laws.

Awareness-raising regarding the prosecutions and evolving clinical practice with respect to HIV and breastfeeding is the first step. Organizations such as US-based The Well Project, the global International Community of Women Living with HIV (ICW) and its regional affiliates, the HIV Justice Network, the AIDS and Rights Alliance of Southern Africa (ARASA) and the Eurasian Women's AIDS Network (EWNA) have been sharing information at conferences, through webinars and online events, and in publications.

Second, legal and community HIV organizations try to ensure that anyone living with HIV who faces prosecution in relation to breastfeeding has a fulsome legal defence and that accurate scientific and human rights evidence is put before the courts.⁴³

Finally, networks of people living with HIV and various legal and community organizations are advocating for law reform and challenging HIV criminalization statutes in the courts of various countries.⁴

The role of clinicians in rectifying criminalization

The criminalization of HIV exposure or transmission (and associated allegations, arrests, trials and sentencing) occurs because actors within legislative and legal spheres accept that there is a significant HIV transmission risk and thus substantial harm with respect to activities including sex, breastfeeding, biting and spitting. As the experts in HIV prevention, transmission and treatment, health care providers and researchers have a critical role to play in the pursuit of justice.

Legal actors interpret medical information and scientific evidence through their own processes, narratives and understandings. Advocates and lawyers need to bring forward appropriate evidence with the assistance of expert witnesses who can contextualize the medical and scientific information for prosecutors and the court. Evidence in these cases may include health records, test results

(HIV status and viral load) and scientific literature. Expert witnesses may be asked to provide an affidavit or testimony, or both, to the court. There is a pressing need for clinicians with knowledge of HIV, pregnancy and breastfeeding to take an active role in investigations and trials related to breastfeeding.

Clinicians can also help their patients avoid prosecution by ensuring they receive accurate and comprehensive information regarding their legal obligations and infant feeding options. Recording this counselling and any referrals made in medical files can help to demonstrate that a person behaved reasonably and should not be prosecuted. Knowledge of their responsibilities and options also provides patients an opportunity to seek legal advice in advance of legal problems.

Finally, policymakers look to clinicians and health practitioners for research and advice on how best to achieve their goals with respect to HIV. They can use this privileged position to advocate against the criminalization of people living with HIV and advance evidence-based, rights-promoting policies.

Conclusion

Over the past 2 decades, a consensus has been emerging at the international level and among people living with HIV and their advocates, that criminalizing not revealing one's HIV-positive status, exposure or transmission in sexual circumstances is not proportionate, fair or helpful in terms of public health.⁴⁴ This consensus has emerged in large part because of the developing science of HIV transmission risk during sexual encounters. As we have come to understand the actual risk of HIV transmission and the preventive effects of ART, employing the heavy hand of the law seems illogical. HIV criminalization threatens the health and well-being of people living with HIV and jeopardizes the goals of ending HIV discrimination and, ultimately, the epidemic. Not only do punitive laws targeting people living with HIV lack a scientific evidence base, they perpetuate stigma and serve as barriers to HIV prevention, treatment and care.

The emerging evidence on HIV transmission through breastfeeding supports the same conclusion: the criminalization of breastfeeding by

people living with HIV is unjustified. Yet, we are witnessing a wave of criminal prosecutions, particularly in Africa. Legal mechanisms are being mobilized to punish and shame rather than protect human rights. In these circumstances, gains in health research have not been translated into gains for women's rights and children's well-being. Science supports that the best outcomes for a mother and a child result from proper medical care, access to treatment and openness. The law should too.

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Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Author contributions

Alison Symington: Conceptualization; Data curation; Formal analysis; Writing – original draft.

Nyasha Chingore-Munazvo: Conceptualization; Data curation; Formal analysis; Writing – review & editing.

Svitlana Moroz: Data curation; Formal analysis; Writing – review & editing.

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