USC Law and Global Health Working Group - Meeting Notes
March 9th, 2015
12:30pm-1:30pm PST

Participants

Alex Capron, David Cruz, Laura Ferguson, Sofia Gruskin, Ian Henry, Shubha Kumar, LaVonna Lewis, Doe Mayer, Alexandra Nicholson, Alison Renteln, Yaneth Rodriguez, Neeraj Sood

Meeting Summary

This was the third meeting of the Law and Global Health working group. The meeting began with a brief summary of the two prior meetings, which started to explore our varied understandings of the intersections of law and global health, established that there was logic to meeting, and demonstrated that there is excitement from various parts of the University about the potential of the group.

The purpose of this meeting was to try to use one topic—criminalization of HIV transmission—to learn the similarities and differences in our approaches to working at the intersection of law and global heath. Laura Ferguson and Neeraj Sood were gracious enough to begin this process with roughly ten-minute presentations of some of their respective work on this topic. They addressed the following questions with informal presentations:

1. What is your starting point for doing this work?
2. What is your outcome of interest?
3. What is the theoretical framework employed?
4. What counts as evidence?
5. What is the population of interest?
6. In what way(s) would you consider public health of importance to how you would frame your research?
7. In what way(s) would you consider law of importance to how you would frame your research?
8. Can you expand on the importance (or not) of considering the interaction of public health and law for the work you did?
9. Can you reflect on the generalizability of your approach and findings?

Participants were encouraged to go beyond the topical focus of the presentations in how they listened, and to consider how each helped clarify larger questions about work across disciplines on research questions at the intersection of law and global health.

Presentation from Neeraj Sood, PhD

Dr. Sood began by discussing how he thinks of outcomes. As a health economist, he is interested in the impact of a given policy on social welfare. By social welfare, he explained that he means the welfare of everyone in society: lawyers, doctors, HIV positive people, HIV negative people, etc., and everything they enjoy. Given that this is a nebulous topic, how does he approach whether a policy is good, bad, etc.? Generally, policy is made through government intervention—and a basic economic principle supports government intervention when there is market failure (or where welfare would be enhanced by intervention). To that end, he asked what would be a market failure here? HIV?

Addressing the key area of interest, Dr. Sood suggested looking at the impact of policies on reducing risky sexual behavior. He noted that when people think about sex, they are generally thinking about themselves, not society as a whole. The theoretical framework employed is neoclassical economics, and thus Dr. Sood is interested in how a policy alters incentives. Does the policy increase the cost of risky sexual behavior? At a basic level, if it does increase the cost, will there be less risky sexual behavior?

Regarding HIV, he suggested that a law criminalizing transmission could be seen like a tax on being HIV positive—will this decrease risk-taking behavior? An initial look would suggest that it does, but on further examination, such laws may have the opposite effect resulting in people wishing to hide their status, so there are competing incentives. There is also the potential effect of social stigma, and the impact stigma can have on behavior both when such a law is in place and when it is not.

To really address this question, Dr. Sood highlighted the need for hard data and stressed the importance of population level data, including, to the extent possible, data on risk taking behavior at a population level. He also highlighted a concern about causation: there may be so many different things impacting risk behaviors in addition to a law on criminalization.
Part of Dr. Sood's intervention focused on what counts as good evidence, and he gave examples both from Malawi and the United States to illustrate the complexities in determining a causal chain between changes in law and changes in risk taking behavior. Regarding the intersection of public health and law as it relates to criminalization of HIV transmission, to date his interest in law has only been at the most general level, without attention to the specifics of the content of the law or its implementation.

Presentation from Laura Ferguson, PhD

Dr. Ferguson described her entry point as public health. Her particular outcome interest for the purpose of this conversation was the uptake of HIV services, testing, prevention, care, and treatment. Regarding criminalization of HIV, based on evidence collected through other work the basic premise is that a punitive legal environment constitutes a barrier to the uptake of these services. If a person knows that HIV transmission is criminalized, they may not go and get tested, for fear of questions, etc. From an epidemiological perspective, HIV epidemics are largely driven by undiagnosed and untreated people, so any barrier to treatment and diagnosis is a bad start.

As for population of interest, Dr. Ferguson deals with the general population, and most of the countries in which she works have high prevalence of HIV. However even within that, certain groups are more affected than others. Barriers to accessing services are particularly common for men who have sex with men and sex workers, based largely on discrimination against those groups. Criminalization of transmission in this context is just one more reason to stay away from services.

So with public health as the entry point and outcome of interest, why is Dr. Ferguson interested in law? One reason as she noted is that it can shape health outcomes, and it is key that this is documented. This approach includes understanding the importance of the specificity of the law: when we talk about criminalization of transmission, what is actually being criminalized? Intentional transmission in all contexts? Mother-to-child transmission (MTCT)? Looking at specific laws, there is a law from Sierra Leone that states that anyone living with HIV must take all reasonable precautions and measures to prevent transmission. What is a reasonable precaution and measure? What does this mean in a country where a woman can't refuse a husband's request

for sex, and there are no marital rape laws? Further, what about criminalizing exposure that doesn't result in transmission? In Bermuda, any kind of sexual contact in which bodily fluids might pass is criminalized, and at least two people have received ten-year sentences under this law.

The nuance of the law matters, as does the impact that this range of laws has on health behaviors and outcomes. Moving beyond content, it is critical to think about how laws are applied. Dr. Ferguson highlighted that there is a strong evidence base to suggest that problems created by criminalization are very real, including country reports, legal environment assessments, key informant interviews, etc. Regarding economic considerations, Dr. Ferguson noted that to determine if one individual did or did not infect another phylogenetic testing is required. There are two labs in the United States that can do this. The cost of the test is $25,000 USD. By comparison, this would put 250 people on antiretrovirals for *a full year* in some countries in SSA.

Group Discussion and Conclusions

The floor was then opened for questions and discussion. Participants first noted the complementary nature of the presentations. Both Dr. Ferguson and Dr. Sood made similar points regarding criminalization and concerns about stigma, but from distinct disciplines and using very different approaches and language.

Participants asked a few clarifying questions, including the nature of risk-taking behavior as a market failure or negative externality according to Dr. Sood. Participants discussed how this may be especially applicable where there is unequal bargaining power, and that intervention may be an appropriate way to correct this unequal bargaining power.

Participants also noted further congruence in the approaches discussed. Both approaches are concerned with the incentives and behaviors created by criminalizing HIV transmission, and both find HIV-related stigma to have very real consequences on health and well-being, and pay attention to the unintended consequences of laws criminalizing transmission.

Participants also noted many very successful campaigns that engage more than one form of media, and have rich data in terms of documenting change.

Participants then expanded on the "what counts as evidence" question. All agreed that it is important to look for empirical answers to questions posed, rather than simply stating, for example, that the law is a bad law simply because it is apparently discriminatory on its face regardless of how it is applied. Participants noted the complexities in making such a determination, using the current example to stimulate discussion. For example, risk-taking behavior may be severely underreported, especially if there is an imposed tax or jail-time, so how does one get a full picture of empirical evidence? Even where there isn't criminalization of sexual activity or status there is often discrimination, but how is that assessed? Can comparative work be useful here?

Participants noted the obvious compatibility of the approaches presented and the potential strength of approaching the same research question from two such distinct points of departure. Different theoretical frameworks shape research questions in distinct ways, and that point is clearly made here: both engaged the intersection of law and public health, but in very different ways. That said, however they are described, unintended consequences--not what we think will happen but what else may happen—were seen as critical to any work at the intersection of law and global health.

Participants noted the value of the conversation, and discussed possibilities for the next meeting. The topical area sparked much discussion, and given the one-hour time frame of these meetings, participants suggested that more time be given at the next meeting to allow substantive issues to be raised around the topic discussed while still ensuring time for the more general discussion as to the implications for working together in the future.

Several proposals were made as to how to move forward. Participants agreed another meeting should be organized in the near future.

As a final note, we wish to again thank Dr. Sood and Dr. Ferguson for their time and willingness to help jumpstart this conversation. We very much look forward to continuing the momentum of this group!

Action Items

- For those that have not done so, please fill out the Law and Global Health Working Group matrix
- Save April 14th 12:30 to 1:30 for the next Working Group meeting