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# Controlling Sex in the Name of “Public Health”: Social Control and Michigan HIV Law

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*In the state of Michigan, people infected with HIV are required by law to disclose their HIV-positive status to their sexual partners. Michigan public health laws enacted in the 1980s provide guidance for health officials tasked with investigating and managing what are termed “health threat to others” cases. Based on interviews with local health officials responsible for managing “health-threat” cases, I argue that the surveillance strategies employed by officials to identify these cases can be understood as an important site of social control. The first, “formal” technique for controlling HIV-positive residents involves health officials in a minority of participating jurisdictions actively cross-referencing epidemiological surveillance technologies such as HIV testing and contact tracing in order to identify potential health-threat cases. The second, “informal” technique is characterized by “third party” phone reports received by health officials from local residents who accuse others in their community, who they suspect are HIV positive, of not disclosing. Through an original analysis of the strategies employed by health officials to control HIV-positive residents, this article brings the theoretical insights of the sociological literature on social control to bear on the field of public health. Keywords: social control; HIV/AIDS; medical sociology; public health; law.*

During a general panic about the potential for AIDS to spread from “high-risk” minority groups to the “general population” in the late 1980s, Michigan legislators enacted a set of laws collectively referred to as “health threat to others” law that requires HIV-positive individuals to disclose their status to their partners before engaging in any form of sexual contact. Included in Michigan’s health-threat legislative package is a felony disclosure statute that makes it a crime punishable by up to four years in prison for HIV-positive people to have sex without disclosing. Like many of the 32 states that have enacted such statutes, Michigan law does not require proof of malicious intent, nor do they require evidence that the sexual practices alleged pose any risk of transmitting the virus (Center for HIV Law & Policy 2011; Galletly and Pinkerton 2006; Wolf and Vezina 2004). In addition, the broader health-threat law allows for labeling offenders “health threats” and ordering that they undergo forced testing, counseling, and/or that they be remanded for quarantine.

Recent reports suggest that over a thousand HIV-positive Americans have been criminally prosecuted for not disclosing to their partners (Bernard and Nyambe 2012). Health scholars have criticized criminal disclosure laws, arguing that they may disincentivize HIV testing by inadvertently turning an HIV-positive test result into a potential legal liability—those who haven’t been tested and thus diagnosed as HIV positive cannot be prosecuted under these statutes (Galletly and Pinkerton 2006). Yet, beyond limited studies in public health and a handful of sociological case

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studies (Shevory 2004), we know little about how these laws are enforced or the sociological implications of their application.

In this article, I report findings from a study involving 25 local health officials who are responsible for managing health-threat cases from 14 health jurisdictions in Michigan. Qualitative, in-depth interviews with these officials reveal two primary techniques of identifying health-threat cases that I argue can be usefully conceptualized as informal and formal forms of social control. In what follows, I first provide an overview of the literature on the social control of public health. While sociological approaches to medical social control have typically examined the practices, forms of authority, and discourses of conventional medicine, I instead bring the insights of the literature on social control to bear on the field of public health. Although medicine and public health have similar aims, I argue that their contrasting orientations towards prevention (public health) and treatment (medicine) have important implications for their strategies of social control. In the second section, I survey the literature on the legal regulation of HIV disclosure. This article builds on its insights by analyzing how public health enforces a broader set of health-threat legal statutes by means that go beyond criminal sanctions. In the third section, I provide background on the history of sexual contact tracing and HIV testing in the United States.

In the fourth and fifth sections, I report findings from my research. I analyze the formal and informal strategies of social control that were described by participants. The first, “formal” strategy for social control is evidenced by reports from health officials in five jurisdictions who described harnessing epidemiological surveillance technologies, such as Partner Services and HIV testing, for legal surveillance. This strategy typically involved asking a client newly diagnosed with a reportable sexually transmitted infection (including HIV but also other infections such as chlamydia) to report the names of their previous sexual partners as well as whether any of those named partners had disclosed that they were HIV positive before sex. Officials would then check the list of named partners against the state’s database that includes anyone ever diagnosed as HIV positive in Michigan in order to identify potential health-threat cases. As I show, the formal techniques for controlling health-threat cases described by health officials often rely on misguided assumptions about sexual practices and HIV risk. Moreover, the application of those techniques reveals vast differences in how officials interpret the law, with some officials conflating not disclosing with engaging in unprotected sex.

The second, “informal” strategy for social control is evidenced by reports from health officials in five jurisdictions who describe receiving a large volume of “third party phone reports” in which local residents accuse others in the community of not disclosing their supposed HIV-positive status to their sexual partners. I argue that these patterned phone calls are suggestive of local gossip cultures fueled by gendered and raced forms of social stigma. Moreover, although the kind of disclosure practiced by community members through gossip is not encouraged by the state’s HIV disclosure law, I argue that these practices reflect underlying assumptions about risk and informed consent similar to those encoded in the law.

## Literature Review and Background

### *The Social Control of Public Health*

This article attempts to bridge two sometimes-disparate traditions in the sociological literature on social control. First, it is framed by the work of medical sociologists who have analyzed how medical knowledge, authority, and technologies come to be an important site of social control. This literature can be traced back to Talcott Parsons’s (1951) novel work on the “sick role” in which he conceptualized illness as form of deviance and medicine as the appropriate resulting form of social control. With a more critical eye towards medicine, Peter Conrad (1979, 1992) argued that medical social control should be understood as having four critical components: medical ideology (the imposition of a medical model as a result of increased influence by medical

authorities); collaboration (the role of doctors as information providers or "gatekeepers" of knowledge); technology (the use of medical technological innovations such as genetic screening); and, based on the work of Michel Foucault (1973, 1977), surveillance (including how the "medical gaze" becomes internalized).

Building on these important pioneering insights and the work of other medical sociologists who have revealed much about how medical institutions and practice operate as sites of social control, this article attempts to bring these critical insights to bear on the field of public health. I argue that public health differs in important ways from more traditional forms of medicine and medical authority. For instance, the Association of Schools of Public Health distinguishes the field of public health from that of "clinical professionals" by its focus on *prevention* rather than *treatment*:

Public health professionals try to prevent problems from happening or re-occurring through implementing educational programs, developing policies, administering services, regulating health systems and some health professions, and conducting research, in contrast to clinical professionals, such as doctors and nurses, who focus primarily on treating individuals after they become sick or injured (Association of Schools of Public Health n.d.).

While this heuristic distinction between treatment and prevention can become blurry in practice,<sup>1</sup> I argue that there are important differences in how public health produces social control as compared to traditional institutions of medicine. This difference is in part due to the fact that public health aims to prevent illness, which requires a different set of strategies for social control and thus a different set of sociological tools for analysis.

To say that public health is a site of social control is, admittedly, not altogether novel. Indeed, within the social sciences, historians of medicine and medical anthropologists have both developed rich, critical traditions analyzing the efforts of public health to control communities. For example, historians have shown how venereal disease control campaigns in the early twentieth century (Davidson 2000; Holloway 2006), as well as psychiatry and mental hospitals (Foucault 1973; Jackson 2005; Sadowsky 1999), operate as institutions of social control. Anthropologists have a similarly rich tradition critical of public health; for example, scholars have criticized the way that stigmatizing, American epidemiological concepts such as the "bisexual bridge" have been problematically mapped on to HIV epidemics in Latin American and Caribbean countries where the word "bisexual" may not even exist (Carrillo 2003; Padilla 2007). However, while sociologists such as Alan Peterson and Deborah Lupton (1997) have theorized how public health can become an important site of moral regulation, there is not yet a rich empirical knowledge base in sociology documenting the various forms that social control can take in public health practice.

### *Informal and Formal Social Control*

In order to bring greater specificity to a concept that has been invoked to refer to very different kinds of social processes (for an overview, see Janowitz 1975; Meier 1982), I rely on a distinction in the criminology literature between "formal" and "informal" modes of social control. For the purposes of this article, when I speak of formal social control, I refer to the regulation, surveillance, and control of individuals and their behaviors by institutions of authority and officials who represent them. I am putting in conversation the concept of "formal" social control that comes out of the criminology literature with the previously described concept of medical social control outlined by Conrad (1992). In this article, I draw on Conrad's (1992) focus on technology and surveillance in particular to analyze the use of epidemiological surveillance technologies by health officials for formal social control.

1. For instance, advocates arguing for the rapid scale-up of antiretrovirals to treat HIV infection in developing nations recently framed the need to provide HIV-positive people access to lifesaving treatments as an indirect but effective way to prevent future infections. Because these medications dramatically reduce or even eliminate the amount of virus in patients' bodily fluids, patients treated with antiretrovirals are less likely to transmit the virus to others. Thus, "treatment as prevention" has become a slogan of many treatment activists, blurring the lines between these two conceptual approaches to health.

When I speak of informal social control,<sup>2</sup> I refer to the ways community members monitor, police, and control each other. Notably, I am drawing on the concept developed by sociologists and policy scholars—"what ordinary citizens do to keep where they live free from crime and disorder" (Carr 2003:1249). This literature is often in conversation with "broken windows theory," which postulates that decaying neighborhood conditions lead to social disorder and crime (Wilson and Kelling 1982). However, while informal social control is sometimes defined positively as a force promoting social order (Carr 2003; Sampson, Raudenbush, and Earls 1997), I argue that it does not necessarily yield laudable social outcomes.

In framing this article around both formal and informal kinds of social control, I aim to highlight the need for a critical sociology of public health. While social work scholars have analyzed how institutions such as homeless shelters (Pitts 1996), battered women's shelters (Murray 1988), and welfare programs in general (Piven and Cloward 1971) operate as sites of social control, public health scholarship is generally uncritical of the role public health institutions play in producing and organizing social control. For instance, while various studies have attempted to examine the role that social stigma plays in structuring the HIV epidemic (Herek 1999; Sayles et al. 2009) the literature rarely acknowledges the role public health may play in producing stigma and the deleterious consequences that flow from it. While this article is not primarily about stigma, I argue that the techniques of social control described and facilitated by public health officials are both informed by and reproduce social stigma.

### *HIV Disclosure and Health-Threat Policies in the United States*

Michigan's health-threat legislative package legally codifies the various steps health officials must follow in handling cases involving "an individual who is a carrier [and] has demonstrated an inability or unwillingness to conduct himself or herself in such a manner as not place others at risk of exposure to a serious communicable disease or infection" (Michigan Compiled Law Annotated § 333.5201). Once identified as a health threat, the offender must be served a "cease and desist warning notice." If health officials later suspect that the individual is not complying with the warning notice, they may request that the case be reviewed by a probate court where a judge can order a variety of interventions, including mandatory education; counseling and/or treatment programs; forced HIV testing; quarantine; and "any other order considered just by the circuit court" (Michigan Compiled Law Annotated § 333.5205). Because the state does not publicly release data on health-threat cases, it is not known precisely how many cases are pursued beyond warning notices.

The health-threat statute also includes a felony criminal provision that applies specifically and only to persons infected with HIV. It states:

A person who knows he or she has HIV, and who engages in sexual penetration with another person without informing that person of his or her HIV status, is guilty of a felony. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body; emission of semen is not required (Michigan Compiled Law Annotated § 14.15 [5210]).

While Michigan State Police records indicate that at least 68 criminal cases<sup>3</sup> have been initiated under the felony HIV disclosure statute between the first prosecution in 1992 and October

2. Readers may note that my usage is somewhat different from how medical sociologists such as Bosk (1979) have used the term to designate the kind of regulation produced through ordinary, everyday social interaction, such as physicians scolding medical residents. The literature in public policy also highlights social interaction in its approach to informal social control, but highlights instead how lay individuals police each other when authority figures are not around.

3. Michigan State Police data indicates there have been 49 convictions and 19 cases in which a defendant *with a prior criminal record* was either found not guilty or succeeded in having the charge dismissed. Records involving defendants who were not convicted *and who did not have a prior criminal record* are expunged, so the number of such cases is unknown. However, local news reports suggest they are few and far between.

2010,<sup>4</sup> what role health officials have played (if any) in initiating or facilitating these charges has not been described until now.

Yet, while 68 known cases have been brought against (allegedly) HIV-positive defendants for failing to disclose their *own* status, no evidence exists that suggests anyone has ever been charged for unlawfully revealing *another person's* HIV-positive status. Under Michigan law, it is illegal for an individual to disclose another person's HIV status without that person's express, written permission. The law requires that "All reports, records, and data . . . that are associated with the serious communicable diseases or infections of HIV infection . . . are confidential" and states that anyone who violates this statute is "guilty of a misdemeanor, punishable by imprisonment for not more than 1 year or a fine of not more than \$5,000.00, or both, and is liable in a civil action" (Michigan Compiled Law Annotated § 333.5131). Even though this statute was enacted at the same time as the felony law requiring HIV-positive individuals to disclose to their sexual partners, I have not discovered any evidence to suggest that charges have ever been filed under its provisions.

Very little scholarship exists that examines the impact of noncriminal health-threat statutes and laws like them in other states. However, in a survey of all 50 state health departments, Ronald Bayer and Amy Fairchild-Carrino (1993) found that 24 states had either no policy in place for handling what they termed "recalcitrant" HIV-positive individuals (which the authors define as "those who knowingly persisted in exposing others to HIV" [p. 1471]) or took no action if they received reports about such individuals. Additionally, this study found that Michigan was one of 16 states where both quarantine and criminal prosecutions had been carried out, although the authors noted that quarantine was much less common than prosecution. They concluded that "despite [the law's] procedural protections, [prosecution] has been deemed a more effective way of seeking to assert social control over individuals whose behavior was considered a threat" (p. 1475). More common than either approach, however, was the issuance of cease and desist orders to "recalcitrant" HIV-positive individuals as provided for under noncriminal health-threat statutes.

Studies focused on criminal disclosure statutes are more abundant. Recent studies indicate that at least 24 states presently have a criminal law that makes it a misdemeanor or a felony for HIV-positive people to have sex without first disclosing their status. Including states with sentence enhancement policies that increase the severity of punishment for certain crimes such as prostitution, 32 states have HIV-specific criminal statutes (Center for HIV Law & Policy 2011; Galletly and Pinkerton 2006; Wolf and Vezina 2004). Michigan's statute in particular has been criticized for being overly broad, in that it criminalizes sexual acts that carry no risk of HIV transmission (Heywood 2008). Like many state disclosure laws, Michigan law neither requires actual transmission or even risk of transmission in order to define the sexual behavior of the HIV-positive individual as actionable, nor does it require malicious intent. Beyond their criminalization of harmless sexual contact, these statutes have also come under attack for making knowledge of one's HIV-positive status a criminal liability, potentially discouraging people at risk for HIV infection from seeking to be tested (see, for example, UNAIDS 2002). However, no study has yet systematically evaluated these claims.

Fourteen of the 24 states with felony or misdemeanor HIV-specific criminal disclosure laws were passed in the mid-1980s and early 1990s, before lifesaving antiretroviral medications were introduced in 1995 (Galletly and Pinkerton 2006). The laws were passed, then, in a context of high mortality rates, at a time when most Americans were uninformed about AIDS and feared contracting it through highly improbable scenarios, such as kissing or malicious exposure (Bateson and Goldsby 1988; Brandt 1988; Burris et al. 1993). Public debates over criminal disclosure statutes have tended to focus on extremely atypical cases that reflect those fears, such as the case of a black New Yorker, Nushawn Williams, who was prosecuted in 1999 for allegedly infecting over a dozen white women (Shevory 2004).

4. Unpublished data from Michigan State Police (333.5210, from January 1, 1989 through October 1, 2010).



HIV-specific criminal statutes have only recently become a subject of sociological inquiry. For instance, Matthew Weait (2007) analyzed how notions of risk, harm, and culpability have been codified into English case law pertaining to HIV exposure. In a review of Canadian court cases regarding HIV transmission, Barry Adam and colleagues (2008) note that while the 1990s were characterized by a rhetoric of “mutual responsibility”—in which “HIV prevention through safer sex is the responsibility of both HIV-negative and HIV-positive people”—recent Canadian cases indicate that the “onus of responsibility may be shifting back toward HIV-positive people” (p. 144). In a qualitative study of HIV-positive people in Michigan, Carol Galletly and Julia Dickson-Gomez (2009) found that the majority of participants supported the law but expressed concern that it could be maliciously used against them. By contrast, a study of attitudes towards disclosure laws among HIV-positive people in the United Kingdom found participants were generally critical of criminal prosecutions (Dodds and Keogh 2006). However, a survey of both HIV-positive and HIV-negative gay men in the United Kingdom found that men in the study generally supported prosecution and expected partners to disclose before sex (Dodds 2008).

Building on these insights, this study is the first sociological analysis that examines the role health officials play in enforcing health-threat statutes. The evidence that it assembles is critical for understanding how these statutes are applied, and the problems that accompany their application. Further, this article demonstrates how the strategies adopted by health officials for surveillance and enforcement can be understood as forms of social control.

### *Sexual Contact Tracing and HIV Testing in Michigan*

The use of sexual contact tracing as a strategy for the prevention and treatment of sexually transmitted infections has a long history that stretches back to syphilis outbreaks in American urban centers in the early twentieth century. Contact tracing was developed then as a novel way to help limit new infections (Smith and Brumfield 1933; Turner, Gelperin, and Enright 1939). A public health researcher in 1939 described contact tracing as a way to notify partners “in order that they may be brought under medical care and rendered noninfectious as promptly as possible” (Turner et al. 1939:768). Since then, state health departments have relied on partner referrals as a way to identify, test, and, if necessary, treat partners of individuals newly diagnosed with a variety of sexually transmitted infections, typically gonorrhea, chlamydia, syphilis, and HIV (see, for example, Judson and Vernon 1988).

Contact tracing was initially developed to “trace” the origins of bacterial infections and to treat them before the infected individual unwittingly exposed others. Adapting this method to an incurable virus required a shift in priority: partners of infected persons could not be “rendered noninfectious” at the time they were identified; they could only be made *aware* that they might have been exposed. Indeed, early HIV-prevention scientists noted that:

Emphasis should be on partners who are unlikely to know they were exposed to HIV, e.g., female partners of bisexual men and of IV drug users . . . Lower priority should be given to notification of casual male partners of homosexual men and female prostitutes because they are difficult to reach and presumably are voluntarily taking a risk (Judson and Vernon 1988:392).

In other words, the need to notify was normatively interpreted as directly related to the likelihood that the partner of an infected person was unaware of the exposure (or the “risk” of exposure). Partners of “homosexual men” and of “female prostitutes” were presumed to be “voluntarily taking a risk” and therefore aware of their possible exposure. They were also presumed to be asking for trouble and to be in less need of state intervention. Health scholars’ emphasis on awareness reveals how knowledge—a key component of disclosure—became a critically important factor when public health practitioners adapted contact tracing to the HIV epidemic.

In Michigan today, the state conducts contact tracing for all individuals newly diagnosed with gonorrhea, chlamydia, syphilis, and/or HIV. Michigan Department of Community Health (MDCH) staff identify the following goals for partner notification: “Counseling HIV/STD-infected

clients on disease state and need to identify their sex and/or needle-sharing partners at-risk for HIV/STD; Locating partners, and notifying them of exposure and offer testing and treatment, prevention, education, and referral to medical and support services" (Peterson-Jones 2009). Thus, health officials in charge of partner referrals in Michigan conceptualize their function largely in terms of "health": Find partners, inform them, counsel them, test them, and when necessary, treat them.

Just as contact tracing had to be adapted to the context of the HIV epidemic, so too did testing. Public health experts and HIV/AIDS advocacy organizations engaged in fierce debates over how HIV test results should be collected and stored by the state (see, for example, Gostin, Ward, and Baker 1997). Two competing strategies emerged for managing HIV testing data. The first, "code-based" method involved assigning each individual a unique, anonymous code that could not be traced back to the client. The alternative, "names-based" method, favored by the Centers for Disease Control and Prevention (CDC), involved collecting the names of individuals who are tested and storing them confidentially, so as to correlate individual test results with the individual persons being tested. Michigan was an early adopter of names-based reporting in 1988 (CDC 2007; Nakashima et al. 1998). Debates raged for years over the vulnerability of names-based systems to privacy violations, fueled by several widely reported leaks in Florida (Landry 1996). Despite these privacy concerns, most states adopted names-based systems and the CDC eventually pressured the states that did not already convert to names-based reporting to do so (CDC 2010). Despite their widespread application, no studies have examined the role these technologies may play in facilitating the enforcement of HIV law.

## Methods

Michigan is divided into 45 local health jurisdictions, 16 of which are classified by the MDCH as high-morbidity jurisdictions for HIV infection. Each of these 16 jurisdictions has its own program for handling HIV/AIDS, which includes staff responsible for managing and responding to health threat to others cases. The remaining 29 jurisdictions, classified as low-morbidity jurisdictions, share one overarching, centralized HIV/AIDS program. Thus, there are 17 proper cases (defined as local public health agencies charged with investigating HIV health threat to others cases) suitable for analysis in this project: 16 high-morbidity jurisdictions, and 1 omnibus, low-morbidity jurisdiction.

With assistance from MDCH staff, I identified two actors whose organizational roles and institutional responsibilities are most closely tied to responding to and managing health threat to others cases: the HIV/AIDS services coordinator and the disease intervention specialist (DIS). The coordinator is responsible for overseeing the jurisdiction's programs and services that are related to HIV/AIDS, while the DIS is charged with making site visits and organizing and implementing interventions developed to deal with health-threat cases. Notably, these roles are not distributed evenly: in smaller counties, they were sometimes united in the same person, while larger counties had multiple DIS positions. In cases where there were multiple DIS positions, I only interviewed staff who had direct experience with HIV health-threat cases.

In coordination with MDCH, I visited 14 of the 17 local health jurisdictions where I interviewed 25 staff members. Two jurisdictions declined to participate because of recent staff turnover, and one never responded to requests to participate. Each in-depth, 45- to 90-minute, semistructured interview was audio recorded. I asked each participant to choose a pseudonym, which are the names used in this article. I conducted all of the interviews myself, and coded transcripts using NVIVO software. In particular, I coded interviews for general techniques of surveillance (e.g., using partner services or testing data); participants' awareness and opinion of the HIV disclosure law; and direct experience with regulating HIV-positive clients. I obtained approval to do research with human subjects from both the University of Michigan's Health Sciences and Behavioral Sciences Institutional Review Board and the Michigan Department of Community Health's Institutional Review Board.



**Results**

*Forms of Formal Social Control*

*Technologies of Surveillance: How Health Departments Employ Epidemiological Surveillance Tools in the Service of Legal Surveillance.* When clients visit one of the many publicly funded health clinics in Michigan to be tested for HIV, they can expect more than just a finger prick or blood draw. Counselors sit down with clients to review copious details pertaining to their sexual practices and partners: How many times have you engaged in anal sex in the last six months? Did any of your partners ejaculate inside you? How many times in the past six months have you used narcotics when having sex? Clients’ responses are often catalogued and collectively analyzed. Considered by health experts as an opportunity for clients to reflect on their sexual lives and perhaps commit to taking more care to prevent acquiring HIV in the future (if they test negative), pre- or post-test HIV counseling has long been one of the cornerstones of HIV prevention.

If a client tests positive for HIV or any other reportable sexually transmitted infection, the testing counselor will not only provide counseling and referrals for treatment but is also legally mandated to ask clients to report the names of everyone with whom they have had sex. Later, health officials attempt to contact those individuals to recommend that they be tested for HIV and other infections. In this section, I argue that we can understand HIV testing and partner referral as forms of social control. HIV testing and the array of surveillance technologies built up around it are well suited to this concept. HIV counseling sessions are not just an occasion to educate people, raise their awareness of the risks they are taking, or collect data on how many people are taking what kinds of risks. The findings in this article reveal that health officials use these encounters as opportunities to regulate their clients’ sexual practices and, more specifically, to enforce Michigan’s health-threat law.

While health officials describe partner services as a tool for epidemiological surveillance and HIV and STI prevention (Peterson-Jones 2009), findings in this study suggest that partner services is also a tool for legal surveillance. As outlined in Table 1, local health officials in three jurisdictions report actively employing contact tracing in order to identify potential health threat to others cases. While these officials described a variety of scenarios in which these surveillance

**Table 1 • Techniques Used in Public Health Jurisdictions in Michigan to Identify Cases of “Health Threats to Others”**

<i>Jurisdiction No.</i>	<i>Partner Services + Names</i>	<i>STI Testing</i>	<i>Contracts</i>	<i>Phone Calls</i>
1	✓			
2			✓	✓
3	✓			✓
4			✓	
5				✓
6			✓ <sup>1</sup>	✓
7				
8			✓	
9	✓			
10				✓
11		✓	✓	
12				
13		✓		
14				

*Notes:* While their HIV/AIDS coordinator stated that their health department did not employ such a contract, the local policy documents they gave to me included such a form. It is not known if this form is actually in use.

techniques were utilized, their descriptions typically featured an individual newly diagnosed with a reportable sexually transmitted infection, who named a sexual partner already known by the state to be infected with HIV. To be clear, there are several critical steps in this process:

1. Person A *tests positive* for HIV (and/or chlamydia, gonorrhea, syphilis);
2. The testing counselor *elicits the names of Person A's prior sexual partners*;
3. The testing counselor asks *if any of the partners disclosed* to Person A that they were HIV positive;
4. The health official attempts to *ascertain the HIV-status of Person A's reported partners*—first against local records, and then against the state's mandatory, confidential names-based database—to see if any of the partners reported are known to be HIV positive;
5. If anyone named is already known to be HIV positive *and* Person A reported that no one said he or she was HIV positive, *an investigation is launched* against the reported partner(s) known to be HIV positive, who, in some cases, are automatically deemed a "health threat to others."

For example, Mitch (HIV/AIDS coordinator, jurisdiction #2) described how she would elicit the names of partners from a client newly diagnosed with HIV, following up with an additional question as to whether any of the reported partners had disclosed that they were HIV positive:

We make sure that we say everything very confidentially. So the one question that we have that we always ask somebody when they're giving us names is—going to this other person, if that person gave me four names, I would say "Did any of these four people ever tell you that they were HIV positive?" Because if they give me a name and I already know that one of them is HIV positive, because I've dealt with that person so much, then that's gonna be a flag to me right there. But I can't say, "Well so-and-so is HIV positive, did they tell you that?" So we just make it very generic, "Did any of these people ever tell you that they were HIV positive?" I may not know any of those people on that list, but the next step that I do is I'm gonna go back to my files and see if I have a file on any of these people. I will then go to the state and see if any of these people have already been reported as positive. And when that report comes back or when we have a file that one of those four people is positive, that becomes a flag.

Notably, Mitch mentions that they may "already know that one of them is HIV positive," meaning that they may simply recognize a partner's name by virtue of having worked with that person in the past. This was reported by several officials, such as Charlie, the HIV/AIDS coordinator and disease intervention specialist in jurisdiction #9:

I was actually testing another individual who had just come in for—for everything, I think they were testing for everything. I tested, they were positive, and after interviewing, I knew the name immediately. After they gave me one of their partner names, I knew the name immediately. After they gave me one of their partner names, I thought—I didn't say anything at that time. But I just, you know, I just said, [sighing] "Oh, I know that name." Went back, sure enough, confirmed that this person was already positive.

Several things are worth noting here. First, Charlie's account suggests that clients who have closer relationships with testing counselors (or whose names are for whatever reason more likely to be recognizable to counselors) may be more likely to be identified as a potential health threat. While health officials in these jurisdictions reported cross-referencing the names reported through the state's confidential names-based database, this is not an automated process. Thus, name recognition may increase the likelihood that health officials take the extra step of checking a particular name against the state data bank. Moreover, clients are often able to provide health officials only with nicknames (e.g., "Shorty") or partial information (e.g., "Johnny who works at McDonald's on Main Street"). In such instances, health officials may be more readily able to make positive identifications of clients with whom they have close working relationships.

This is sociologically important for several reasons. First, the clientele of public clinics is not a random sample of the surrounding population: Women, African Americans, and men who have

sex with men are overrepresented among those who seek services at state-run health clinics. Because racial and sexual minorities and women are overrepresented at health clinics, they may be more likely to be identified as a health threat. Second, health officials in jurisdictions with relatively large HIV-positive populations may be less likely to recognize a particular name than those who work in jurisdictions with smaller numbers of HIV-positive residents.

While this article is not primarily about the legal outcomes of cases identified through these surveillance technologies, it is worth noting that legal action, while rare, may be a consequence of health officials' cross-referencing the names of sexual partners reported by newly diagnosed clients against the state database. For example, Mitch described how they had handled a recent case in which a newly diagnosed client reported a partner that the health department later identified as HIV positive. Because regulations enacted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prevent the health department from reporting that discovery to their client, they described taking further action as requiring "tiptoeing":

There's a lot of tiptoeing. There's a lot of, "Well, we'd like you to come back into the office and talk to you a little bit more about your situation." And that's when we'll try and say, "Have you had any other partners? Have any of your other partners ever said anything about being HIV positive?" And at that point, sometimes we might say, "Well, we'd like you to report this to the police. We'd like you to contact the police." Recently we had somebody we had called back to come in and do that, and then the person never showed. We were going to tell them to contact the police, because we have a person who is being a health threat to others. But the person never showed up (Mitch, HIV/AIDS coordinator, jurisdiction #2).

While reports suggest that individuals who allege that their partners did not disclose must be willing to testify in order for a prosecutor to intervene legally, health officials can facilitate their contact with law enforcement as Mitch describes here. Thus, the strategies and techniques health officials described employing to identify health-threat cases can lead to serious legal consequences for the individuals under surveillance. For example, the only person ever known by the author to be quarantined under Michigan's health-threat law, in 1992, was a woman described in news reports as "mentally deficient"; she was later convicted under the felony disclosure statute in 1995 (*AIDS Policy and Law* 1998; Walsh 1992). As I show in the next section, health officials in several jurisdictions have recently begun implementing a record intended to prove that newly diagnosed clients have been informed of their HIV-positive status and of their responsibilities under the health-threat statutes. This suggests that health officials are invested in facilitating legal action against their clients.

*Can HIV-Positive People Legally Have Sex Without Condoms—Even After Disclosing?* In addition to using the confidential names-based database to identify health-threat cases, health officials in certain jurisdictions use STI-testing technologies more generally as a means of identifying health-threat cases. In two jurisdictions (see Table 1), officials reported classifying HIV-positive clients who later test positive for a secondary infection (such as syphilis or chlamydia) as well as HIV-positive women who become pregnant as health threats. When I asked Fern (disease intervention specialist, jurisdiction #11) how most health-threat cases came to her attention, she replied:

Well, usually it's all the sudden their name appears with another STD . . . All the STDs have to be reported on the [Michigan Disease Surveillance System]. So . . . if the [syphilis coordinator] has any syphilis cases where they're also showing that they're HIV positive, then her and I work together and we—you know, if I've got a case report—then it goes to a health threat to others, more or less. Because if they come up with syphilis, they're having unprotected sex.

The conclusion Fern reaches is notable: "they're having unprotected sex." While Michigan's state health department maintains that contracting a secondary infection is not sufficient grounds for categorizing an individual a health threat,<sup>5</sup> health officials in two jurisdictions reported using

5. E-mail message to author from the Michigan Department of Community Health, October 11, 2011.

STI testing in order to identify health-threat cases. I followed up with Fern to try to clarify this logic:

Author: A positive STI test result . . . y'all see as evidence of nondisclosure—well, I guess, how . . . what's the . . . why is that interpreted as a potential health threat?

Fern: Well they're having unprotected sex. But, again too, sometimes what I come up against is when I do get there, they'll say, "Well I did tell them." You know, "They're positive also." I say, "Well that doesn't matter." You know, "Just because they're positive also, you still need to be using protection."

Fern's concern in this case is not that the client might not be disclosing their HIV-positive status, but rather that the client was not using condoms, despite the fact that the client was engaging in a harm reduction strategy known as "serosorting," or intentionally seeking out sex with people of the same HIV-status to reduce or eliminate the risk of HIV transmission (Parsons et al. 2005). Thus, it appears that at least some health officials believe that having unprotected sex was sufficient grounds to be classified as a health threat.

Moreover, in a 2008 e-mail obtained through a Freedom of Information Act request by Todd Heywood, a local reporter, the state health department's legal director interpreted Michigan's health-threat statute to mean that HIV-positive people are legally forbidden from ever engaging in unprotected sex "even if the partner is HIV positive":

Would an HIV-infected individual who has unprotected sex be a health threat to his/her sex partner? Are there any circumstances where unprotected sex would not be a health threat? . . . It sounds like the individual would always be a health threat, even if the individual's partner is also HIV positive. An HIV-infected individual is not relieved of all responsibility to prevent transmission simply because he/she has warned their sex partner of the HIV-infection. We (in public health) and the infected person still have responsibilities to prevent the spread of serious communicable disease even if the infected individual's sexual partner consents to the risky behavior. In fact, under section 5203, the local health officer *shall* issue a warning notice against such an individual.<sup>6</sup>

While the state health department maintains that Chrysler's statement was not an official legal opinion,<sup>7</sup> the fact that its own legal director believed that an HIV-positive person engaging in unprotected sex "would always be a health threat" suggests that what actually constitutes an actionable health threat to others is not a precise offense but turns out to be subject to a range of interpretations.


Local health department policies also indicate that many local officials do in fact interpret the health-threat statute as requiring HIV-positive people always to use condoms. Five jurisdictions<sup>8</sup> (see Table 1) have developed so-called "client acknowledgement forms" that newly diagnosed HIV-positive clients are asked to sign immediately after learning that they have tested HIV positive. While there are various versions of the form, the most controversial language was found in forms that asked clients to place their initials beside the following statement (quoted from the form used in Macomb County<sup>9</sup>; see Figure 1): "You are required to inform individual/s of your HIV infected status **BEFORE** sexual contact. You and your sexual partner/s must use a barrier protection such as latex condoms, dental dams, and/or female condoms in a correct and consistent manner." While most forms were more ambiguous in that they simply referred to a requirement that clients engage in "safe behaviors" and/or "risk reduction," the language used in some of these forms suggests that at least some health officials believe their HIV-positive clients must use condoms at all times.

6. E-mail message from Denise Chrysler, 2008, "Re: Legal Counsel / Macomb CHD," obtained by Freedom of Information Act Request; emphasis added.

7. E-mail message to author, October 11, 2011.

8. Health officials either directly described using such a form ( $n = 2$ ), and/or they provided me with policy documents that included such a form ( $n = 5$ ).

9. This is a public document and its inclusion should not be read as an indication that Macomb County did or did not participate in this study.



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**CLIENT NOTIFICATION OF POSITIVE HIV ANTIBODY STATUS AND MICHIGAN LAW**

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Client ID Number \_\_\_\_\_  Male  Female

Date of Pre-test Counseling and Testing \_\_\_\_\_

Date of Post-test Counseling & Notification of Test Results \_\_\_\_\_

HIV Antibody Test Result:      Elisa = Reactive      Western Blot = Reactive

You have just been informed your test result for HIV Antibodies is reactive. This means you are infected with the Human Immunodeficiency Virus (HIV) and you have the potential to be infectious to others. It is important that you understand this test result and the HIV/AIDS laws in Michigan. You have the option to decline signature of this form, but you must follow the law and statements below:

- 1. You are required to inform individual/s of your HIV infected status **BEFORE** sexual contact. You and your sexual partner/s must use a barrier protection such as latex condoms, dental dams and/or female condoms in a correct and consistent manner.
- 2. **MICHIGAN LAW STATES THAT IT IS ILLEGAL FOR AN HIV-INFECTED INDIVIDUAL, WHO KNOWS HE/SHE IS INFECTED, TO ENGAGE IN SEXUAL PENETRATION WITHOUT FIRST INFORMING THE OTHER PERSON OF THE HIV INFECTION. FAILURE TO DISCLOSE PRIOR TO PENETRATION IS A FELONY.**
- 3. You must not attempt to sell or donate blood, plasma, semen, ovum (eggs), or any other body tissue or organ.
- 4. You must notify current and past partners (sexual or needle-sharing) of your infected status. Health Department staff can assist you with a *confidential* notification process (call Ms. Fern @ 586-465-8434).
- 5. You are strongly advised to notify all of your health care providers (i.e. doctors, dentist, first aid responders) of your HIV infected status to allow them to provide appropriate care.
- 6. You have been given, read, and understand the meaning of the Health Infection Notification and **WILL NOT ENGAGE IN BEHAVIORS THAT ARE KNOWN TO TRANSMIT HIV, SPECIFICALLY, UNPROTECTED ORAL, ANAL OR VAGINAL SEXUAL INTERCOURSE AND THE SHARING OF DRUG INJECTION EQUIPMENT.**

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Client declined to sign form      Date \_\_\_\_\_      Counselor Initials \_\_\_\_\_

• Macomb County Health Department keeps this information *confidential*, except when disclosure is allowable per Michigan law. You should keep this Health Infection Notification in a place that is safe and private.

**Figure 1 • Client Notification of Positive HIV Antibody Status and Michigan Law**

More than just a way to inform clients about their legal responsibilities, these “client acknowledgement forms” are a means of holding clients legally responsible for not disclosing their HIV status at a later date. As Mitch (HIV/AIDS coordinator, jurisdiction #2) reports, these forms were developed after clients suspected of not disclosing simply denied knowing they were HIV positive in the first place:

Sometimes, they’ll try and say, “Well, nobody ever told me I was positive. I tested but I didn’t get my results. They didn’t tell me I was positive.” And that’s why—we do a lot of paperwork now about, a lot of the education that we do, we actually have to have the people sign, anytime we have a positive, we go through felony law and do all of this education—what you need to do and what you don’t need to do. Get them hooked up with support services and then we make them sign a paper that basically says, “I’ve been educated. I know that I can’t do this without disclosing my status. I’ve been warned of that and I could potentially have charges brought against me if I don’t do that.” So we make everybody sign that, so that when we have that piece of paper and the name, say this person were to come up again all of the sudden, we’ve got that on file and we would say, “You can’t tell me that you didn’t know that you were positive, because we’ve got this on file.”

These forms have already played a role in prosecuting HIV-positive people in Michigan. Indeed, a news report on the 2007 sentencing of a man to 5 to 15 years in prison for failing to disclose his HIV-positive status to two sexual partners noted that “Police say [the defendant] knew what he did was illegal because he had signed a disclosure form with [a neighboring county’s] Department of Public Health” (*WWMT News* 2007). Other reports suggest these forms have been used to help prosecute HIV-positive defendants in three additional counties (Heywood 2011d).

Thus, at least in some places in Michigan, HIV-positive individuals are asked to sign a document that the Center for HIV Law & Policy criticizes for “effectively [asking] the client to acknowledge in writing his/her potential liability for failure to disclose under Michigan’s HIV-specific criminal law” (Center for HIV Law & Policy 2007). Curiously, while Mac (HIV/AIDS coordinator, jurisdiction #6) indicated that their jurisdiction did not employ such a form, the policy documents that they provided me actually included one (perhaps the form had been developed but was not being used). Nonetheless, they criticized the use of such forms because “it takes that right away from them”:

Mac: There are some agencies that actually have them sign that they are aware of that law. We don’t have anything at the health department stating that. And I don’t know . . . I kind of feel . . . I guess I have mixed feelings on that.

Author: In what way?

Mac: In the way that it was stated in the form that was sent to us, it was basically . . . I just feel like it doesn’t . . . it takes that right away from them almost. I don’t know how to explain it. Some of the wording just didn’t sound—I don’t wanna say “good” to me. I don’t know. It was just something about the wording of it. I don’t know. I don’t know how to explain it . . . But basically saying, “You”—and I’m not saying that they don’t have to follow it, they do. But it’s more strong and stern and to the point where it’s like, “Oh my gosh. You *have* to do this.” And I know they have to, but it just didn’t sound right to me.

Based on Mac’s comments, it appears that controversy over the use of these “client acknowledgement forms” extended to within health departments themselves. As data were being collected for this project, however, the controversy exploded publicly when Todd Heywood obtained these “contracts” and published a series of articles highlighting their problematic nature (Heywood 2011a, 2011b, 2011c, 2011d). Heywood (2011d) quotes Catherine Hanssens, the director of the Center for HIV Law & Policy, as saying:

The form . . . treats all types of sex as equally risky, and all persons with HIV as equally infectious . . . This is a level of medical inaccuracy that is unacceptable from a state Department of Health. Lawyers who think that banning only unprotected sex is legal might want to acquaint themselves with the U.S. Constitution and legal opinions which have long since established the decision to conceive children as a Constitutionally-protected, fundamental right (n.p.).



After these articles were published, the Michigan Civil Rights Commission expressed interest in investigating the use of these forms (Heywood 2011c), prompting state health officials within a few hours to “reverse” their position by deciding to advise “local health departments that if they are going to use client acknowledgment forms . . . —and there is nothing saying they must use such forms—they need to quote the law” (Heywood 2011b). However, state health officials did not require that local health departments discontinue their use.

Moreover, even if local health departments decided to discontinue using these forms, the practice of relying on STI- and HIV-testing technologies to facilitate the identification of health threat cases may continue. While previously I described jurisdictions in which HIV-positive people who present with secondary infections are classified as a health threat, it is important to point out that partner referrals for other sexually transmitted infections (such as chlamydia or syphilis) are also used to identify health-threat cases. Donna, a disease intervention specialist in jurisdiction #13, describes this process:

Let’s say, they come in and they have a secondary infection. Let’s say they have chlamydia and gonorrhea. Okay, by law—or by our duty, basically—gonorrhea cases are reportable to us . . . So we ask, part of our investigation process is to ask, “Who’s your partner?” In this instance, this person mentioned, “So-and-so is my partner.” So when we pulled up the file looking for the other person, we realized at that time that the person was HIV-infected also . . . so that tells us, “You’re having unprotected sex.”

The logic inherent in this process is that sexually transmitted bacterial infections such as gonorrhea are necessarily the result of unprotected sex, but this is not necessarily true. While latex condoms can *reduce* the risk of transmission of STIs such as gonorrhea, they do not eliminate it (CDC 2006). Recent legal cases suggest that this logic is not restricted to Michigan: an HIV-positive man in North Carolina was recently found guilty of violating his probationary agreement not to have sex without condoms when he tested positive for an undisclosed sexually transmitted infection at a local health clinic (Thorpe 2008).

The evidence presented in this section suggests that health officials are using information about sexual partners gathered from clients in ways they do not announce publicly. These practices may conflict with some health law scholars’ demand that:

Where government authorizes or mandates the collection of identifiable health data, both the data to be collected and the reason for collection should be a matter of public record. The public ought also be entitled to know the proposed use, how long the data will be stored, the circumstances under which the data will be expunged, and the extent to which third parties (e.g., regulators, researchers, and government officials) may obtain access thereto (Gostin, Burris, and Lazzarini 1999:125).

Many studies have demonstrated that patients often fear disclosing sensitive information to medical providers because they do not know for what purposes that information will be used: this research includes studies of battered women (Rodriguez, Szkupinski-Quiroga, and Bauer 1996), men who have sex with men (Miamaga et al. 2007), and sex workers (Cohan et al. 2006). Data from this section suggests that that sense of mistrust may be warranted in some circumstances.

This section has documented the formal techniques of social control reported by health officials. In the next section, I describe the ways in which community members police one another, reaching out to health officials to report others in their communities. As I argue in this section, while the practice of disclosure that underlies the gossip cultures described by officials is not consistent with official health policy, it relies on a similar practice of documentation and exclusion, whereby knowing who is HIV positive allows one to avoid sexual contact with them.

### ***Forms of Informal Social Control***

*Gossip, Rumor, and Stigma: How Communities Practice Disclosure as a Form of Informal and Formal Social Control.* Therese (disease intervention specialist, jurisdiction #5) described numerous

inquiries to health department staff invoking the notorious "book down by the river," a near-mythical object that allegedly contains the names of everyone in the area who is HIV positive.

You know, the big thing we have here is people talk. And that's how most things are done around here, how most complaints are filed. In fact, it all usually starts with the same phone call. And they're like, [im-personating stereotypical black female voice] "Well . . . I'm calling because I know . . ." —and they'll go on this whole rampage, like—my cousin's baby's daddy's uncle who watches TV and they produce for the show—you know, it's like, all these weird things! You know, like they find every string to connect this person to them. "And I just wanna verify if that's true." [And I ask,] "Well, why do you wanna do that?" "Well, because I know . . . I can't find it today, but I know that there's a book" —oh my God, this whole county swears to God that's there's a book that's down by some railroad tracks in [name of town] by the river. There's a book that has all the HIV-positive people's names in it.

Pointing to a map on the wall in the conference room we were in, Therese pointed out the general area where residents claim the book can be found, emphasizing that it was "not a good area." When her job requires her to visit this particular area, she makes a point to bring along a male coworker whose physicality resembles his nickname, "Muscles." The neighborhood in question is almost entirely African American, plagued by widespread poverty and devastatingly high rates of unemployment. Like countless towns across the state, the manufacturing jobs that once provided the lifeline to this neighborhood are long gone.

Even if the book does not in fact exist as a real object to be found and consulted, it is still useful to consider what social purposes or ends this legendary volume may serve in the community Therese supervises. I argue that we can think of the book as something of a social vector—a kind of social pipeline—through which gossip and rumor flow:

Even people that just moved to this county . . . they will say the same exact thing. "Yeah, I just moved here and I heard that there's a book here. And I wanna see the book of all the positive people" (Therese, disease intervention specialist, jurisdiction #5).

Through years of gossip and rumor, "the book" has become a vehicle that enables individuals to trade, seek, and reveal information about others without anyone being held responsible for doing the original telling. As described in the beginning of this article, it is illegal in Michigan for anyone to disclose another person's HIV-positive status without their express, written permission. The book, then, may well provide the perfect alibi for community members looking to trade information without being held legally liable.

The rumor of a list of everyone in the county who is HIV positive was not idiosyncratic to this jurisdiction. I heard a similar tale from health officials in another jurisdiction, who also spoke of people asking to see "the list." As Doctor Q (disease intervention specialist, jurisdiction #14) laments:

Well, and you'd be surprised too . . . the people that come in and want to see the list of HIV-positive people [laughs] . . . They think it's just like the Post Office, where you've got your "Ten Most Wanted"—well, we got the HIV-positive list here! I had some woman here, God, it was probably six months ago, she came in with her two teenage daughters. She wanted to see the list. And I said, "We don't keep a list of HIV-positive people." "Oh c'mon now, I know you got a list of HIV"—and I says, "And if we did, why would you want to see that list?" "Cause I want my daughters to look at it, so they know who not to have sex with." I wanted to reach across there and slap her. "You stupid bitch, is that how you teach [your daughters], "Oh here's the list, don't fuck any of these guys."

After years of working in the same job at the health department, Doctor Q was secretly planning to call it quits. His frustration with his job and his clients was, to say the least, palpable.

However, Doctor Q's frustrations may have unintentionally revealed much about the contradictions of disclosure as public health imperative. As he points out, his client was seeking the identities of everyone in the area known to be HIV positive so that her daughters could avoid having sex with them. The state actually *does* possess that information, even if the county does not keep

a list available for the public to consult. So the client was not in fact as “stupid” as Doctor Q inferred. While her desire to gain access to such information is obviously in direct conflict with medical confidentiality, it is perfectly aligned with the strategy embedded in the logic of disclosure as a public health strategy. Disclosure as a strategy presumes that knowledge is prevention: if an HIV-negative person knows who is HIV positive and who is HIV negative, then he or she can make informed decisions that will mitigate the risk of contracting HIV. Within this logic, disclosure is conceived as the basis of informed consent.

As a prevention strategy, however, disclosure is flawed for several reasons. First, many people who are HIV positive do not know that they are infected and believe themselves to be HIV negative. Nationally, the CDC recently estimated that approximately one in five people in the United States living with HIV is not aware of being infected (CDC 2008). Moreover, given that the most commonly used HIV antibody tests cannot detect infection until three to six months after transmission, the disclosure of the results of a nonreactive HIV-antibody test from *yesterday* may not be a reliable indicator of someone’s actual HIV status. Compounding this problem, those who are undiagnosed also tend to be the most infectious, because their viral loads remain unchecked by available antiretroviral treatment and because HIV viral load typically peaks soon after infection. A recent study estimated that between 54 and 70 percent of new sexually transmitted HIV infections were attributable to sexual contact with someone unaware of their HIV-positive status (Marks, Crepaz, and Janssen 2006). Some scholars have argued that antiretroviral treatment may be rendering some HIV-positive individuals noninfectious in specific contexts (Vernazza et al. 2008). Under certain conditions, then, having unprotected sex with an HIV-positive person may actually be *safer* than having unprotected sex with someone who does not know their status or who thinks they are HIV negative.

This evidence suggests that disclosure is a crude and dubious tool for mitigating HIV risk. As I show in the following section, the way that community members like Doctor Q’s client go about practicing and promoting “disclosure” may not quite resemble what health officials intend, though it follows from it. While the notion of disclosure in public health discourse resembles medical informed consent, health officials report a rather different form of “disclosure” in operation within the communities they serve, one that more readily resembles social control.

*Third Party Phone Reports: How Stigma and Gossip Produce Formal Social Control.* In five jurisdictions (see Table 1), health officials reported receiving a large volume of what they term “third party phone reports.” These calls typically involve a resident phoning the health department to report that someone they believe to be HIV positive is having sex without disclosing their HIV status. This is what criminologists would describe as “indirect” informal social control, because it involves community members not taking action themselves, but demanding intervention from authorities (Warner 2007). Notably, these callers do not report actually having sex with the accused; instead, they offer a variety of explanations for how they know an individual is not disclosing their status (usually word-of-mouth rumor). According to guidelines distributed to local health departments by MDCH in 2006, officials should “determine if the information has merit” by:

1. Securing the full name, address, and if available, the telephone number of the third party.
2. Requesting that the third party submit a written statement that describes the behavior/s of the suspected carrier, and supports the allegations.
3. Requesting that the third party provide the local health department with the suspected carrier’s name and other information such as an address or telephone number to locate the suspected individual (MDCH 2006:3–4).

These instructions turn out to be flexible. The standards for determining the merit of third-party denunciations may be relaxed where: (1) the reported individual has previously been identified as an at-risk partner during contact tracing; or (2) there have been repeated allegations concerning the same individual by different parties.

Health officials were often ambivalent about relying on this kind of "rumor mill" to identify health-threat cases. For example, Therese (disease intervention specialist, jurisdiction #5), the official quoted at the beginning of this section, acknowledged that most phone calls she received were "bogus claims" that were sometimes maliciously motivated. To illustrate this, she recounted a case in which the health department received a series of coordinated phone calls all reporting the same individual:

[People around here are] very judgmental and just angry. And they don't like to talk about controversial subjects. And it's an older population that was calling in. It wasn't like I had somebody young calling in. I had somebody in their sixties calling in, and [they were all older]. And it turns out they all actually belong to the same church. And as you may know, it's very big around here too in our black churches—in our African American churches here. They do express . . . um . . . not good things about people who are gay and homosexual and people who have HIV and AIDS and so on and so forth . . . [The person they were calling in about] was a female who had male partners, however . . . that doesn't . . . you know, it . . . they were black and so . . . in the churches around here, somebody told their business and everybody just kind of ganged up. A lot of people around here . . . you think you're . . . living in the Salem Witch Trials, basically, and it's terrible.

After investigating these claims, she discovered that the callers were all members of the same church. Linking the local church's negative views about homosexuality to its prejudices against HIV, Therese speculates that it was the churchgoers' judgmental attitudes that resulted in callers "ganging up" on one sexually nonconforming individual—a coordinated attempt that exemplifies how communities police individuals they suspect of being HIV-positive people.

Notably, race and gender played a significant role in the way that health officials in several jurisdictions in which "third party" phone reports were common narrated health-threat cases. In the citation above, Therese notes the influence of black church leaders in stigmatizing HIV and non-normative sexuality more generally. Moreover, it is significant that the HIV-positive person targeted for harassment by church members was not just African American, but more specifically a black woman who lived in the community. Indeed, Therese's reference to the "Salem Witch Trials" is a tellingly gendered reference point, suggesting that black women who are HIV positive in this community may face a particularly raced and gendered form of stigma—a stigma that results in not just gossip and rumor, but reports to the health department that could result in serious consequences.

While black men were also discussed as objects of concern, in jurisdictions where health officials explicitly invoked race, black women featured prominently in discussions of health-threat cases. For instance, in another jurisdiction across the state, I interviewed an HIV/AIDS coordinator who chose the pseudonym, "Sentient." She reported that third party phone reports were a common way cases were identified, but also noted a peculiar annual trend: During the "holiday season," they received numerous prank calls reporting famous African American women as potential health threats:

Author: Can you walk me through—point A to point B—in terms of how those cases come onto your radar screen?

Sentient: Usually, they come in the form of a phone call. If they call the health department's general number, they usually go to the administrative floor for HIV . . . and then they take down the person's information and they call me and give it to me and I call the person back. And usually the person will say, "I know someone who's HIV infected and they're having unprotected sex." Or, "I was infected by this particular person, and I wanna know how to report them or what I should do." During the holiday season, we usually have unusual claims. Like, they're a star and—like, Aretha Franklin seems to be a very common one. Diana Ross. And they have been infected and they're infecting all these people in the area" (Sentient, HIV/AIDS coordinator, jurisdiction #3).

Though it could well be a coincidence that both celebrities Sentient named were African American women, it is also plausible that this pattern is the result of community members perceiving black women's sexualities as threatening.

Although black male sexuality has been the source of considerable HIV panic, both within and outside of black communities in the United States (Boykin 2005; Cohen 1999), limited research does suggest that black women's sexualities are the subject of particular scrutiny and anxiety in black communities. For example, Bronwen Lichtenstein (2003) found that black health workers in the Deep South expected their black female clients to be "lady like" and held stigmatizing views of "bad girls" whose sexualities did not conform to those expectations. While the findings reported here are not conclusive in demonstrating a gender bias in black communities' informal social control of sexuality, they do suggest there may be a trend worth exploring in future research.

In the remaining jurisdictions in which third party phone reports were common, health officials gave few clues about the race or gender of the individuals involved. Because of the delicate confidentiality issues involved in these interviews, officials sometimes chose to talk neutrally about individuals, avoiding male or female pronouns or other demographic markers. While there were scant indications about the individual doing the calling or about whom they were calling to report, it was clear in one instance that a concerted effort had been made against an individual. Following up about a recent case that Lucy (one of the two disease intervention specialists in jurisdiction #10) had described, I asked how that case came to her attention:

It was just a community person—somebody from the community concerned about somebody in their neighborhood who they were thinking had HIV. And I guess they just felt that they needed to report it to the health department as a concern. Preliminary record search, nothing was found on this individual. The caller was unwilling to give their information—and it was a situation where there were other people in the background, kind of egging the person on the phone on. So in that case, after I briefed my supervisor about it, no further follow-up was done.

The presence of "other people in the background" whom Lucy heard and suspected of "egging on" the caller implies a collective effort at social control. In this case, Lucy went ahead and attempted to verify whether the accused person was known to the state to be HIV positive. The person was not, and thus the case was closed. However, the fact that Lucy took the call, recorded the information about the person being accused, and conducted a record search suggests that she nonetheless determined the anonymous group report deserved further inquiry. She did not speculate about what she might have done had the accused person been found to be HIV positive.

However, Mitch, the HIV/AIDS coordinator from jurisdiction #2, reported having serious doubts about the validity of information obtained from informants over the phone. But just as Lucy decided to run a record search in the case described above, Mitch similarly indicated that if the accused person was in fact determined to be HIV positive, someone from the health department would "make an appearance":

We get a lot of phone calls, "I know that so-and-so's positive and I know that they're sleeping around with a whole bunch of people and not telling their status." You know, if that person is not willing to come in and write out a statement, then we may look for that name and see if there is actually a report on that name and then we may try and make contact and go, "Hey, how's things going? You remember that felony law thing that we talked about? You doing okay with that?" [Laughs]. Kind of just make an appearance with them. But we don't put a whole lotta . . . a whole lotta . . . what do I wanna say? We have a lot of people that call us and complain about other people and a lot of the time it ends up being a, you know, a he said-she-said type of thing, because so-and-so is mad at so-and-so because they slept with so-and-so."

Mitch stressed that this "appearance" would be more akin to a check-in than a serious investigation. However, while these meetings may on paper be nothing more than a "check-in," having a health official show up on your doorstep asking questions about your knowledge of the HIV disclosure law is likely to have a chilling effect: We've got eyes in the community, don't do anything stupid. And that effect is presumably intended.

## Conclusion

The ethical issues raised by state health surveillance are complicated. Many people may think that disclosing one's HIV-positive status to one's sexual partners before having sex with them is the ethical thing to do—perhaps, even a moral mandate. Many people may believe that HIV-negative people have a "right" to know their partner's HIV-positive status. Others may consider that HIV-positive people have a right to decide when to reveal that status. It seems indisputable that every effort should be taken to reduce new HIV infections, but what are the best ways to do that, and what limits should be imposed?

While this article cannot resolve such ethical questions, it does open up new possibilities for inquiry by reframing public health as critical site of social control. I have argued that the forms of social control produced through institutions of public health differ from those forms produced through traditional institutions of medicine. By extending the insights of medical sociologists and criminologists to the field of public health, this article suggests new possibilities for theorizing and empirically analyzing social control. More specifically, while previous studies have demonstrated that criminal HIV disclosure laws may be counterproductive for public health, this study indicates for the first time how public health institutions themselves contribute to and facilitate the enforcement of Michigan HIV law. I do not seek to advance a complete theory of the social control of public health; there are other important kinds of social control exercised by public health that are not examined in this article, such as longstanding traditions of managing population health that typically include testing, treatment, and vaccination campaigns. Thus, more research is necessary to begin to adequately theorize collectively all the many facets of the social control of public health.

Rather than an all-inclusive treatise, then, this article is intended to be a starting point for thinking critically about a set of institutions that have yet to be thoroughly examined by sociologists. While historians and anthropologists have their own rich traditions in critical public health, sociologists' methodological and theoretical tools can offer unique contributions to this field. In particular, conceptualizing HIV testing as a form of social control allows for a critical analysis of what are generally regarded as taken-for-granted public health necessities. Tens of thousands of people never question having to reveal to the state extremely intimate details about their sexual histories in order to be tested for HIV. Should we provide the state with this kind of information, if we discover it could potentially be used to put others in legal jeopardy? This information is a form of power, and some may well consider resisting its exercise.

Of course, these critical insights extend well beyond HIV testing and counseling. Framing public health surveillance as social control opens up possibilities for examining not just strategies of surveillance, but also their potentially stigmatizing outcomes within communities; their impact on sexual behavior more generally; and even the potential for the emergence of forms of resistance that may respond to these interventions. Such a critical approach would help inform policy initiatives, such as the now-widespread use of so-called confidential names-based reporting surveillance systems. These systems were not intended for legal surveillance, yet this article shows that data collected by them are susceptible to being used for criminal proceedings. Now that it has become clear that these data can be used for legal purposes, it is necessary for policy makers, advocates, and stakeholders, including HIV-positive and -negative community members, to consider whether or not they *should* be used in this manner.

Furthermore, as I have shown in the second section of this article, stigma and fear often drive community members to police HIV-positive neighbors' disclosure practices. While these findings are limited to Michigan and may not be generalizable, they do suggest that the practice of euphemistically synonymizing informal social control with the positive concept of "collective efficacy" (see, for example, Sampson et al. 1997) may not always be warranted. More research is necessary to evaluate the generalizability of this study's findings regarding HIV disclosure and local gossip cultures, as well as to determine whether health officials' reports of gossip cultures



accurately reflect the communities in which they work. Future research might also explore the potential gender bias in the informal social control of female sexuality, particularly within black communities.

In terms of practice, this article suggests that how officials interpret the law—and therefore their techniques for enforcing it—may vary greatly from jurisdiction to jurisdiction. As I have shown, some health officials interpreted the law to mean that HIV-positive clients must always use condoms even when they have disclosed their status. This interpretation was codified into policy in counties that employed a kind of “contract” that newly diagnosed individuals were asked to sign, agreements that could later be used in court against them (as they have already been). Multiple conflicting interpretations confound the ability of state or local actors to communicate the law clearly to their clients and community members, potentially adding confusion to a situation with relatively high stakes, including incarceration.

Finally, while critics have charged that these laws are poor behavioral deterrents and that they may in fact be discouraging some people from *testing* and not just from failing to disclose, there is not yet sufficient scientific evidence to evaluate such claims. We know even less about the impact of treatment and/or education programs legally mandated by health-threat statutes. Further, while the data presented in this article suggests that race and gender may in part be shaping the application of Michigan’s health-threat law, no systematic data on prosecutions yet exist that would demonstrate whether or not the application of these statutes is patterned by discrimination.

In its broadest dimensions, this article raises questions about the complicated logics that undergird punitive approaches to problems traditionally conceptualized as medical. For instance, should patients who test positive for illicit substances through their doctor be investigated for drug use? Should the mothers of obese children diagnosed with diabetes be investigated for child abuse? As medical issues come to be discursively framed in terms of morality and responsibility that are more readily legible to the law, both officials and community members may find the law a more appealing recourse for intervention and punishment. This is not just a theoretical possibility; examples across the globe suggest a widespread interest in using punitive measures to combat disease, from Canadians being prosecuted for herpes exposure (Syms 2010) to Australian lawmakers punishing parents who do not vaccinate their children (Betts 2011) to Ugandan efforts to make HIV infection a capital crime for gay men (*BBC News* 2009). These are just a few of the many examples that we might better understand collectively if we framed them through the critical lens of sociology.

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