

The Public Health Police

As the HIV epidemic wore on in the 2000s, the scientific evidence demonstrating that antiretroviral treatment could virtually eliminate the risk of sexual transmission grew steadily into a mountain. In the midst of widespread pessimism that a vaccine or cure would ever be found, public health authorities focused on a target they viewed as more pragmatic: ending AIDS. Of course, ending AIDS did not imply eliminating new HIV infections; instead, it referred to the hope that HIV infection could be halted from progressing to AIDS by putting every newly infected person immediately on antiretroviral therapy. To succeed, however, health authorities would need to find a way to get HIV-positive people to take their pills. The age of condoms was over. The age of positive prevention had begun.

For decades, AIDS activists resisted public health efforts to track HIV-positive people more closely on civil liberties grounds. Because of the disease's highly stigmatized nature, advocates worried that the standard intrusions into patient privacy in the name of public health were likely to drive the epidemic underground. For these reasons, they lobbied for an approach that came to be known as "AIDS exceptionalism," or treating HIV differently from other infectious diseases. Instead of the standard, more invasive approach, activists proposed that protecting civil rights and squashing discrimination would be a much more effective strategy for containing the epidemic. These arguments prevailed in the early years, when an HIV-positive diagnosis was terminal and effective treatment was nonexistent. However, as this chapter will

assistance. It is no coincidence that the major piece of federal legislation that continues to fund HIV treatment to this day—the Ryan White CARE Act of 1990—is titled in White's memory.

AIDS activists cited discrimination against people living with HIV, such as White's expulsion from his school, as evidence against calls for more invasive public health measures to track and control HIV-positive people. Activists argued that although other diseases were stigmatized, HIV stigma was exceptionally potent in the way that it fostered discrimination and exclusion in American society. For these reasons, they lobbied for treating HIV differently from other infectious diseases.

Campaigns to treat HIV differently were often successful in the early years of the epidemic. However, a series of scientific advances over the next decade would take the wind out of the sails of AIDS exceptionalism arguments. First, heating experiments published in 1984 demonstrated that HIV could be eliminated from tainted blood products used by hemophiliacs, ending the epidemic in that population nearly overnight.¹ Second, scientists developed an accurate HIV test in 1985, and screening was immediately implemented for all donated blood. Third, scientists discovered that an experimental drug, azidothymidine (AZT), worked against HIV and that it was particularly good at preventing mother-to-child transmission during childbirth; the number of babies born with HIV in the United States peaked in 1992 and declined by an estimated 67 percent through 1997.² In short, the two most sympathetic faces of HIV, children and medical patients, were no longer being infected with the disease in large numbers. Mercifully, there would never be another American AIDS activist like Ryan White.

However, if the inventions of safe blood products and AZT were flesh wounds to AIDS exceptionalism, the introduction of effective HIV treatment in 1996 was the coup de grâce. As HIV was transformed from a terminal illness to a chronic disease, the logic of affording special protections to people living with HIV was gravely undercut. Many in public health began to argue for a return to more invasive surveillance practices. In a *New England Journal of Medicine* essay published in 2005, then-commissioner of New York City's health department Thomas Frieden and colleagues argued that the time for treating HIV differently had passed. Frieden—whom President Obama would later tap to become director of the Centers for Disease Control in 2009—argued that it was time public health implemented “traditional disease-control principles and proven interventions that can identify infected persons, interrupt transmission, ensure treatment and case management, and

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Safe blood products and AZT were available, the introduction of effective HIV treatment came de grâce. As HIV was transformed from a fatal disease, the logic of affording special treatment for HIV was gravely undercut. Many in the medical community returned to more invasive surveillance. A *Journal of Medicine* essay published in 1990 in New York City's health department thought that the time for treating HIV differently had passed. President Obama would later tap to the Centers for Disease Control in 2009—argued for a new, more traditional disease-control approach that can identify infected persons, provide treatment and case management, and

monitor infection and control efforts throughout the population.”³ With HIV-positive people living normal lives instead of dying soon after infection, controlling the behavior of people living with HIV became a top priority for prevention efforts.

At the center of many such debates was whether health departments should collect the names of people newly diagnosed as HIV positive in order to track the epidemic in each state. Proponents argued that name-based systems were critical to collecting and maintaining accurate surveillance data; without names, they argued, it would be much more difficult to ensure that anyone diagnosed as HIV positive was not later counted again as a new infection. AIDS activists countered that the privacy pitfalls that came with amassing the names of people living with HIV in a single data set were unacceptable.⁴ These concerns were inflamed by egregious examples in which those pitfalls were exposed, such as a Florida health department staff member being accused in 1996 of using a health department list of over four thousand HIV-positive people to screen potential sexual partners—and inviting his friends to do the same.⁵

Instead of adopting name-based systems, activists proposed that states adopt anonymous, code-based systems. They argued that systems based on sufficiently unique codes could achieve similar results to name-based systems without compromising the privacy of such a marginalized population. Health officials argued that the risks associated with name-based systems were minimal and that the public health value of good surveillance data outweighed them. Moreover, collecting names not only produced better surveillance data, they argued, but it also enabled health department staff to follow up with newly diagnosed patients in order to offer them additional services such as counseling and, in later years, treatment.

Without the ability to follow up with HIV-positive clients, health officials could not universally implement additional surveillance programs targeting those diagnosed as HIV positive—programs such as universal contact tracing. Developed in the early twentieth century for managing syphilis outbreaks, contact tracing involves asking diagnosed individuals to reveal the names of their sexual partners so that they might be tested and treated, if necessary.⁶ The practice is best suited to diseases that are curable and highly contagious—two things that HIV is not. Despite questions over its effectiveness (not to mention its potential threat to privacy), the practice was widely implemented in HIV testing clinics around the country.⁷

By 2005, debates over privacy and HIV surveillance programs had quieted. Forty-three state and local health departments had adopted name-based reporting and, for the most part, the proverbial sky had not fallen. The CDC leveraged this momentum by issuing a dear colleague letter to encourage the fourteen state and local health departments still using code- or name-to-code-based systems to transition to name-based systems.⁸ The next year, CDC officials pushed even further by issuing new guidelines recommending that all Americans between 13 and 64 should be tested for HIV and that providers should abandon the practice of requiring informed consent for HIV testing. Instead, they proposed that clinics implement a practice of "presumed consent" in which HIV testing is performed unless the individual explicitly and proactively objects. By 2008, every health department in the United States had implemented name-based HIV case reporting.

This chapter explores how local health officials in one state have put these tools to work in their efforts to control HIV-positive people. Michigan was an early adopter of many of these policies, moving to implement name-based reporting in 1988 when less than a dozen states were using such systems. The Michigan legislature provided the legal basis for its surveillance practices in a sweeping omnibus legislation package passed in December 1988. This wide-ranging set of bills dealing with HIV was "tie-barred" together, requiring that they all pass in order for any of them to go into effect. It included a little-debated legislative package aimed at controlling "recalcitrant" HIV-positive people deemed a "health threat to others" (HTTO).

This bundle of statutes is most well-known for its criminal provision making it a felony crime for HIV-positive individuals to engage in a wide range of sexual practices without first disclosing their status (chapter 5 explores how Michigan criminal courts enforce this law). But the bulk of the "health threat" legislation outlines civil law procedures for controlling HIV-positive clients labeled "recalcitrant"—procedures such as forcing individuals to undergo counseling, treatment, and/or quarantine.

This chapter explores how twenty-five Michigan health officials tasked with managing HTTO cases interpret and apply both the criminal and civil portions of this law. These officials hail from fourteen of the seventeen local health departments in Michigan with staff specifically assigned to handle HIV in their community. Eleven manage their jurisdiction's HIV program; eleven serve as "disease intervention specialists," who are responsible for tracking down newly diagnosed people's prior sexual partners for contact tracing; and three serve both

and HIV surveillance programs had health departments had adopted. For the most part, the proverbial sky had not fallen on them by issuing a dear colleague letter. State and local health departments still had time to transition to name-based systems. The push was even further by issuing letters to all Americans between 13 and 64 years of age. Providers should abandon the practice of "presumed consent" in which they did not ask individual explicitly and proactively for their participation in the United States had no reporting.

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functions. While the state maintains that the work of local health officials is done solely in the interests of promoting public health, many of the strategies they employ suggest they are also engaged in policing and law enforcement.

Why Michigan? When it adopted these policies in 1988, its combination of epidemiological surveillance technologies, civil law, and criminal penalties was pioneering.⁹ Others states had name-based reporting, health-threat laws, and criminal disclosure laws, but few had all three. Today, most states have similar public health practices in place and similar laws on the books. Consequently, Michigan provides a useful test case for understanding the social implications that these policies and practices have for public health, social justice, and inequality. All the participant names used in this chapter are pseudonyms chosen solely at the discretion of the interviewee in order to protect confidentiality.

POLICING PUBLIC HEALTH

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. HIV testing counselors sit down with clients, reviewing their sexual history with a fine-tooth comb. 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 (STI), the testing counselor will not only provide counseling and referrals for treatment but is also legally required to conduct contact tracing and ask the client to report the names of sexual partners. Health officials later attempt to contact those individuals to recommend that they be tested for HIV and other infections—a program known as “partner services.” However, health officials use the information gathered through HIV testing and partner services to do more than just inform partners and facilitate their testing. In some jurisdictions, health officials use these surveillance data as a mechanism for identifying potential health-threat lawbreakers.

Mitch (HIV/AIDS coordinator, jurisdiction 2) paints a clear picture of how this works in her jurisdiction, where she coordinates the local health department's HIV/AIDS programs. The process begins when a person is newly diagnosed with an STI like HIV or gonorrhea and is asked to disclose partners' names. But a very pointed question is tacked on: "Did any of the named partners disclose 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 . . . if that person gave me four names, I would say, "Did any of these four people ever tell you that they were HIV positive?"

Tacking on this question is not standard practice. Indeed, it is specifically added in order to catch people who are not disclosing their HIV-positive status.

The state health department—the Michigan Department of Community Health (MDCH)—describes the following as goals of partner services:

- "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 offering testing and treatment, prevention, education, and referral to medical and support services."¹⁰

The state health department positions the work of partner services solely in the terms of public health and medicine. However, despite these claims, some local health departments have clearly modified partner services for law enforcement purposes.

Notably, partner services is not limited to HIV testing; public health staff attempt to collect the names of past sexual partners for anyone newly diagnosed with other STIs such as gonorrhea, chlamydia, and syphilis. For example, although a client may be diagnosed with, say syphilis rather than HIV, health officials are still required to provide partner services. And despite the fact that the client did not test for HIV, health department staff can still use the occasion to seek out HIV-positive partners. Donna (disease intervention specialist, jurisdiction 1) 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

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Of course, many HIV-positive people disclose to their HIV-negative partners. Even so, some health officials regard HIV-positive people with a certain level of suspicion when they report a relationship with an HIV-negative partner. Cash (HIV/AIDS coordinator, jurisdiction 8) was concerned after an HIV-positive man came to the health department for regular STI testing and tested positive for gonorrhea. The client assured Cash that he had disclosed his status to all his partners, including his HIV-negative girlfriend. But Cash was not convinced:

So I'm thinking, okay, it's possible maybe he didn't do disclosure. I'm going to call [his partner] in for regular STD, and then when she reports that she's never had anybody who's been a sex partner who's HIV positive . . . then there will be that whole question.

But when his partner came in to get tested, she named him as a partner and said that he had, in fact, disclosed his HIV-positive status. "It's like all the pieces fit together. He did tell her."

The pieces do not always fit together, however. When they do not, policing public health requires carefully navigating the numerous health privacy regulations that limit what health officials can and cannot do to intervene. For example, health officials often described immediately recognizing a named partner as someone they already knew to be HIV positive in the community. But strict patient confidentiality laws forbid them from revealing that information, which is protected by laws such as the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, Michigan law makes it a misdemeanor for someone to reveal another person's HIV-positive status without his or her express permission, a provision included in the same set of laws as the HTTO regulations.

These regulations are the reasons behind Mitch's efforts to word her questions to clients during partner services interviews "carefully." For example, let's say that a newly diagnosed client reports having had sex with two people: John and Bob. Even if Mitch were to recognize Bob's name as that of an HIV-positive client, she cannot directly ask the client whether he knew that Bob was HIV positive. That would be tipping her hand. To prevent revealing more than she is legally allowed, Mitch says, "We just make it very generic: 'Did any of these people ever tell you that they were HIV positive?'"

While health officials never described breaking patient privacy laws outright, they did describe navigating them in ways that might be described as bending the law. For example, Shirley (HIV/AIDS coordi-

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For example, Shirley (HIV/AIDS coordi-

nator, jurisdiction 4) describes one case in which a public health nurse
struggled to get an HIV-positive client who had recently been released
from prison to disclose to his new girlfriend:

The nurse asked the new positive man, "Have you told your partner about
your HIV status?" The new HIV guy said that he hadn't told his partner yet,
and [the nurse] . . . told him, "You need to tell her. If you don't tell her I will."
So [the nurse] gave him two weeks, made both of them an appointment in
two weeks' time, and told him that "when you come to that appointment, if
she hasn't been told about your status yet by you, then I'm going to tell her."

In this case, the nurse did not actually reveal the client's HIV-status to
the partner—the nurse merely threatened to do so. When the couple
returned two weeks later, things did not go well:

It was kind of interesting how he told her, because he waited until they were
in the waiting room, waiting for the appointment. They were waiting in the
waiting room with families, with their children waiting for immunizations.
It became physical.

That the situation described by Shirley became physical is not particu-
larly surprising; disclosing one's HIV-positive status to a partner is rife
with emotional volatility. HIV-positive women are particularly vulner-
able in these situations; reports of violent reactions from male partners
are common. In 2012 and 2014, for example, two HIV-positive women
were murdered in Texas by their male partners when the women's HIV-
positive status was discovered.¹¹ And as the instance described by
Shirley demonstrates, even heterosexual men can risk physical retalia-
tion from their partners when disclosing.

Although the nurse did not, in fact, disclose the partner's status,
reports suggest that this sometimes happens—and that such reports can
directly result in criminal charges being filed under Michigan's felony
HIV disclosure law. A man in Kent County pleaded guilty in 2000 to
charges that he did not disclose his status to a woman with whom he
had a sexual relationship. According to a newspaper report, "Authori-
ties have said the woman had no idea [the defendant] was infected with
AIDS until contacted by a health worker who knew about [his] condi-
tion. The victim then went to police."¹²

THE CONDOM QUESTION

Partner services programs are not the only tools health officials have for
catching potential health threats. Local health officials in Michigan

repeatedly described using the test results of other sexually transmitted infection—such as syphilis, chlamydia, and gonorrhea—as evidence of “recalcitrant” behavior. CT (disease investigation specialist, jurisdiction 10) describes a recent case involving a local HIV-positive man:

He then had picked up actually gonorrhea and syphilis in one occasion. . . . It became obvious that the person picking up these diseases was likely not using the appropriate protection. Bacterial STD is probably the most objective thing to look at as far as the person being in an unsafe sexual activity. The people who are actually picking up those STDs are probably not using protection. What we find is that they are oftentimes too not disclosing their HIV status. It's almost a given in that regard.

CT viewed a diagnosis with an STI as evidence that individuals were having sex without protection—referring presumably to the use of condoms during anal or vaginal sex. Many health officials agreed, frequently citing positive STI results as a common way that health threats are identified. 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 of a 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 she and I work together, and . . . 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 logic inherent in this perspective is that sexually transmitted bacterial infections such as gonorrhea are necessarily the result of sex without condoms. 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.¹³

In a letter written to me after these findings were originally reported, Michigan's state health department explicitly denied that an STI diagnosis is sufficient grounds for classifying someone as a health threat. But reports from local health officials suggest otherwise: in many jurisdictions, local health department staff described STI screening as a primary technique for identifying health-threat cases.

Although many people reported viewing STI results as evidence of a health threat, it is important to note that not everyone agreed. Mark, a disease investigation specialist in a large, urban jurisdiction (3), says he differs from others on this point:

A client comes here—and they are HIV positive—and to the STD clinic, and the doctors see there was syphilis; they just made it a health threat. Me,

results of other sexually transmitted diseases, gonorrhea—as evidence of investigation specialist, jurisdiction of a local HIV-positive man:

gonorrhea and syphilis in one occasion. . . . Picking up these diseases was likely not bacterial STD is probably the most objectionable person being in an unsafe sexual activity. Picking up those STDs are probably not using condoms are oftentimes too not disclosing their status at regard.

It is as evidence that individuals were referring presumably to the use of condoms. Many health officials agreed, frequently the common way that health threats are identified. Intervention specialist, jurisdiction of the intervention specialist, jurisdiction of the intervention specialist, she replied:

Her name appears with another STD . . . All the [Michigan Disease Surveillance System]. I have any syphilis cases where they're also positive, then she and I work together, and . . . if someone is a "health threat to others," more or less. If someone has syphilis, they're having unprotected sex.

It is not that sexually transmitted bacterial diseases are necessarily the result of sex without condoms. While latex condoms can reduce the risk of gonorrhea, they do not eliminate it.¹³ These findings were originally reported, and the intervention specialist explicitly denied that an STI diagnosis is a health threat. But these findings suggest otherwise: in many jurisdictions, STI screening is a primary public health threat case.

Instead of viewing STI results as evidence of a health threat, note that not everyone agreed. Mark, a health official in a large, urban jurisdiction (3), says he thinks:

People who are HIV positive—and to the STD clinic, and to the STD clinic; they just made it a health threat. Me,

myself, I don't consider them a health threat, because they could have had sex with their partner and told them they are positive, so you never know.

That there is disagreement on the issue suggests that where a person lives and who manages their case file may play an important role in shaping whether they are labeled as a health threat.

Mark's comments illustrate the complicated logic of interpreting STI tests as evidence of health-threat behaviors. How did Fern make sense of this connection?

Hoppe: A positive STI test result . . . you all see as evidence of nondisclosure. . . . 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 was not that the client might not be disclosing HIV-positive status but that the client was not using condoms. Even in cases where their partners are also HIV positive, Fern insists that HIV-positive clients are required to use condoms. Contracting an STI is evidence that they failed to do so and is used as evidence to label an HIV-positive client a health threat. This raises the question of whether HIV-positive people can legally have sex without condoms in Michigan.

In a 2008 e-mail obtained through a Freedom of Information Act request by journalist Todd Heywood, the state health department's legal director, Denise Chrysler, clearly describes how she interprets Michigan's health-threat statute:

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 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.¹⁴ (emphasis added)

The state health department maintains that Chrysler's statement was not an official legal opinion.¹⁵ However, the fact that its legal director believed

that an HIV-positive person engaging in sex without condoms "would always be a health threat" suggests that the law is open to interpretation—contradicting the state's assertion that the law is unambiguous.

In many cases, local health department policies reflect an interpretation of the health-threat statute as requiring HIV-positive people always to use condoms. Five jurisdictions have developed "client acknowledgment forms" that newly diagnosed HIV-positive clients are asked to sign immediately after learning that they have tested HIV positive.¹⁶ 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, shown in figure 11): "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."¹⁷ While most forms were more ambiguous and 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.

These forms are not just a way to inform clients of their legal responsibilities. They serve as a means of holding HIV-positive clients legally responsible for not disclosing their HIV status at a later date. As Mitch 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." 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. For example, a news report on the 2007 sentencing of a man to 5–15 years in prison for failing to disclose his HIV-positive

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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 11. Sample client acknowledgment form. Source: Macomb County Health Department.

status to two sexual partners noted, "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."¹⁸ Other reports show these forms have been used to help prosecute HIV-positive defendants in three additional counties.¹⁹

As data were being collected for this project, journalist Todd Heywood obtained several of these forms and published a series of articles highlighting their use.²⁰ AIDS activists around the country expressed outrage. One of the nation's leading organizations working on HIV and the law, the Center for HIV Law and Policy, spoke out against the forms. Its executive director, Catherine Hanssens, told one media outlet:

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.²¹

In my interviews, some local health officials echoed these concerns. Mac (HIV/AIDS coordinator, jurisdiction 6) criticized client acknowledgment 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.

Hoppe: 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 want to say *good* to me. I don't know. It was just something about the wording of it. 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.

Mac's comments suggest that the controversy over the use of these client acknowledgement forms reached within health departments themselves.

In the wake of these articles, the Michigan Civil Rights Commission expressed interest in investigating the use of these forms, raising the stakes of the debate considerably.²² The state health department issued

"Police say [the defendant] knew and signed a disclosure form with [a] Public Health."¹⁸ Other reports help prosecute HIV-positive defend-

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e controversy over the use of these client and within health departments themselves. the Michigan Civil Rights Commission regarding the use of these forms, raising the only.²² The state health department issued

a carefully worded statement, saying that it was changing its position by advising "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."²³ However, state health officials did not require that local health departments discontinue their use.

"LIVING IN THE SALEM WITCH TRIALS"

Health officials are not the only ones in the community keeping tabs on people living with HIV. Community members are also actively engaged in policing their HIV-positive neighbors. In five health department jurisdictions, officials reported regularly receiving what they bureaucratically 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 his or her HIV status. 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 his or her status (usually word-of-mouth rumor).

These calls are so common that the state health department developed guidelines for handling them. According to guidelines distributed to local health departments by the 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.²⁴

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) 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. 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. 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 person—a coordinated attempt that exemplifies how communities can police their HIV-positive neighbors.

Notably, race and gender played a significant role in the way that health-threat cases were described by health officials in several jurisdictions in which third-party phone reports were common. In the incident above, Therese notes the influence of Black church leaders in stigmatizing HIV and nonnormative sexuality more generally. That the church leaders were orchestrating an effort against a Black woman (rather than a man) reflects the higher stakes women face in navigating HIV stigma. Indeed, that Therese referred to a campaign against women—the Salem witch trials—suggests that Black women who are HIV positive in this community may face a particularly noxious stigma. Gossip and rumor thrive and fester in this context, helping to feed hostility in the community against HIV-positive Black women who step out of line.

Indeed, in jurisdictions where health officials discussed race explicitly, Black women featured prominently in their comments. For instance, in another jurisdiction across the state, an HIV/AIDS coordinator in jurisdiction 3, who chose the pseudonym Sentient, reported that third-party phone reports were a common way that health-threat cases were identified. However, Sentient also noted a peculiar annual trend: During the holiday season, the health department received numerous prank calls:

Hoppe: Can you walk me through those [health-threat] cases come

Sentient: Usually, they come in the health department's general num floor for HIV . . . and then they they call me and give it to me and person will say, "I know someone unprotected sex." Or "I was in want to know how to report the holiday season, we usually have Aretha Franklin seems to be a v have been infected and they're in

Though it could well be a coincidence, named were African American women. The pattern is the result of community and sexuality as threatening—a pattern

In the remaining jurisdictions where were common, health officials gave of the individuals involved. Because involved in these interviews, officials about individuals—avoiding male graphic markers. While there were doing the calling or about whom in one instance that a concerted effort individual. Following up about a disease intervention specialists in how that case came to her attention

It was just a community person—so about somebody in their neighborhood. And I guess they just felt that they ment as a concern. Preliminary rec individual. The caller was unwilling situation where there were other people the person on the phone on. So in about it, no further follow-up was c

The presence of "other people in pected of egging on the caller suggests effort. In this case, Lucy attempted was known to the state to be HIV thus the case was closed. However recorded the information about t

ties of coordinated phone calls all

mental and just angry. And they don't like it's an older population that was calling [ing calling in. I had somebody in their [older]. And it turns out they all actually [may know, it's very big around here too [can American churches here. They do [about people who are gay and homo- [AIDS and so on and so forth. . . . [The [was a female who had male partners, [ow, it . . . they were Black and so . . . in [y told their business and everybody just [round here . . . you think you're . . . liv- [ly, and it's terrible.

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Hoppe: Can you walk me through—point A to point B—in terms of how those [health-threat] 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 want to 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—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.

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 sexuality as threatening—a pattern reflected in the scientific literature.²⁵

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 person doing the calling or about whom the caller was reporting, it was clear in one instance that a concerted effort had been made against a specific 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 suspected of egging on the caller suggests a collective community policing effort. In this case, Lucy 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 con-

ducted 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.

This kind of community policing takes several forms. In one county, HIV stigma took on a life of its own in the form of a legendary "book down by the river," a near-mythical object that allegedly contains the names of everyone in the area who is HIV positive. Therese describes this book:

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. They're like, [*impersonating 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"—all these weird things! They find every string to connect this person to them. "And I just want to verify if that's true." [And I ask,] "Well, why do you want to 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 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.

During our interview, Therese gestured to a map on the wall to identify the general area in town where people say the book can be found. Emphasizing that it was "not a good area," she noted that she usually brings along a male coworker whose physicality resembles his nickname, "Muscles," when her job requires her to visit this particular area. The neighborhood in question is almost entirely African American, plagued by widespread poverty and high rates of unemployment. Like countless towns across the state, the manufacturing jobs that once provided the lifeline for this neighborhood are long gone.

In all likelihood, the book probably does not exist as a real object to be found and consulted. Assuming that the book is more legend than reality, what social purposes might this mythical volume serve? Through years of gossip and rumor, "the book" has become a way for people to trade, seek, and reveal information about others in the community without anyone being held responsible for doing the telling. Therese explains that people who move into the county visit the health department and demand to see the book: "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.'" As described in the

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takes several forms. In one county, in the form of a legendary "book" object that allegedly contains the names of HIV positive. Therese describes

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ured to a map on the wall to identify people say the book can be found. "Good area," she noted that she usually whose physicality resembles his nickname requires her to visit this particular area. s almost entirely African American, and high rates of unemployment. Like the manufacturing jobs that once pro- hood are long gone. bably does not exist as a real object to ng that the book is more legend than ht this mythical volume serve? Through book" has become a way for people to ation about others in the community possible for doing the telling. Therese into the county visit the health depart- k: "They will say the same exact thing: heard that there's a book here. And I positive people." As described in the

beginning of this chapter, 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. Health officials in another jurisdiction told a similar tale of people asking to see "the list." 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, come on now, I know you got a list of HIV"—and I said, "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]: '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 as "stupid" as Doctor Q inferred. Obviously, the client's desire to gain access to such information was in direct conflict with medical confidentiality. However, her desire to know the identities of HIV-positive people in the community makes sense given that health officials promote HIV status disclosure as a public health strategy. Promoting disclosure implies 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 reduce the risk of contracting HIV. If this is your primary HIV prevention strategy, then having a list of HIV-positive people is the equivalent of a crib sheet for a college exam.

"SCARE TACTICS"

So what happens after someone is flagged for investigation? Health departments have a range of options for handling potential health-threat cases. Most departments described a tiered approach to managing these cases. First, the person is issued a tersely worded warning letter telling them that they have been identified as putting others at risk; reminding them of their legal obligations; and warning them that if they are identified again, they will be formally labeled a health threat and legal action against them will be taken. Figure 12 is an example of the model warning letter distributed by the Michigan Department of Community Health to local health departments as guidance in 2006.

Along with the warning letter, health officials meet with the client to offer counseling and other services. If the client does not comply with health department demands, officials then move to petition the probate court to intervene. The entire process is painstakingly depicted in policy documents obtained from local health departments. Figure 13 illustrates a condensed version of the typical process as it was reported to me by local health officials. The process begins with a report of "recalcitrant" behavior either as a result of a positive STI test or from first-party witnesses (prior sexual partners) or third-party complainants (neighbors, friends, etc.). Officials consider a number of factors in their assessment of each case, including whether a client has a mental illness; whether health officials believe the allegations have merit; and whether the complaining witness is willing to testify in court.

If the complaint came from a third party, health officials reported treating it with a great deal of skepticism. Mitch, the HIV/AIDS coordinator from jurisdiction 2, reported having serious doubts about the validity of information obtained from informants over the phone. Despite these doubts, Mitch 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." 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 lot of . . . a whole lot of . . . what do I wanna say? We have a lot of people that call us and complain about other people, and a lot

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FIGURE 12.

flagged for investigation? Health officials for handling potential health-related issues described a tiered approach to managing such cases: issued a tersely worded warning letter; identified as putting others at risk; warnings; and warning them that if they are not properly labeled a health threat and action. Figure 12 is an example of the letter from the Michigan Department of Community Health as guidance in 2006.

Health officials meet with the client to discuss the case. If the client does not comply with the requirements, then move to petition the probate court. This is painstakingly depicted in policy manuals for health departments. Figure 13 illustrates a typical process as it was reported to occur. The process begins with a report of "recalcitrant" behavior, such as a positive STI test or from first-time offenders, or third-party complainants consider a number of factors in their decision, including whether a client has a mental illness; whether the allegations have merit; and whether the client is willing to testify in court.

In this third party, health officials reported that they had been told by informants over the phone that if the accused person was in court, someone from the health department would be there.

What that so-and-so's positive and I know that the whole bunch of people and not telling their names, and then coming in and write out a statement, and see if there is actually a report on that. Then make contact and go, "Hey, how's things? We talked about this law thing that we talked about? You doing anything about it? Just make an appearance with them. But we have a whole lot of... what do I wanna say? We want to and complain about other people, and a lot

Page 1 of 2

Logo of Health Department Issuing Warning Notice For Recalcitrant individual in Person.

Attachment B

Name and Address of Recipient

MODEL WARNING NOTICE

Dear (Subject's Name):

The (Health Department) has determined that you are infected with the Human Immunodeficiency Virus, a serious infection that is spread from person to person through contact with certain body fluids (blood, semen, vaginal secretions). Based upon information supplied to our department, it is believed that you represent a health threat to others by putting others at danger because of the behaviors indicated:

In compliance with Michigan's Public Health Code, Part 52, Hazardous Communicable Diseases, you are required to cooperate with the (Health Department) in its efforts to prevent or control the spread of this infection. You are required to:

- (1) CEASE and DESIST any activity which puts others at risk of infection including, but not limited to: 1) the misrepresentation of your infectious status to future sexual or needle-sharing partners; 2) engaging in sexual intercourse or needle-sharing activity without first notifying the individual of your HIV status; and/or, 3) the donation of blood or body tissue.
- (2) Present yourself to the (Health Department) at (time) on (mth/day/yr) to receive HIV prevention, risk reduction and behavior modification counseling. The health department is located at (Address/City).

If you are unable to keep this appointment, you must contact (name of contact individual) at (telephone number) to reschedule.

- (3) Possibly undergo testing for Sexually Transmitted Diseases (Syphilis, Gonorrhea, Chlamydia), and/or the presence of other serious communicable diseases, to the satisfaction of the health officer to verify your status as a carrier.

Failure to comply with the conditions set forth within this notice will result in the health department's petition to the probate court of this county to implement enforcement procedures as defined by Michigan's Public Health Code, Part 52.

Except in the case of emergency, you have the right to a notice and hearing before the probate court issues an order in your case.

Copy 1: Client Copy 2: Serving Agent

FIGURE 12. Model warning letter. Source: Michigan Department of Community Health.

Determining a Health Threat to Others

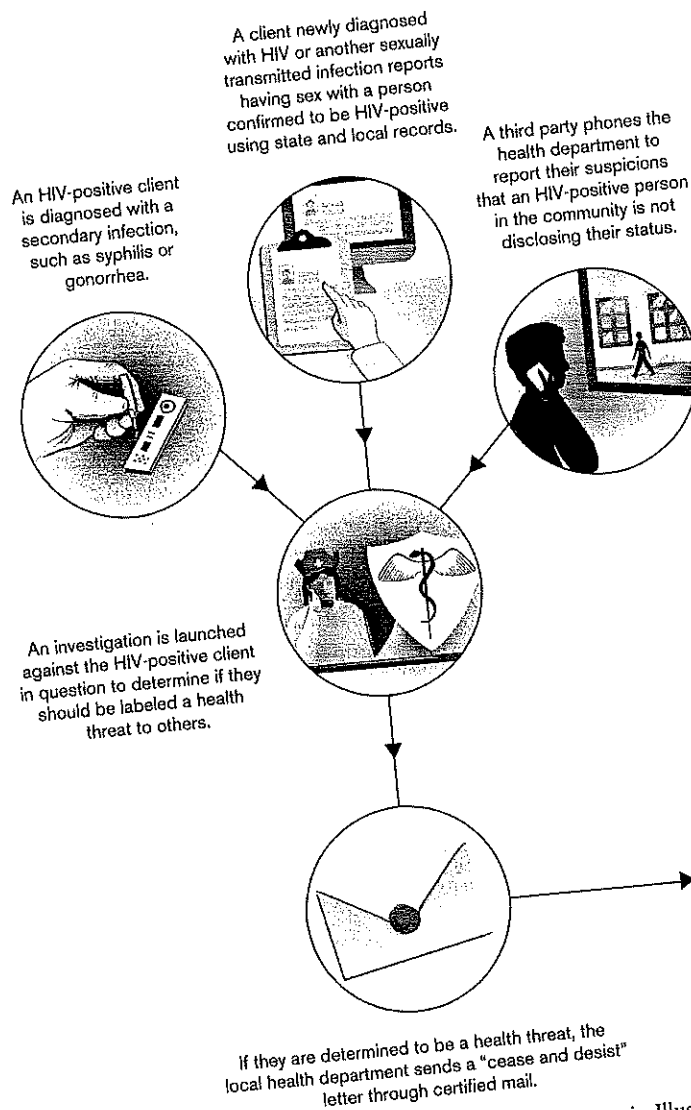


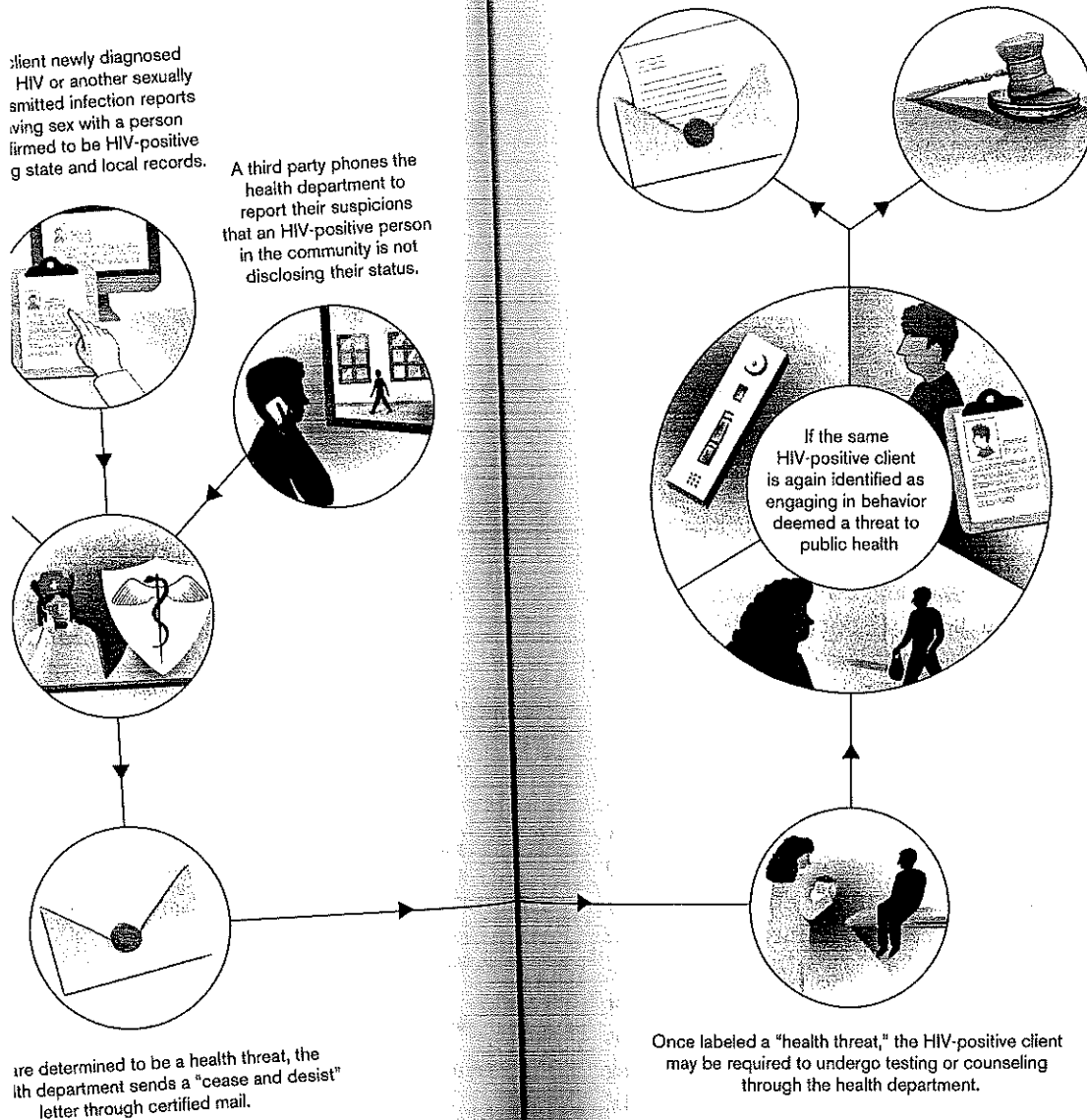
FIGURE 13. HTTO identification. Design: Jonathan Lefrançois. Illustration: Justin Karas for Pulp & Pixel.

Treat to Others

Client newly diagnosed HIV or another sexually transmitted infection reports having sex with a person presumed to be HIV-positive using state and local records.

A third party phones the health department to report their suspicions that an HIV-positive person in the community is not disclosing their status.

Another certified letter may be issued or civil proceedings may be brought against the client to force them to be quarantined or (more likely) undergo counseling and testing.



ification. Design: Jonathan Lefrançois. Illustration: ixel.

of the time it ends up being 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 be nothing more than a check-in on paper, 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.

Whether they are delivered by informal "appearance" or certified cease-and-desist letter, health department demands are not always heeded. Doctor Q, a disease intervention specialist, explained his particular frustration with a client deemed a health threat to others in 2008. The client was identified as a health threat after "showing up here every 3 to 5 months with a new STD. . . . His excuse was 'I would go down to [the city], just these parties, probably get drunk and high, pass out, and I'd wake up and somebody would be having sex with me.'" But Doctor Q believed he was lying. "I might buy that once or twice . . . But hey, after the twelfth time you've had a disease, I'm not buying it." After "probably the eighth time over a couple of years" of testing positive for a secondary STI, Doctor Q called the state's partner services director to discuss his case. After a certified warning letter was delivered to his home, the client agreed to meet with health department staff. "He came the first time, then basically blew us off. He was supposed to get into a group for positives . . . which he said he didn't want to get into, because he didn't want people to know that he was positive."

Frustrated with the client's disregard for health department demands, Doctor Q called the county prosecutor's office. An assistant county prosecutor met with health department staff but informed Doctor Q that the county could not pursue criminal charges without testimony from a partner. "That's basically where I became disillusioned with the system," Doctor Q lamented. Echoing the punitive attitudes of American social conservatives in the early years of the HIV epidemic, Doctor Q reported that he told the client he wished he could have his status tattooed on his body: "I told this guy . . . if it was up to me, if I was king [of the county], I would have a tattoo across his pubic hair: 'I'm HIV positive.' Where if somebody rips your pants down while you are passed out, then at least they can read, they can see that you are HIV positive."

Policy documents obtained from several health departments refer to the need for testimony from previous sexual partners in order to proceed

he-said type of thing, because so-and-so
apt with so-and-so.

It would be more akin to a check-in
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having a health official show up on
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"I might buy that once or twice . . .
I've had a disease, I'm not buying it."
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Q called the state's partner services
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with criminal legal intervention. Even before the warning letter is issued, health department staff are instructed to advise the complaining witnesses that they could meet with law enforcement personnel to discuss their complaints if they so choose. Health privacy laws sometimes make this difficult, however, in cases where health department staff discover a reported partner is HIV positive but the original client did not report knowing that any of their partners were HIV positive. How do you tell someone to call the cops if they do not know what to report? In Mitch's words, handling such cases requires a bit 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." 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?" At that point, sometimes we might say, "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.

Policies for interacting with the police may vary by county. But in at least some jurisdictions in Michigan, health department staff encourage clients to report their complaints to law enforcement.

Rather than personally appealing to the police or to the prosecutor, most health officials use the threat of legal intervention in order to frighten clients into compliance. When asked what it means for clients that are labeled a health threat, Debra, an HIV/AIDS coordinator in jurisdiction 13, responded that it's mostly a "scare tactic":

I let the [disease intervention specialist] build the relationship, get the information, try to see if our tactics on changing behavior work, and if they don't work, then I will go through the process of getting the HTTO, or try to bring in the law. But I think we just use it as a scare tactic. The fact is we can send people to jail. That is a fact. But at the same time, we don't want the community to stigmatize testing, or the health department, or that sort of thing. But my thing is that I can recognize when someone is being malicious versus somebody just having difficulty disclosing.

Debra's scare-tactic approach reflects how most Michigan health officials viewed the value of the HTTO law in their own work. Ninety-six percent of health officials I interviewed believed that health departments should strive to use public health interventions before calling the prosecutor's office (see table 1). However, even if most health department staff try to avoid immediately involving law enforcement, the strategies

Punitive Disease Control

TABLE 1 WHAT DO HEALTH OFFICIALS THINK ABOUT MICHIGAN'S "HEALTH THREAT" LAWS?

Issue Item	Agree	Disagree	Neutral
Any given "health threat to others" case, the HIV-positive person should not be charged with a crime unless one of their partners tests HIV-positive as a result of having sex with them.	12%	80%	8%
Laws that mandate HIV-status disclosure for HIV-positive people should be repealed.	0%	76%	24%
If an HIV-positive person was known to have used condoms consistently with their partners, they should not be criminally charged for failing to disclose their HIV status to their partners before having sex.	8%	64%	28%
An HIV-positive person should only be criminally charged for failing to disclose their HIV status if there is evidence that they were engaging in high-risk sexual behaviors with their partners.	28%	56%	16%
Laws requiring that HIV-positive people disclose their HIV status before having sex help to reduce the number of new HIV infections each year.	44%	20%	36%
Public health officials should first attempt to intervene in "health threat to others" cases by attempting behavioral counseling and/or other health interventions before referring a person for prosecution.	96%	0%	4%

NOTE: In 2012, I asked every health department official I interviewed to complete a survey regarding their attitudes towards "health threat" laws and HIV/AIDS more generally. These are their responses to questions about the law and cases brought under it. They are ordered from the statements most disagreed with to the statements agreed with by the most officials.

and techniques health officials employ to identify health-threat cases can have grave legal consequences for HIV-positive clients.

Three cases help to illustrate these consequences. First, in 1992, a woman in Muskegon County, Michigan, became one of a handful of people living with HIV known to be legally quarantined in the United States. The media widely reported the case of Brenda J. (discussed more extensively in chapter 5), which was made particularly controversial by her IQ of 72—just two points above the medical threshold for an intellectual disability diagnosis.²⁶ After reports surfaced again that she was having sex without disclosing her HIV-positive status, the Muskegon county prosecutor charged her under Michigan's felony HIV disclosure law. She was convicted in 1995 and sentenced to thirty-two months in prison.²⁷

NK ABOUT MICHIGAN'S "HEALTH

	Agree	Disagree	Neutral
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HIV-	0%	76%	24%
used	8%	64%	28%
they g to before			
nally atus g in ners. close	28%	56%	16%
o reduce ear. intervene	44%	20%	36%
pting	96%	0%	4%

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In another case in Muskegon County, in 2003, news reports revealed that a police investigation explicitly began when the health department contacted police. According to a May 22, 2003, news report, "An investigation by police was started last week after the Muskegon County Health Department contacted the prosecutor's office."²⁸ That investigation was triggered by an HTTO notice issued by the health department. "Prosecutor Tony Tague said that a 'warning notice' had been sent to the woman by the health department on May 7. . . . The investigation revealed that [the defendant] had sex on May 9 and 12 with the victim without telling him she was HIV positive."²⁹

This appears to not have been the only time Michigan health officials have forwarded cases to law enforcement for investigation. Documents obtained by a Michigan-based journalist reveal that the Grand Traverse County Health Department wrote to the county prosecutor about complaints against a local HIV-positive man in February 2009. The recently unearthed memo was prompted by allegations to health department staff that the man—referred to as Mr. X in the redacted memo—was engaging in "unprotected" sex with partners he met online and in public restrooms. In the memo, the health department director writes:

I suggest three options: 1. This Mr. X be warned by you and/or prosecuted for failure to inform his sex partners of his HIV status. 2. There be a "sting" operation by the police at the public bathroom where this person is reported to have had his encounters. 3. That I go public and inform the public via the media that this activity is happening and that anyone who has engaged in this behavior should get tested for HIV and other STI. I would not divulge the name of the person or the public bathrooms. 4. All or two of these options.³⁰

Despite these efforts, follow-up requests to the prosecutor's office suggest that Mr. X was not criminally charged.

Of course, these cases are atypical examples. The first case involves the only person known to have been placed under quarantine for HIV in Michigan. And although the following cases suggest some coordination between health departments and prosecutors, health departments did not routinely send memos to county prosecutors recommending sting operations. Nonetheless, these cases illustrate the high stakes involved when health departments become arms of the police.

WHY DISCLOSURE?

Reports from around the country reveal that the tactics employed in Michigan to control HIV-positive people are not unique. A North Caro-

lina court found an HIV-positive man guilty of violating his probation in 2008 when he tested positive for an undisclosed sexually transmitted infection at a local health clinic. He had been arrested "after Wake County Public Health officials contacted his probation officer with information that he had possibly violated court orders by having sex without a condom. . . . Health officials became aware of the DJ's violation after he contracted another sexually transmitted disease that could have been prevented by the use of a condom."³¹

In Indiana, a county health department administrator went on local television news in April 2015 to report that the health department was pursuing criminal charges against an HIV-positive client that it determined "has infected eight people with HIV, one with AIDS." (As it is not possible to infect someone with AIDS, presumably the health department staff person meant that one of the partners' HIV infections had progressed to AIDS.) The health department reportedly knew the person was aware of the legal obligations because "the person in question signed a document saying that person 'would' warn others." In Tennessee, a judge cited a similar information form designed by a local health department as a basis for enhancing the sentence of a criminal defendant.³² Reports suggest that health departments in additional states, including Mississippi, North Carolina, and Florida, currently or have recently employed such forms.³³

In other cases, local health departments appear to have violated confidentiality laws in ways that facilitated the prosecution of people living with HIV. In a criminal case reviewed for the analysis in chapter 5 of this book, for example, a Tennessee prosecutor revealed that a woman pressed felony HIV exposure charges in 2002 after the local health department informed her that a man she reported as a partner during a partner services interview was HIV positive—echoing several of the statements made by local Michigan health department staff earlier in this chapter.³⁴ This report resembles a previously mentioned case from Kent County, Michigan, in 2000 in which court reports revealed that the complainant learned of the defendant's HIV-positive status directly from a "health worker."

What are the consequences of a local health department that begins to act like the police? At the most basic level, one likely outcome is that people will think twice before speaking candidly to health officials. Studies since 1996 have shown that marginalized communities often fear disclosing sensitive information to medical providers because they do not know how that information will be used.³⁵ In this chapter, we

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have seen that Michigan health officials engaged in surveillance prac-
tices that they did not disclose to their clients. For example, when they
asked newly diagnosed clients if any of their partners disclosed to them
that they were HIV positive, they did not preface that question with an
explanation that they were trying to catch lawbreakers. This lack of
transparency directly conflicts with the public health ethical principle
that "where government authorizes or mandates the collection of iden-
tifiable health data, both the data to be collected and the reason for
collection should be a matter of public record."³⁶

But policing public health and punitive disease control more broadly
may have other, even more harmful effects that are difficult to predict.
Clearly, some people viewed the health department in much the same
way that they viewed the police. If there is a person in your neighbor-
hood causing trouble, who are you going to call? At least in some cases,
the answer appears to be your local health department. By accepting
their phone calls and collecting their information, health officials are
inviting community members to participate in the naming, shaming,
and blaming of their HIV-positive neighbors. This may encourage com-
munity members (like the "stupid" client described by Doctor Q) to
seek out and trade in the HIV statuses of people in their communities,
intensifying stigma and prejudice while ramping up the everyday sur-
veillance of HIV-positive people.

Health officials participate in this network of gossip in the name of
promoting disclosure. But community members may interpret this
emphasis on disclosure as a license to know who is and who is not HIV
positive. Public health promotes a model of disclosure that resembles
informed consent in medicine, where an HIV-positive person discloses
his or her status to potential partners so that they can weigh the risks
and benefits of having sex with him or her. Community members, how-
ever, trade in the disclosure of other people's HIV statuses without their
permission—using a mythical book as an alibi for their illegal behavior.
While the two forms of disclosure seem unrelated, they both rely on the
assumption that knowing another person's HIV-positive status is an
effective tool for reducing HIV risk.

But does disclosure actually work as an HIV prevention strategy?
Health officials did not think so. While none of the officials believed the
felony HIV disclosure law should be repealed, fewer than half (44 per-
cent) believed that the law actually helps to reduce the number of new
HIV infections (see table 1). Rather than a tool for HIV prevention, the
law's utility seems to be that it reinforces the belief that HIV-positive

people have an ethical duty to inform their partners of their HIV status. But the new science of HIV begs the question of why HIV-positive people should be compelled to tell others about their infection if it is impossible for HIV-positive people on treatment to transmit the virus sexually. Why do HIV-negative people have a right to know?

This book cannot directly answer these ethical questions. However, what it can do is to explain the consequences that flow from punishing disease. The next three chapters explore this more closely by analyzing the criminal justice system. Who is being punished? Why? By better understanding how HIV-specific criminal laws are being applied across the United States, the stakes involved in these ethical debates become clearer.

Making HIV a Crime

On October 15, 1982, a White House reporter asked President Ronald Reagan's press secretary Larry Speakes about the AIDS epidemic for the first time. More than a year had passed since the June 1981 report from the Centers for Disease Control (CDC) documenting a handful of pneumonia cases involving young gay men in Los Angeles. The CDC had recently termed the disease "acquired immune deficiency syndrome," but the president had remained silent, even as the disease claimed the lives of hundreds of Americans. In an almost-casual act of callous indifference, Speakes feigned ignorance, asking, "What's AIDS?" When the reporter replied, "It's known as the gay plague," the entire room erupted in laughter. "I don't have it," Speakes replied. "Do you?"

For several years, the Reagan administration's official response to AIDS would be no response at all. AIDS had become political fodder for religious conservatives who characterized the disease as the "cure for homosexuality." Any legislation introduced to fund AIDS research, treatment, or prevention became mired in moralizing debates over whether these efforts might have the effect of "promoting homosexuality"—a view summarized neatly in a 1983 Oklahoma newspaper editorial criticizing calls for increased federal AIDS funding:

Any human being is entitled to compassion. And any American citizen deserves the best medical care he can afford. But the public is under no moral obligation to provide a disproportionate share of its wealth to deal with a problem that, at least for 75 percent or more of the victims, results from their

own pursuit of a lifestyle that the vast majority considers to be perverted, abnormal and immoral.¹

By 1985, over one hundred thousand Americans had contracted the disease. Many of them had died—including America's one-time heart-throb, actor Rock Hudson. With so many Americans affected by the epidemic, it became increasingly indefensible for the government to remain indifferent, even in the face of sharp criticism like the editorial above. Yet, even as legislators across the country finally began to mount a response to the disease, fear and stigma continued to guide their approach. When the U.S. House considered \$189.7 million in funding for AIDS research and prevention in the fall of 1985, Republican legislators tacked on a provision allowing the surgeon general to close gay bathhouses. Representative William Dannemeyer (R-CA) justified the effort to crack down on gay establishments, arguing that "God's plan for man was Adam and Eve, not Adam and Steve."²

Beyond just a question of funding, however, the legal and regulatory problems posed by AIDS were systemic. Basic bureaucratic concerns such as what agencies were responsible for managing which aspects of the government's response to AIDS needed to be sorted. Monitoring the epidemic also required clarifying technical public health surveillance issues such as how newly diagnosed cases were to be reported to health authorities. And with so much misinformation and stigma circulating among Americans, there was an urgent need to clarify whether existing civil rights legislation protected HIV-positive children from being barred from enrolling in school and dying tenants from being evicted by their landlords.

While the federal government had a role to play in providing funding, instituting regulations, and designing guidelines, much of the day-to-day work of prevention, treatment, and surveillance was not done at the federal level. As is the case in most areas of public health practice, the bulk of the responsibility for managing the response to HIV lay instead with state departments of public health and their county- and city-run counterparts.³ In most states, basic provisions for public health practice are housed in state public health codes enacted by the state legislature—meaning that adapting each state's public health infrastructure to HIV generally required action by lawmakers.⁴

In many states, this was a daunting task: most states had adapted their disease control laws piecemeal over time in response to the specific epidemics of the day. As legal experts Lawrence Gostin, Scott Burris, an

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Zita Lazzarini put it, these laws "tell the history of disease control in America much as geologic strata tell the history of the earth":

In the eighteenth century, communicable disease statutes focused primarily on smallpox, though quarantine regulations were generally applied to any identified disease or "fever" that might be perceived as a threat. . . . In the nineteenth century, states and municipalities enacted regulations in response to periodic epidemics of yellow fever and cholera. . . . Increasing attention was also paid to tuberculosis, which was one of the leading causes of death. . . . Continuing efforts to control syphilis in the first half of twentieth century led to statutes authorizing premarital screening, reporting, contact tracing, and involuntary treatment.⁵

Each new disease brought a new layer of legal regulation and control. However, rather than overhauling the entire public health code when new threats emerged, lawmakers tended to either draft new provisions specific to the new illness or simply tack it on to antiquated statutes.

Although AIDS bore similarities to diseases that came before it, three key differences set it apart from epidemics of the past. First, while HIV was transmitted sexually like syphilis and gonorrhea, it was also frequently transmitted through nonsexual *blood-to-blood contact*. Regulating injection drug use was not quite the same as regulating sexual behavior. This made HIV somewhat ill suited for the "venereal disease" statutes enacted during the syphilis panics of World War II.

Second, although AIDS could be deadly like tuberculosis (TB), it was *untreatable and incurable*—meaning that inserting AIDS into long-standing TB quarantine statutes would have entailed locking up people living with HIV for the rest of their lives; the human rights implications were perilous, not to mention the cost to the state of such a program. HIV is also different from TB in that it is not highly contagious. For these reasons, quarantine has never been widely regarded by public health experts as a sensible approach to HIV prevention.⁶

Third, because the disease was sexually transmitted, deadly, and primarily associated with gay men and drug users, the *stigma* attached to HIV was considerable: HIV-positive children were kicked out of their schools;⁷ prominent conservatives promoted conspiracy theories that the government was lying about the contagiousness of AIDS;⁸ and some funeral homes even turned away people who died of AIDS-related illness out of an unfounded fear of contracting the disease.⁹ Consequently, many in public health argued that lawmakers needed to codify exceptionally stringent privacy safeguards to help promote HIV testing—an approach that came to be known as AIDS exceptionalism.¹⁰

These complexities made it all but impossible for legislators to simply tack HIV onto existing public health law; they needed to draft entirely new, HIV-specific legislation. Over the next five years, legislators across the country introduced a flurry of legislative proposals for testing, treating, and preventing HIV.

At the heart of many of these legislative efforts was a debate over whether to restrict the civil liberties of people diagnosed with the disease—often positioned as necessary to protect the “general population” (a category that presumably excluded gay men and other minorities). Conservatives called for invasive and punitive measures to curtail the rights of people living with HIV, and polling data suggests that support for such proposals grew over time. A 1987 *Los Angeles Times* poll found that 42 percent of Americans believed that “civil liberties must be suspended in the war on AIDS,” and 68 percent favored “criminal sanctions against people with acquired immune deficiency syndrome who remain sexually active.”¹¹ Perhaps even more troubling, the *Times* poll found that the number of people supporting conservative columnist William F. Buckley’s proposal to tattoo newly diagnosed patients had doubled from 15 percent in 1985 to 29 percent in just two years.

AIDS emerged in this punitive culture of fear, which directly shaped how legislators in the United States responded to the disease and sought to manage it. By harnessing AIDS stigma, lawmakers stoked Americans’ fears in order to justify new punitive policies that explicitly and implicitly targeted gay men, sex workers, and injection drug users—a tactic lifted straight out of the war on drugs playbook.¹²

This chapter analyzes how HIV-specific criminal legislation spread throughout American state legislatures between 1985 and 2014. Historically, scholars have suggested that federal policies were responsible for prompting states to enact HIV-specific criminal penalties. Specifically, they point to Ronald Reagan’s presidential commission, described in more detail later in the chapter, which recommended enacting HIV-specific criminal laws in its 1988 report. They also point to the Ryan White CARE Act of 1990, which included a provision that required states to certify that their criminal laws were “adequate to prosecute any HIV infected individual” who knowingly exposes a person to HIV.¹³ However, as this chapter shows, by the time the commission issued its report in the spring of 1988, lawmakers in sixteen states had already introduced over two dozen bills that would impose some form of criminal sanction against HIV-positive people during the 1985, 1986, and 1987 legislative sessions. This chapter argues that rather than being the

impossible for legislators to simulate health law; they needed to draft. Over the next five years, legislative flurry of legislative proposals for

legislative efforts was a debate over the rights of people diagnosed with the disease. The effort to protect the "general population" included gay men and other minorities. The use of punitive measures to curtail the disease and polling data suggests that support for such measures was high. A 1987 *Los Angeles Times* poll found that 68 percent favored "criminal sanctions" for people with HIV. Even more troubling, the *Times* poll found that 68 percent of newly diagnosed patients had a "culture of fear," which directly shaped the response to the disease and sought to stigmatize, lawmakers stoked Americans' fears of the disease and sought to punish those who used injection drugs—users—a tactic that explicitly and implicitly supported conservative columnists. The *Times* poll found that 29 percent in just two years.

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spark that ignited a wave of criminalization, these federal policies played a diminished, institutionalizing role, legitimizing the moves toward criminalization that were already well under way.

This chapter explains four factors that actually did motivate states to enact HIV-specific criminal laws. First, *prosecutors attempted and failed to use general criminal laws* such as assault and attempted murder to punish HIV-positive defendants, but a series of high-profile acquittals and dismissals drove many prosecutors and members of law enforcement to conclude that HIV-specific criminal laws were necessary.

Second, numerous news reports from the mid-1980s reveal an *organized aggravation* among police and prosecutors confronted with sex workers who had tested positive for HIV; police, prosecutors, and media organizations cried out for HIV-specific felony prostitution penalties.

Third, some states began to consider criminalizing HIV as a necessary measure in response to the *decriminalization of sodomy*—a move that some believed would lead to an explosion of new HIV cases.

Fourth, a Republican state representative from Illinois and member of Reagan's presidential commission—wryly referred to in this book as "Lawmaker Zero"—worked with an influential lobbying organization to leverage her institutional networks, helping to disseminate a model statute to dozens of states around the country.

Rather than a singular top-down story of federal influence, these four factors reveal a far more complex origin story of the movement to criminalize HIV.

PROSECUTION, INTERRUPTED: WHY LAW ENFORCEMENT DEMANDED HIV-SPECIFIC CRIMINAL LAWS

In October 1985, the San Antonio Health Department took an unprecedented step in its effort to control HIV: department staff hand-delivered letters to the homes of fourteen of the seventeen city residents known to have contracted HIV. These letters were not intended to console or provide counsel for the terminally ill patients, but rather to warn them: if they engaged in any sexual activity whatsoever with an HIV-negative person, they would face felony criminal charges.¹⁴

The letters were reportedly sparked by warnings from an area physician that "at least three" people living with the disease "had not limited their sexual activities."¹⁵ San Antonio's health director, Dr. Courand Rothe, reassured the public at a news conference organized to respond

to criticism over the letters. "I'm not interested in putting people in jail. I just want to control this disease," he said. Nonetheless, the hand-delivered letters threatened the recipients with third-degree felony charges carrying a maximum penalty of ten years in prison and a \$5,000 fine under the Texas Communicable Disease and Control Act. The letter specifically instructed:

You must not engage in sexual intercourse with anyone not having a confirmed diagnosis of AIDS. You must not share the use of needles with another. You must not donate blood, blood products, semen, body organs or other tissues. You must make the fact that you are a diagnosed AIDS patient known to physicians, dentists, and others whom you consult as a patient on a professional basis.¹⁶

The National Gay Task Force (one of the nation's leading gay rights organizations) called the response "hysterical" and criticized health authorities for making "people think gays with AIDS are being irresponsible."¹⁷ The organization argued that the best way to control the disease was not punishment but education and the use of condoms.

The health department director's threat of criminal charges represents one of the first systematic attempts in the United States to criminalize the behavior of people living with HIV. At the time, it was not specifically a crime for HIV-positive people to engage in sexual activity under Texas law—or anywhere else in the country, for that matter. Rather, the director was creatively deploying a provision in a 1983 Texas statute providing for felony charges against any person who "knowingly refuses to perform or to allow the performance of certain control measures ordered by a health authority or the department."¹⁸ The health director did not wait for a particular person to demonstrate behavior that might put others at a risk of transmission. Instead, he simply delivered his orders to almost every single person diagnosed as living with HIV in the city of San Antonio, effectively writing a city-level, HIV-specific felony into law.¹⁹ This provision gave local health departments in Texas the unilateral power to classify as felonious any actions they deemed a threat to public health.²⁰

San Antonio turned out to be an aberrant case; few health departments took such strident actions. Much more typical were efforts by prosecutors to devise creative strategies for using other statutes not specifically designed to punish people living with HIV. For example, on October 6, 1985, police arrested Blaine Prairie Chicken "during a disturbance at a laundromat" in El Cajon, California.²¹

interested in putting people in jail. he said. Nonetheless, the hand-picked individuals with third-degree felony of ten years in prison and a \$5,000 fine under the Disease and Control Act. The letter

course with anyone not having a contact share the use of needles with another. products, semen, body organs or other if you are a diagnosed AIDS patient others whom you consult as a patient on

of the nation's leading gay rights "hysterical" and criticized health care workers with AIDS are being irritated that the best way to control the transmission and the use of condoms. The threat of criminal charges represents an attempt in the United States to criminalize living with HIV. At the time, it was not easy for people to engage in sexual activity freely in the country, for that matter. By deploying a provision in a 1983 law that charges against any person who allows the performance of certain health authority or the department."¹⁸ For a particular person to demonstrate a risk of transmission. Instead, he lost every single person diagnosed as an AIDS patient, effectively writing a city's law.¹⁹ This provision gave local health officials the power to classify as felonious any public health.²⁰

an aberrant case; few health departments. Much more typical were efforts to use strategies for using other statutes to punish people living with HIV. For example, police arrested Blaine Prairie Chicken "indomitable" in El Cajon, California.²¹

"Chicken is accused of biting one of the officers through his uniform, drawing blood, and then telling the officer that he was a homosexual who had AIDS and that he hoped the officer contracted the disease," reported the *San Diego Union-Tribune*.²² Prosecutors charged Chicken initially with resisting arrest and battery on a peace officer but fought to keep him behind bars while they could determine what charges to seek in the case. After effectively denying Chicken bail, municipal court judge Victor Bianchini told the media: "This is such a novel case. . . . We could have a homicide or an attempted homicide case."²³

Despite the fact that HIV was not known to be transmitted through biting, Chicken's case dragged on for nearly a year as prosecutors waited to determine if Chicken did, in fact, have the disease. His defense attorney and the prosecutor came to a plea agreement that was contingent on the outcome of those tests: "Prairie Chicken will be sentenced for misdemeanor assault if the officer is determined not to have been exposed to AIDS. If the officer has been exposed, however, Prairie Chicken will receive a felony sentence."²⁴ Ultimately, testing showed Chicken to be HIV negative; he pled guilty to misdemeanor offenses and was sentenced to ninety days in jail.

Several miles away in San Diego County, authorities were simultaneously trying to determine the HIV status of a man who was arrested during the city's twelfth annual gay pride festivities after he reportedly "squirited water" at antigay demonstrators.²⁵ As he was being arrested, Brian Barlow allegedly bit two officers on the hand and shoulder. After taking Barlow to the hospital to be treated for injuries sustained during the arrest, police officers asked him if he was gay and HIV positive.²⁶ He said that he was gay, but denied being HIV positive twice before finally stating that "for the officers' sake, you better take it that I do." After refusing to voluntarily submit to a blood test for HIV, police forcibly drew his blood and booked him on charges of battery on a police officer. The officers planned to test the sample for HIV, and, if the tests came back positive, prosecutors intended to increase the charges against Barlow to felony assault with a deadly weapon. State law, however, prohibited the results of an HIV test from being shared, barring authorities from accessing vital records. Officers appealed a lower court's ruling that prohibited them from accessing the results, but the California Supreme Court ultimately ruled against them. A jury ultimately acquitted Barlow of the lesser criminal charges.²⁷

Across the country, police and prosecutors were often thwarted in their attempts to apply general criminal statutes against people

living with HIV. In cases like Chicken's and Barlow's, medical privacy laws prevented accessing defendants' HIV-test results. In other cases, however, prosecutors struggled to fit HIV-related prosecutions into legal structures that were not designed for punishing disease. Like the judge assigned to Chicken's case, authorities often boasted of their goals to charge defendants with attempted murder. However, their efforts to do so were almost never successful, as homicide statutes require that prosecutors prove that the defendant specifically intended to kill.

In 1987, for example, Fresno, California, prosecutors dropped attempted murder charges against a woman sex worker and a man described as her "pimp." The prosecutor told the media that murder charges were deemed inappropriate "because California law requires proof of a specific intent to kill in order for the charges to be made."²⁸ Later that year, a Los Angeles judge dismissed attempted murder charges against a gay man accused of selling his blood to a plasma bank because "the prosecution failed to show the defendant intended to kill anyone."²⁹ These widely reported cases came on the heels of similar cases in which homicide-related charges were dismissed or failed to stick in Florida and Michigan in 1986.³⁰

In the face of these failed prosecutions, media outlets demanded that legislators introduce HIV-specific criminal laws. An *Orlando Sentinel* editorial specifically argued that stiff penalties were necessary to discourage "case-by-case experimenting" in which authorities "dream up novel ways to prosecute today's version of Typhoid Mary."³¹ But nowhere in the country was the discussion as heated as in California, where conservative extremist Lyndon LaRouche had stoked the fears of Americans through repeated ballot initiatives aimed at restricting the civil rights of people living with HIV.³² In a 1987 editorial titled "There Ought to Be a Law," *Daily News of Los Angeles* staff wrote that "it is time for Sacramento to exercise the political will needed to prevent unstable AIDS victims from passing on a death sentence to others."³³

Although some were skeptical, public health experts had different opinions as to whether criminalization was a good idea. Some did expressly oppose criminalization, such as public health law expert Lawrence Gostin, who frequently argued against imposing criminal sanctions on the grounds that they "would make it more difficult to combat the disease."³⁴ In a 1987 address to a joint session of the California legislature, Nobel laureate and AIDS researcher Dr. David Baltimore implored lawmakers to "hold in check the instinct to punish the infected."³⁵ Other experts were more ambivalent, such as Surgeon Gen-

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public health experts had different opinions. Criminalization was a good idea. Some did not. Such as public health law expert Lawrence, who argued against imposing criminal sanctions, would make it more difficult to combat the disease. At a joint session of the California AIDS researcher Dr. David Baltimore said he checked the instinct to punish the disease was more ambivalent, such as Surgeon Gen-

eral C. Everett Koop, who questioned whether such laws were enforceable: "There are people who say you should make it [a] felony for [people living with HIV] . . . to 'exchange bodily fluids.' How are you going to do that? Are you going to monitor every bedroom?"³⁶

Other public health experts, however, were explicitly in favor of criminalization. In an *American Journal of Public Health* article published in 1989, Dr. Victor E. Archer proposed a six-point HIV control plan that included implementing a quarantine system he termed "HIV parole" as well as a call for public health officials to sponsor "uniform laws throughout the United States making it a felony . . . to infect someone else with HIV."³⁷ Findings from a 1994 survey of state health departments reflect this diversity of opinion: one-third supported the use of criminal laws to punish people living with HIV; one-third were opposed; and one-third were uncertain or did not respond.³⁸ In short, there was no consensus on the matter among public health practitioners, leaving the professionals with the most expertise largely relegated to the sidelines as these debates unfolded.

Although initially dismissive, President Ronald Reagan's administration did eventually put together a commission tasked with making policy recommendations for addressing the HIV epidemic in the United States. When Reagan's Presidential Commission on the HIV Epidemic issued its final report in 1988, the authors did not equivocate on the subject of the criminal law. They argued that "HIV-infected individuals who knowingly conduct themselves in ways that pose a significant risk of transmission to others must be held accountable."³⁹ However, they recognized the problems facing authorities hoping to do so:

Use of traditional crimes such as murder or attempted murder to prosecute an individual for HIV transmission presents such difficulties as proving that the intent of the HIV-infected individual . . . and proving that the act of transmission was the actual cause of death. Although the assault model provides a more useful tool for criminal prosecution of HIV transmission, the penalties for assault would prove too lenient in those cases where the transmission was intentional.⁴⁰

In this passage, the presidential commission's report zeroes in on a key problem facing prosecutors hoping to press charges against HIV-positive defendants. Under criminal statutes such as assault with a deadly weapon and attempted murder, the prosecutor must show that the defendant acted with criminal intent, or mens rea. A string of high-profile acquittals and dismissals for failure to prove intent and/or to legally secure the defendant's medical records fueled a belief among

some in law enforcement that general statutes were insufficient. While it did not explicitly say that general statutes were insufficient, the presidential commission nonetheless spoke to this concern by encouraging states to review their statutes and determine whether HIV-specific laws were necessary.⁴¹

"SELLING DEATH": ORGANIZED AGGRAVATION AND THE FIGHT FOR FELONY PROSTITUTION PENALTIES

During the early 1980s, there was considerable anxiety among public health professionals and the public that prostitution might provide a "bridge" for HIV to jump from urban centers to American suburbs. These fears were inflamed by a series of small studies that found high levels of HIV prevalence among female sex workers in several African countries.⁴² In 1985, a team of researchers examining the heterosexual transmission of HIV warned that "prostitutes could serve as a reservoir for [HIV] infection for heterosexually active individuals."⁴³ Based on these findings, health authorities worried that HIV in the United States could become what epidemiologists call a "generalized epidemic"—diffuse throughout the American population instead of concentrated in specific subpopulations.

But as a 1989 article in the *San Francisco Chronicle* describes, the impending heterosexual epidemic driven by prostitution never came:

In 1985, public health officials—particularly in New York City, where as many as half of all prostitutes are estimated to be HIV-infected—predicted that it was only a matter of time before the businessman from Cleveland was spreading around viral souvenirs to his wife or girlfriend. At the CDC, the epidemiologists waited for evidence that this would happen. And they waited. Several years into their watch, however, it hasn't.⁴⁴

A CDC researcher told the *Chronicle*, "There isn't any evidence that I'm aware of that clearly indicates prostitutes as a transmitter of HIV infection."⁴⁵ As most sex workers are women, this was likely due to the fact that it is much more difficult for HIV to be transmitted from women to men than the reverse. This was not uncommon knowledge. For example, a legal expert reported in a 1988–1989 law review article: "Current statistics reveal that prostitutes are an unremarkable source of AIDS infection. . . . Nor is the virus spread effectively from the female prostitute to the customer."⁴⁶

Numerous news reports from the mid-1980s had described a sense of aggravation among law enforcement authorities confronted with sex

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e mid-1980s had described a sense of ent authorities confronted with sex

workers who had tested positive for HIV. Prostitution was generally a misdemeanor offense in most states, which meant that anyone arrested for prostitution would likely be free from jail in a matter of months or even days. Police were upset that there was little they could do to keep these individuals behind bars. In a criminal justice context, *aggravation* typically refers to factors that make an individual crime more egregious and, thus, deserving of a more severe punishment. As the next chapter reveals, HIV is frequently viewed by judges and prosecutors as an aggravating factor in a court of law. But as this section reveals, a similar phenomenon can be observed on a broader scale when members of law enforcement organize to label a set of practices as especially egregious and deserving of increased punishment—what this book terms *organized aggravation*.

In Georgia, the Fulton County prosecutor declared his intent to charge HIV-positive sex workers with felony assault.⁴⁷ He relied on a newly implemented regulation issued by the Georgia Department of Human Services that allowed that agency to report the HIV-test results of convicted sex workers to local judges.⁴⁸ In Rhode Island, Chief Judge Albert E. DeRobbie invoked a new state law that allowed the health department to involuntarily test a person deemed to be a threat to public health, demanding that district court judges relay the names of individuals convicted of prostitution to local health departments for testing; Judge DeRobbie justified these efforts by labeling AIDS as deadly and anyone who infects someone else as an executioner. "If you give someone AIDS, you sentence them to death."⁴⁹ In Minnesota, prosecutors sought to revoke the probation of a woman suspected of being HIV positive after she was entrapped by an undercover police officer for soliciting. The prosecutor did not mince words in defending his efforts: "It is akin to someone walking down the streets carrying a bomb."⁵⁰

In the face of these legal challenges, lawmakers in several states sought to enact legislation that would aid the efforts of prosecutors and the police to put sex workers living with HIV behind bars for far longer. They did not rely on scientific studies to justify their efforts; instead, they sensationalized individual arrests of HIV-positive sex workers. These widely publicized cases represent one type of what crime policy scholars call "triggering events," which include sensationally reported crimes, court decisions, interest-group lobbying, and other factors that trigger lawmakers to devise new criminal sanctions.⁵¹ Police lobbied for new laws on the basis that these individual sex workers were just the tip of the iceberg, representing a much larger problem that they believed needed to be addressed through legislative action.

In fact, the practice of pointing to specific HIV-positive sex workers dates back to the first known attempt to pass HIV-specific criminal legislation. On May 6, 1985, New Jersey legislators introduced the first HIV-specific crime bill in the United States. Assembly Bill 3577 was broadly construed so as to impose penalties on any person living with HIV who, "knowing that he is infected by acquired immune deficiency syndrome, transmits the disease to another person through sexual contact."⁵² Nonetheless, the bill's sponsor, New Jersey state senator Gerald Stockman, told media outlets that he drafted the bill "at the request of Trenton police," who were reportedly concerned that "a 25-year-old AIDS victim who has two young children with the disease had been working as a prostitute on city streets."⁵³ (The bill did not pass.)

Notably, it was police who brought the issue to the attention of New Jersey lawmakers. Throughout the 1980s, law enforcement frequently lobbied for legislation that would impose criminal sanctions against people living with HIV—far more than any other interest organization. Although police representatives occasionally made their case in public to the media, they also lobbied lawmakers behind closed doors—evidence of their influence remains only in lawmakers' public statements such as Stockman's. Although New Jersey's bill failed, police continued to press lawmakers in several states to enact specific legislation that would enable prosecutors to charge HIV-positive sex workers with what is sometimes termed *aggravated prostitution*—a felony offense targeting HIV-positive sex workers.

In Nevada, the only state in the country that allows local jurisdictions to permit prostitution, lawmakers led the way in enacting such legislation when they passed a landmark bill in 1986 requiring anyone convicted of prostitution to be tested for HIV; those who tested HIV positive would face felony charges if they were ever again caught selling sex. According to Nevada state legislator John DuBois, the bill was supported by law enforcement. He told the media that "law enforcement was particularly for this because it fills a void. . . . They have no law on the books to really do anything about these people except something that makes spreading an infectious disease a misdemeanor."⁵⁴

In other states, aggravated-prostitution legislation was influenced by partisan politics as legislators jockeyed to position themselves as tough on crime to their constituents. In 1988, for example, California representative Bruce Bronzan introduced a felony bill targeting sex workers living with HIV. Bronzan, a Democrat, had voted against punitive AIDS bills in the past, but in 1988, he was up for reelection in conservative

Two Republican representatives, Rich Crotty and Javier Souto, introduced a felony prostitution bill a mere nine days after the *Sun Sentinel* editorial went to print. The American Civil Liberties Union lobbied against the bill, arguing that the issue should be labeled as a problem for doctors instead of the criminal justice system: "These people are a medical problem, not a criminal problem."⁶⁴ Souto defended the stiffer penalties by again invoking the homicide label, arguing that "60 days is a very short period of time when we're dealing with a killer."⁶⁵ Ultimately, the felony prostitution penalty was folded into a much larger bill relating to public health and HIV—House Bill 1519—and was voted into law.⁶⁶

Over the next several years, familiar stories played out in more states—such as Colorado two years later. News broke in early January that a woman living with HIV named Avis had been arrested for prostitution for the twenty-sixth time in Denver.⁶⁷ But while medical privacy laws prevented health authorities from publicly discussing Avis's case, city prosecutors and the police publicly expressed their frustration with her case to the media. City attorney Steve Kaplan complained, "Yea, we're frustrated. . . . We're real frustrated. We're the ones who have to deal with her."⁶⁸ The police did more than just complain, however; reports reveal that they reacted to Avis's case by actively organizing to label sex work for people living with HIV as a felony, launching a media campaign and sending lobbyists to the Denver capitol building to advocate for an HIV-specific felony prostitution bill. On January 31, 1990, a *Rocky Mountain News* article opened with the following lede: "Denver police say AIDS is spreading among the city's prostitutes, many of whom continue to work the streets despite knowing they are dying of the disease and passing it on to their clients."⁶⁹ Mostly informed by police sources, the story does not cite a specific case of transmission from a sex worker to a client; instead, it relies on police representatives' claims that a group of women sex workers were exposing countless Denver residents to the disease.

Less than a week later, the *Denver Post* ran a story picking up where the *Rocky Mountain News* story left off, dedicating much of the story to Avis's case.⁷⁰ In this story, however, police explicitly label the woman's actions as homicidal—not just to her clients, but to her family. Sergeant David Watts told the *Post* that "Avis and others like her are selling death. . . . People say that the john (solicitor of prostitutes) gets what he deserves. Well, it goes further than that. AIDS is transmitted to his wife and to their baby." In Watts's view, prostitutes were not just killing their clients, they were endangering the lives of innocent women

Crotty and Javier Souto, introduced nine days after the *Sun Sentinel* in Civil Liberties Union lobbied should be labeled as a problem for system: "These people are a medical system." Souto defended the stiffer penalties, arguing that "60 days is a very long time with a killer."⁶⁵ Ultimately, the bill was expanded into a much larger bill relating to prostitution—519—and was voted into law.⁶⁶ Familiar stories played out in more cities later. News broke in early January 1988 that Avis had been arrested for prostitution in Denver.⁶⁷ But while medical privacy laws prohibited publicly discussing Avis's case, the public expressed their frustration. Attorney Steve Kaplan complained, "I'm frustrated. We're the ones who did more than just complain, how- ever, to Avis's case by actively organizing with HIV as a felony, launching boycotts to the Denver capitol building to pressure the prostitution bill. On January 31, the editorial opened with the following lede: 'Among the city's prostitutes, many die despite knowing they are dying of their clients.'⁶⁹ Mostly informed by the citation of a specific case of transmission, the editorial relies on police representatives' claims that sex workers were exposing countless

The *Post* ran a story picking up where the editorial left off, dedicating much of the story to police explicitly label the women as prostitutes to her clients, but to her family. The story stated that "Avis and others like her are not johns (solicitors of prostitutes) gets her more than that. AIDS is transmitted to prostitutes's view, prostitutes were not just endangering the lives of innocent women

and children. However, no incidents in which HIV was transmitted along such a route were identified.

In previous cases, police had frequently pointed to isolated cases rather than scientific data to justify their calls for criminalization. This is likely due to the fact that scientific studies conducted in the United States largely contradicted their claims that sex workers posed a significant health threat. While sex workers often had elevated HIV prevalence rates, studies concluded that prostitution was not likely to drive a heterosexual epidemic in the United States.⁷¹ Rather than relying on published figures, however, Denver police made up their own statistics, telling the *Post* that 75 percent of male sex workers and 50 percent of female sex workers were HIV positive. These figures were outrageously high and stood in stark contrast to scientific findings published at the time that less than 7 percent of women sex workers in American urban areas were living with HIV.⁷² Police representatives told the *Post* that they had "no way of verifying our statistics." However, the *Post* story suggests that this was not true: Apparently police could have obtained more reliable figures had they picked up the phone and called the state health department: The director of Colorado's HIV control problem informed the *Post* that only 1 percent of sex workers tested *by order of the police* had tested HIV positive. "It's not like it's a widespread problem. I don't know where they are getting their figures," he added.⁷³

In an editorial published days later, the *Rocky Mountain News* relied on those health department figures to argue for a more well-informed debate on the issue.⁷⁴ Police and prosecutors, it argued, were identifying the wrong cause driving the epidemic: injection drug use, not prostitution, was the deserving culprit. "While we don't necessarily object to such a law," said the editorial,

we do dissent from pointless fear-mongering. The fact is that female prostitutes are not spreading AIDS willy-nilly. . . . Between 1986 and '88, Denver General Hospital tested 372 prostitutes picked up by Denver police. Only four tested positive. . . . True, of 538 other people tested last year who admitted several "high risk factors" at some time in their lives, including IV drug use and prostitution, 51 tested positive. But this says little or nothing about the risk of getting AIDS for either non-drug-using prostitutes or their customers, since needle-sharing is a great way to transmit the virus.⁷⁵

However, the engines of criminalization already in motion were not fueled by statistics or science; the organized aggravation of police was instead based on emotions and stigmatizing views of HIV and its transmission. Denver police assigned Detective John Schnittgrund to lobby

lawmakers for an HIV-specific felony bill targeting sex work, even going as far as drafting statutory language for lawmakers, specifically modeled on Nevada's felony law.⁷⁶ Although police initially struggled to find a sponsor for their proposed bill, the repeated high-profile media stories may have helped to pressure lawmakers to take up the police bill. Two weeks after the *Rocky Mountain News* urged caution, House Bill 1255 was introduced and ultimately approved by the legislature.

By 1995, ten states had enacted felony HIV-specific penalties targeting sex workers. In many cases, those laws paved the way for broader statutes that criminalized any form of "exposure," or any sexual activity by an HIV-positive person who did not disclose his or her HIV status—HIV exposure and nondisclosure laws, for short. Among the seven states that enacted both laws targeting HIV-positive prostitutes and more general HIV disclosure or exposure statutes, four enacted prostitution penalties in advance of broader statutes. Many more states would go on to pass much broader HIV-specific criminal laws, which are discussed in the following section; however, the prostitution panic of the mid-1980s provided the kindling for the wave of criminalization to come.

"A CESSPOOL FOR DISEASE": PUBLIC HEALTH AS PRETENSE FOR PUNISHING GAY SEX

In May 1985, a three-judge panel of the United States Court of Appeals for the Eleventh Circuit struck down Georgia's sodomy law, ruling that it had violated Michael Hardwick's right to privacy when he was arrested for engaging in oral sex with another man in 1982. The court ruled that Georgia could not justify such an invasion into the private lives of American citizens without demonstrating a compelling state interest. "The Constitution prevents the states from unduly interfering in certain individual decisions critical to personal autonomy because those decisions are essentially private and beyond the reach of a civilized society," the justices ruled.⁷⁷

By the time the appeals court ruled in 1985, much had changed since Michael Hardwick's arrest. Some observers wondered whether states might pivot to argue that the need to control AIDS—rather than simply a bigoted view of homosexuality—provided a renewed justification for sodomy laws. Frederick Allen, a columnist for the *Atlanta Journal and Constitution*, proposed such a strategy for Georgia's legal team:

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The court's challenge to Georgia officials to find a rationale for regulating sexual behavior has a distinctly defiant tone, as if no rationale could possibly exist—but the 11th Circuit panel has opened precisely that door. The state of Georgia is free to argue, for instance, that promiscuous homosexual contact encourages the spread of AIDS, and that the public at large thus has a compelling interest in closing down gay bathhouses or policing the interstate rest stops that have become gay gathering places.⁷⁸

The problem with that approach, Allen continued, was that "the state would be defending a severe, sweeping, unenforceable law that was written with morality, not AIDS, in mind." A more sensible solution would be "for the General Assembly to rewrite Georgia's statute so that it adopts the limited goal of outlawing the public practice of acts that are known to spread a fatal disease."⁷⁹

Georgia ultimately appealed the decision to the Supreme Court of the United States, which heard oral arguments in *Bowers v. Hardwick* in late March 1986. Most of the arguments centered on whether American citizens have a right to engage in whatever forms of consensual sexual behaviors in private that they choose. But at the very end of the hour-long hearing, Justice Sandra Day O'Connor asked the lawyer for the Georgia man arrested under the state's sodomy ban, Laurence Tribe, a curious question: "You suggested that if the state were to assert its desire to promote traditional families instead of homosexual relationships would not suffice in your view. . . . Perhaps the state can say its desire [sic] to deter the spread of a communicable disease or something of that sort?"⁸⁰ In other words, if promoting the heterosexual family was not a sufficient justification for enforcing anti-sodomy laws, then perhaps the state might instead argue that these laws serve a public health interest. In his response to Justice O'Connor, Tribe cites an amicus brief submitted by the American Public Health Association in which it argued that sodomy laws are more harmful than helpful when it comes to public health.⁸¹ However, he suggested that a more specific law might pass muster: "Surely, if a narrowly tailored law could be shown necessary to protect the public health, that would be a compelling justification, but Georgia offers no such justification here."⁸²

As the court deliberated for the next several months, lawmakers across the country braced for its decision. Dozens of state legislatures by then had repealed their anti-sodomy laws. However, so-called buggery laws—which had the effect of criminalizing homosexuality—were still on the books in nearly half of U.S. states when the court decided

Bowers in 1986.⁸³ In the end, the court reversed the Eleventh Circuit's decision, ruling that homosexuals did not have a fundamental right to privacy; it made no mention of AIDS or public health in its ruling. Nonetheless, the notion that a "narrowly tailored law" might replace or buttress the state's effort to criminalize homosexuality persisted.

In the summer of 1993, for example, Nevada lawmakers took up Senate Bill 466. The bill would repeal sections of the state's sodomy law that criminalized private, consensual sex between members of the same sex, while adding more severe penalties for anyone who engaged in the "infamous crime against nature" with a minor.⁸⁴ The bill also implemented mandatory HIV screening for prisoners admitted to the Department of Corrections, a provision that one lawyer argued was necessary to protect prisoners in the wake of the anti-sodomy law's repeal (presumably because prisoners were now vulnerable to being legally sodomized by HIV-positive inmates).⁸⁵

At the May 24, 1993, Senate Judiciary Committee hearing on the bill, AIDS loomed large in the debates over whether to repeal the state sodomy law. Of the eighteen individuals who testified in support of the bill, three specifically argued that repealing the anti-sodomy law would help to promote HIV prevention by easing relationships between medical providers and gay patients, who sometimes feared reporting illegal sexual practices. Of the thirteen critics who testified in opposition to the bill, however, eight specifically argued that repealing the anti-sodomy law would *encourage* the spread of AIDS. Echoing pamphlets distributed to legislators by antigay crusader Paul Cameron, one local woman, Carolyn Nelson, argued that "garden variety sexual practices of homosexuals are a medical horror story. . . . This population of gays and lesbians is a cesspool for disease."⁸⁶ Another woman, Lynn Chapman, argued that "she has had acquaintances who have died of AIDS, is acquainted with homosexuals, and . . . did not understand how the behavior which spreads the disease could be condoned." Lobbyist Andy Anderson later held up a book about AIDS to the committee members and argued that "the book shows the result of the private lovemaking referred to in the law at issue. . . . Therefore, there is no such thing as a private affair, and what is done by homosexuals does affect the rest of the public." Finally, a lobbyist for the Nevada Coalition for Concerned Citizens, Lucille Lusk, asked Senator Mark James whether "a law could be written which would assure the protection from the various possible effects spoken of by her and other opponents of S.B. 466." Senator James asked Ms. Lusk what law she might have in mind, but she declined to elaborate.⁸⁷

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Four days later, the Senate convened and read the bill for the third time.⁸⁸ Two Republican senators—Ann O'Connell and Ray Rawson—spoke in favor of the adoption of Amendment No. 679, which would have added felony penalties to the sodomy decriminalization bill for any person who tested HIV positive to "willfully, wantonly or negligently [engage] in conduct in a manner that is intended or likely to transmit the disease."⁸⁹ At least on paper, the amendment was defended purely as a strategy for promoting public health. To make this noble goal explicit, the amendment authors penned a lengthy—if convoluted—preamble justifying the need for the anti-sodomy law (which would remain on the books to punish public sex, prostitution, and statutory rape) entirely on public health grounds:

WHEREAS, It is in the interest of the residents of this state to encourage the control, prevention and treatment of communicable diseases; and

WHEREAS, The state has a vital interest in protecting the welfare of the public by restricting behavior that increases the risk of transmitting such diseases; and . . .

WHEREAS, It is recognized that certain private behavior is beyond the scope of the state's interest in protecting the health and welfare of its residents; and

WHEREAS, It is the public policy of the State of Nevada and the purpose of this act to balance the interest of the state in protecting the health, welfare and safety of its residents with each resident's legitimate right to privacy; now, therefore . . .

However, while the language of the amendment may have been painstakingly neutral, the authors' remarks on the senate floor reveal the anti-gay bias that at least in part inspired them. Asking his fellow senators to vote yes on the amendment, coauthor Senator Ray Rawson declared: "The fact is, and this is fact, that much of the activity associated with homosexual sex is dangerous. We can forget all of the moral arguments. We can forget all of the religious arguments. But there is a danger that is associated with the practice of this sexual activity." One senator expressed sympathy with the author's intentions but vowed to reject the amendment on the grounds that it would "muddy the waters" on an otherwise narrowly drafted piece of legislation.⁹⁰ Chairman of the Senate Committee on Judiciary Mark James warned his fellow lawmakers that, "if this amendment is defeated, the Senate Judiciary Committee will introduce a bill which handles Section 2 of the amendment on Tuesday morning."⁹¹

The amendment was voted down by a vote of 4-16. Senator Rawson lamented, "This is the most disappointing day that I have ever had in

the Senate." He went on to cite pseudoscientific materials produced by Paul Cameron's Family Research Institute, an antigay organization the Southern Poverty Law Center classifies today as a hate group: "Eighty percent of the heterosexual men, in this country, will die of old age. Two percent of the homosexual men will die of old age." Despite these highly stigmatizing and wildly inaccurate claims, Senator Rawson insisted "I am not talking about morality."⁹²

The amendment's failure did not stop legislators who intended to enact the HIV-specific criminal language in a separate bill. Senator Ernest Adler declared that he intended to have the chairman of the Senate Judiciary Committee "amend one of my bill drafts to place language in it [that would criminalize willful HIV transmission]. . . . I would like to say that I, for one, do take the whole idea of transmittable diseases very seriously."⁹³ Even local newspapers urged the legislature to act. In an editorial published just days after the amendment's failure, the *Reno Gazette-Journal* notes, "There is one amendment, though, that merits approval as a separate measure. This is the proposal . . . that would make the willful transmission of AIDS a felony."⁹⁴

Senate Judiciary Committee chairman Mark James made good on his promise to act, introducing a bill containing identical language to Amendment 679, Senate Bill 514, on June 1, 1993—just two business days after the senate rejected the amendment. Although it received far less debate than the sodomy repeal bill, many of the same organizations and interest groups turned up to argue the issue. Although one prominent AIDS services provider argued against singling out HIV among other diseases, no one staunchly opposed the legislation; rather, they debated the specific wording of the statute, prompting lawmakers to amend the law to provide for a defense if the person disclosed his or her status.⁹⁵ It passed unanimously in the senate and the house and was signed by the governor on July 9, 1993.

The notion that enacting HIV-specific criminal legislation was tied to state sodomy laws persisted right up until the Supreme Court again revisited the issue in 2003, when it decided *Lawrence v. Texas*. In 2000, for example, Virginia lawmakers had introduced House Bill 141, the latest in a string of bills introduced since 1989 that would have made it a misdemeanor for someone living with HIV to expose someone else to the disease. While bills had failed to move out of committee in previous legislative sessions, the 2000 effort finally made it to the floor of the senate after the language was modified to require proof of intent for prosecution, a provision not included in previous legislation.

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Whereas Nevada lawmakers argued that decriminalizing sodomy would have the unintended effect of legalizing HIV exposure, Virginia lawmakers worried instead that criminalizing HIV might have the unintended effect of legalizing sodomy. The reason, they argued, was that the laws effectively criminalized the same practices—but under the HIV law the practices would be misdemeanors, whereas under the sodomy statute, they were felonies. When the bill came up for debate in the General Assembly, Virginia delegate Brian Moran explained this argument:

Another objectionable provision of this bill is that these behaviors that you have to engage in to be guilty of this are in fact felonies in the Code of Virginia 18.23621, "Crimes against Nature." There is already felony punishment to engage in such behaviors. When I asked the Patron in the Courts and Justice Committee how a victim of this law could possibly incriminate themselves in testifying as to this behavior. He said that some sort of deal would be made with the prosecutor. It's objectionable to me and I hope it would be objectionable to you that we would be asking the prosecutor to absolve felony behavior so that he or she may prosecute misdemeanor behavior.⁹⁶

Virginia delegate and Democrat minority leader C. Richard Cranwell took the floor later in the day to again highlight this concern: "I suggest to you that what you're fixing to do is to legalize sodomy and a lot of other crimes between consenting adults where one may have HIV."⁹⁷

Although the bill passed the house 71–26, a senate committee subsequently amended the bill to classify HIV exposure as a felony rather than a misdemeanor. It is not known precisely what motivated the Virginia senate to modify the penalty provisions of the bill. However, it may have been motivated by the concerns expressed by delegates Moran and Cranwell that the HIV bill would exonerate felony sodomy crimes in favor of punishing misdemeanor HIV exposure. By raising the HIV-related penalties to the same felony level as sodomy statutes, the senate may have sought to neutralize this criticism. This suggests that, at least in part, the heightened felony penalty for HIV exposure in Virginia may be a vestige of the state's commitment to punishing sodomy.

In the United States, the interplay between sodomy laws and HIV-specific criminal laws largely ended in 2003 when the Supreme Court ruled that American adults had a right to engage in whatever kinds of consensual sex they wished—at least in private and not for money—in its *Lawrence v. Texas* ruling. However, evidence that efforts to criminalize HIV are interwoven with a desire to punish sodomy and gay sex continue to be found abroad. In 2009, for example, lawmakers in

Uganda famously debated a bill critically labeled by Western LGBT activists as the “kill the gays” bill.⁹⁸ In fact, the bill would have criminalized “the offense of homosexuality” (punishable by life in prison) and introduced a set of “aggravating” factors under which that offense could be punishable by death. These factors included seven possible scenarios, including sex with a minor, sex with a person living with a disability, and any homosexual act committed by a person living with HIV.⁹⁹ The death penalty clause was ultimately removed from the bill when it was finally signed into law in 2014 and was replaced by life imprisonment; it was soon thereafter struck down by the country’s Constitutional Court.¹⁰⁰

These cases illustrate how the logic of criminalizing HIV has been propelled at least in part by homophobia. For legislators who held antigay beliefs such as those expressed on the Nevada Senate floor by Senator Rawson, AIDS provided a scientific glaze for their efforts to crack down on gay sex—a cover that allowed Senator Rawson to insist that he was not motivated by antigay morality but instead by a desire to promote public health. These strategies echo those of early twentieth-century eugenicists, who used pseudoscience to argue for racist policies in the name of promoting population health.¹⁰¹ In this case, however, they resulted in a set of still-standing policies that criminalize people living with HIV.

AN EPIDEMIC OF LEGISLATION: “LAWMAKER ZERO” AND THE INSTITUTIONALIZATION OF HIV CRIMINALIZATION

When Ronald Reagan’s Presidential Commission on the HIV Epidemic issued its final report in 1988, it issued a forceful call for criminalization. In the commission’s view, HIV-specific criminal laws “would provide clear notice of socially unacceptable standards of behavior specific to the HIV epidemic and tailor punishment to the specific crime of HIV transmission.”¹⁰² The commission was made up of thirteen experts and leaders, including doctors, policy makers, and other authority figures. Only one elected official joined them: Illinois representative Penny Pullen, a conservative lawmaker who would go on to become a champion of the antiabortion movement.

Before Representative Pullen joined the antiabortion movement, she cut her teeth fighting for punitive policies against people living with HIV. In 1988, her influence was even noted by one Missouri newspaper, which reported that “Illinois Rep. Penny Pullen, R-Park Ridge and a member of President Ronald Reagan’s AIDS task force, led the

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forces in the Illinois Legislature seeking mandatory contact tracing, quar-
antines and other coercive measures to combat the deadly disease."¹⁰³ In
addition to serving on the presidential commission, Representative Pullen
also contributed to a 1989 report on AIDS policy from the American
Legislative Exchange Council (ALEC), a conservative think tank that
drafts and disseminates model legislation to state lawmakers.

Evidence suggests that Representative Pullen was a key figure behind
mobilizing both the presidential commission and ALEC to take a strong
stance in favor of criminalization. By the time both reports were issued
in 1988, the evidence already presented in this chapter clearly showed
that the path to criminalization had been well laid: state governments
from Florida to Nevada had already approved HIV-specific criminal
legislation. Yet, these influential reports helped to institutionalize the
argument in favor of criminalization and served to disseminate the con-
cept to lawmakers across the country.

It would be impossible to trace the criminalization of HIV back to
one lawmaker, state, or interest group, as Randy Shilts tried to do with
HIV in his "Patient Zero" narrative that drove his dramatized account
of the early years of AIDS, *And The Band Played On*. In that book,
Shilts famously laid the epidemic at the feet of one promiscuous French
Canadian gay male flight attendant who was said to have helped cata-
pult the epidemic across the Americas. As discussed in chapter 1, we
now know that the concept of a Patient Zero was a fantasy invented by
the book's publisher to drive sales. But this chapter concludes with an
effort to rehabilitate Shilts's concept by using it to analyze how one state
and one lawmaker played an outsize role in sparking a different kind of
epidemic—not of contagion, but of legislation.

In 1989, ALEC issued its final report on AIDS policy, *The Politics of
Health: A State Response to the AIDS Crisis*.¹⁰⁴ The working group
behind the report included over two dozen members of both the private
sector (pharmaceutical and insurance companies) and the public sector
(mostly conservative state legislators). The 161-page report included
model legislation on a range of HIV-related issues, including public edu-
cation, insurance regulations, partner notification, and the mandatory
screening of prisoners. One section of the report titled "Extraordinary
Situations" included two coercive proposals: the "Model HIV Assault
Act" and the "Model Emergency Public Safety Measures Act." The lat-
ter related to quarantine and isolation procedures for people living with
HIV. The former presented states with a model statute for criminalizing
the actions of people living with HIV.

In a 2013 report, investigative journalist Todd Heywood interviewed the author of the 1989 ALEC report, Michael Tanner, to understand what had prompted ALEC to include this model statute proposal.¹⁰⁵ The author recalled that it was Representative Penny Pullen who first proposed the idea; although she had not served on the working group that drafted the report, she was invited to testify before the working group (presumably given her experience as a member of the presidential commission). According to Heywood, "Tanner said he recalls that former Presidential Commission member Pullen, who testified before the ALEC working group, introduced the Model HIV Assault Act during her testimony." Pullen declined to comment on the story.

Representative Pullen would have had experience in drafting such legislation. Earlier that year, she had acted as lead house sponsor for Illinois Senate Bill 1180 of 1989, a bill that would have enacted HIV-specific criminal penalties. On June 8, 1989, she introduced an amendment in the House Committee on the Judiciary that gutted the entire bill and replaced its contents with the following language:

Sec. 12-16.2. Criminal Transmission of HIV. A person commits criminal transmission of HIV when he or she, knowing that he or she is infected with HIV:

- 1) engages in intimate contact with another;
- 2) transfers, donates, or provides his or her blood, tissue, semen, organs, or other potentially infectious body fluids for transfusion, transplantation, insemination, or other administration to another; dispenses, delivers, exchanges, sells, or in any other way transfers to another any nonsterile intravenous or intramuscular drug paraphernalia.

For purposes of this Section,

- a) "HIV" means the human immunodeficiency virus or any other identified causative agent of acquired immune deficiency syndrome.
- b) "Intimate contact with another" means the exposure of a mucous membrane of one person to a bodily fluid of another person.
- c) "Intravenous or intramuscular drug paraphernalia" means any equipment, products, or material of any kind which are peculiar to and marketed for use in injecting a substance into the human body.

Nothing in this Section shall be construed to require that an infection with HIV has occurred in order for a person to have committed criminal transmission of HIV. It shall be an affirmative defense that the person exposed knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and consented to the action with that knowledge.

analyst Todd Heywood interviewed Michael Tanner, to understand this model statute proposal.¹⁰⁵ Representative Penny Pullen who first not served on the working group tested to testify before the working group as a member of the presidential commission. "Tanner said he recalls that member Pullen, who testified before the Model HIV Assault Act during comment on the story. She had experience in drafting such bills and acted as lead house sponsor for a bill that would have enacted HIV legislation. In 1989, she introduced an amendment to the Judiciary that gutted the entire bill following language:

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immunodeficiency virus or any other acquired immune deficiency syndrome. "HIV" means the human immunodeficiency virus or any other identified causative agent of acquired immunodeficiency syndrome. "Intimate contact with another" means the exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of HIV. "Intravenous or intramuscular drug paraphernalia" means any equipment, product, or material of any kind, which is peculiar to and marketed for use in injecting a substance into the human body.

Nothing in this Section shall be construed to require that an infection with HIV has occurred in order for a person to have committed criminal transmission of HIV. It shall be an affirmative defense that the person exposed knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and consented to the action with that knowledge. A person who commits criminal transmission of HIV commits a Class 2 felony.

A person who commits criminal transmission of HIV commits a Class 2 felony. Section 2. This Act shall take effect upon becoming a law.¹⁰⁶

She did not invent this language specifically for Senate Bill 1180. Instead, she lifted it directly from her bill in the house, House Bill 1871. That bill was amended slightly, resulting in the following language when it was finally approved by both legislative bodies (differences from Senate Bill 1180 are highlighted in bold):

Sec. 12-16.2. Criminal Transmission of HIV. (a) A person commits criminal transmission of HIV when he or she, knowing that he or she is infected with HIV:

- (1) engages in intimate contact with another;
- (2) transfers, donates, or provides his or her blood, tissue, semen, organs, or other potentially infectious body fluids for transfusion, transplantation, insemination, or other administration to another; or
- (3) dispenses, delivers, exchanges, sells, or in any other way transfers to another any nonsterile intravenous or intramuscular drug paraphernalia.

(b) For purposes of this Section:

"HIV" means the human immunodeficiency virus or any other identified causative agent of acquired immunodeficiency syndrome.

"Intimate contact with another" means the exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of HIV.

"Intravenous or intramuscular drug paraphernalia" means any equipment, product, or material of any kind, which is peculiar to and marketed for use in injecting a substance into the human body.

(c) Nothing in this Section shall be construed to require that an infection with HIV has occurred in order for a person to have committed criminal transmission of HIV.

(d) It shall be an affirmative defense that the person exposed knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and consented to the action with that knowledge.

(e) A person who commits criminal transmission of HIV commits a Class 2 felony.

Both bills were ultimately approved by the Illinois legislature, but the governor vetoed the senate version due to their redundancy.

Representative Pullen's legislation bears a striking resemblance to the Model HIV Assault Act disseminated to state lawmakers by ALEC in its

report issued later that year.¹⁰⁷ That model legislation reads as follows (differences from House Bill 1871 are highlighted in bold):

Section 2. (A) A male or female commits the crime of HIV Assault if, knowing that he or she is infected with the Human Immunodeficiency Virus (HIV), he or she:

- (1) engages in intimate contact with another;
- (2) transfers, donates, or provides his or her blood, tissue, semen, organs, or other infectious body fluids for transfusion, transplantation, insemination, or other administration to another; or
- (3) dispenses, delivers, exchanges, sells, or in any other way transfers to another any nonsterile intravenous or intramuscular drug paraphernalia used by said person.

(B) HIV Assault is a felony and shall be punished by a fine of not more than \$20,000, or imprisonment in a state correctional institution for not less than one year or more than several years, or both.

(C) Nothing in this section shall be construed to require that an infection with HIV has occurred in order for a person to have committed HIV assault.

Section 3. Any individual who commits the crime of HIV Assault under Section 2 of this Act shall be civilly liable for damages if another individual becomes infected with the human immunodeficiency virus as a result of such violation.

Section 4. It shall be an affirmative defense that the person exposed knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and consented to the action with that knowledge.

Section 5. For purposes of the Act:

- (A) "HIV" means any human immunodeficiency virus (HIV) or any other identified causative agent of acquired immune deficiency syndrome (AIDS).
- (B) "Intimate contact" means the exposure of the body of one person to the bodily fluid of another person in a manner that can transmit the HIV virus.
- (C) "Intravenous or intramuscular drug paraphernalia" means any equipment, products, or material of any kind that is peculiar to and used for injecting a controlled substance into the human body.

Apart from the penalties outlined (civil liability and the specified term of imprisonment), Illinois House Bill 1871 and ALEC's Model HIV Assault Statute are nearly identical. Notably, of the eight states that have enacted HIV exposure or nondisclosure laws before 1989 (Florida, Georgia, Idaho, Michigan, Missouri, Oklahoma, South Carolina, and

model legislation reads as follows highlighted in bold):

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Washington), none enacted legislation that bears any resemblance to the ALEC model law. Representative Pullen's legislation appears to be the only plausible source of inspiration.

In the wake of the ALEC report, legislators in seven states would go on to introduce twenty-two bills between 1990 and 2004 that use a structure similar to ALEC's model statute—suggesting that it helped to plant the seed of criminalizing HIV in state legislatures across the country.¹⁰⁸ However, as all but one of the twenty-two bills that use language similar to the ALEC model statute failed or was vetoed, the legacy of Representative Pullen's efforts is not that her bill's language was perfectly adopted by states across the country. Instead, her legacy lives on in the inspiration her efforts provided for other lawmakers around the country. This was especially true for Illinois's southwestern neighbor, Missouri. Even *before* Illinois passed its felony HIV-specific criminal bill in 1989, officials in Missouri were citing Representative Pullen's efforts to enact punitive measures against people living with HIV. As previously noted, the *St. Louis-Dispatch* specifically cited Representative Pullen's efforts to enact coercive policies against people living with HIV, such as mandatory contact tracing and quarantines.¹⁰⁹ Those measures are credited with inspiring Missouri lawmakers to enact similar efforts in Missouri, including an criminal HIV disclosure law later that year.

Further, even though Representative Pullen's statute was not widely adopted verbatim, it was cited frequently by other state lawmakers in their debates over whether and how to criminalize HIV. When Nevada lawmakers considered Senate Bill 514 in 1993, committee records reveal that they looked to Illinois for clarification regarding what language to use to describe the offense. Nevada lawmakers were concerned that "married couples or people in a relationship . . . [should] not be made to be committing criminal conduct."¹¹⁰ They noted that the language devised by Illinois lawmakers regarding an affirmative defense for individuals who have disclosed their status "would take care of one of the major concerns of the committee."¹¹¹ The Nevada lawmakers repeatedly turned to Illinois's statute during committee meetings to help them consider the issue and draft amendments to their own bill.¹¹² Thus, although the Nevada statute does not perfectly mirror Illinois's HIV-specific criminal law, aspects of the Illinois law did directly inform Nevada lawmakers as they drafted their own bill.

A similar story played out in 1995 when Alaska lawmakers considered Senate Bill 91. Although the language of the bill is not identical to

Illinois's statute, it does rely on a highly similar structure that outlines the prohibition of intimate contact, the transfer of bodily fluids or organs, and the sharing of drug paraphernalia. Committee records reveal that the legislative aide to Republican representative Scott Ogan—the bill's sponsor—made repeated calls to Illinois officials to seek counsel in drafting the legislation:

[Rep. Ogan's aide] informed the committee that he had contacted numerous staff attorneys in the Attorney General's office in Illinois for information. He spoke to people at the policy making level, and he spoke with actual prosecutors who tried cases like this. Illinois law is similar to Alaska's. He asked for input about any problems that we could address in our law and they brought up two concerns. One was that there was a challenge that went all the way to the Supreme Court; it was challenged because of the lack of definition to intimate contact. They said it should be defined further. Still, the Illinois Supreme Court upheld their looser language with less definition.

The fact that the Illinois law had survived a constitutional challenge—in spite of its "looser language"—was later cited as an important justification for Alaska lawmakers to use it as a model. After the 1995 bill failed, lawmakers introduced similar legislation in 1997. Senate Bill 17 was virtually identical to the Illinois statute. Indeed, at a committee hearing of the bill, a staff member for the bill's sponsor, Republican senator Robin Taylor, noted that "in drafting S.B. 17, the Illinois statute was used almost verbatim."¹¹³

The bill read as follows (differences from Illinois House Bill 1871 are highlighted in bold):

Sec. 11.66.160. Criminal transmission of HIV. (a) A person commits the crime of criminal transmission of **human immunodeficiency virus (HIV)** if the person, knowing that the person is infected with HIV,

- (1) voluntarily engages in intimate contact with another person;
- (2) transfers, donates, or provides the person's blood, tissue, semen, organs, or other potentially infectious body fluids for transfusion, transplantation, insemination, or other administration to another, excluding perinatal transmission; or
- (3) dispenses, delivers, exchanges, sells, or in any manner transfers to another person any nonsterile intravenous or intramuscular drug paraphernalia.

(b) In a prosecution under this section,

- (1) it is an affirmative defense that the person exposed to HIV by the intimate contact, the transfusion, transplantation, insemination, or other administration or the transfer, knew that the defendant was

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infected with HIV, knew that the action could result in infection with HIV, and consented to the action with that knowledge;

(2) it is not necessary to show that the victim has been actually infected with HIV for the defendant to be convicted.

(c) In this section,

(i) "HIV" means the human immunodeficiency virus or another identified causative agent of acquired immunodeficiency syndrome;

(2) "intimate contact" means sexual penetration or any contact in which the body of one person is exposed to a body fluid of another person in a manner that could result in the transmission of HIV;

(3) "intravenous or intramuscular drug paraphernalia" means any equipment, product, or material of any kind that is peculiar to and marketed for use in injecting a substance into the human body.

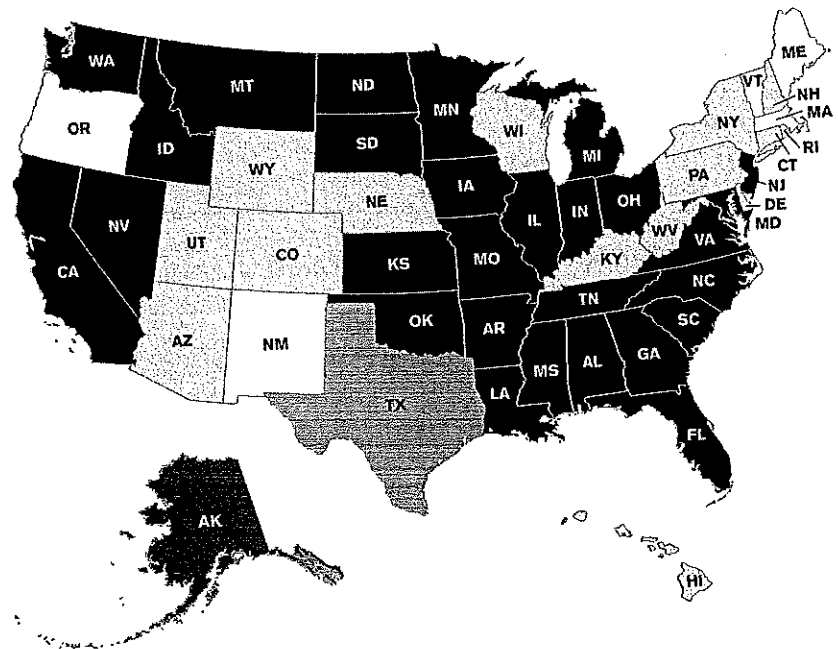
(d) Criminal transmission of HIV is a class B felony.¹¹⁴

But the language of Illinois's statute was not the only source of inspiration for Alaska lawmakers. In committee records for Senate Bill 17, lawmakers reference the Illinois statute in some way thirty-two times. For example, they cite figures from the Illinois Department of Health regarding the annual number of HIV tests before and after the bill's passage. To refute the common charge that criminalizing HIV will negatively impact the number of people seeking HIV tests, Alaskan lawmakers cited figures from Illinois, noting that the number of tests had not changed in the six years since the Illinois law had been passed.¹¹⁵

Senate Bill 17 went on to be approved by the Alaska legislature, but Governor Tony Knowles used his veto power to block the bill's passage. Nonetheless, the debate over its passage is one end of a thread of Illinois influence and Representative Pullen's legacy that is woven into the history of HIV criminalization. No other state is cited as frequently in the archives obtained for this research project, nor does any legislative leader have such a lasting influence as Representative Pullen. Indeed, she is as close to "Lawmaker Zero" as one could find in the history of HIV criminalization in the United States. Her efforts as a moral entrepreneur helped influence both the presidential commission and ALEC to use their resources to push for HIV-specific criminal laws—prompting almost two dozen states to consider legislation directly modeled on the Illinois statute.

AN EPIDEMIC OF CRIMINALIZATION

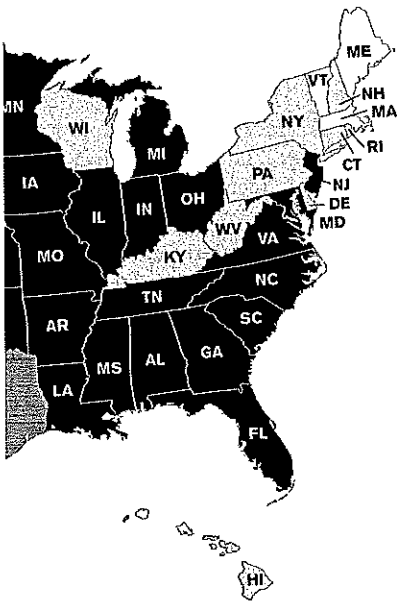
As this chapter has demonstrated, AIDS is not just a viral epidemic—it is also an epidemic of laws, bills, committee hearings, legislative debates,



- States that enacted criminal HIV exposure or nondisclosure laws
- States that vetoed criminal HIV disclosure or nondisclosure laws
- States that passed and then repealed criminal HIV exposure or nondisclosure laws
- States that considered but voted down criminal HIV disclosure or nondisclosure laws
- States that have not attempted to enact criminal HIV disclosure or nondisclosure laws

FIGURE 14. HIV-specific criminal legislation, by state. Design: Jonathan Lefrançois. Illustration: Justin Karas for Pulp & Pixel.

and bureaucratic administration. Today, twenty-eight states have misdemeanor or felony laws on the books that make it a crime for people living with HIV to have sex without disclosing their HIV status or to more generally “expose” another to the disease. In forty-five states across the country, lawmakers considered over 150 criminal bills between 1985 and 2014 targeting HIV (for a list of bills identified and studied for this chapter, see appendix 2). Figure 14 illustrates where



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, by state. Design: Jonathan Lefrançois.

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bills that would have criminalized HIV exposure or nondisclosure in the United States were considered and enacted, and where they failed.

To continue the epidemiological metaphor, the epidemic of HIV-specific criminal laws has spread throughout the country, but what are its root causes? This chapter identified four broad trends that facilitated the spread of HIV-specific criminal laws: high-profile failures to apply general statutes, organized aggravation by police against sex workers, the decriminalization of sodomy, and the institutionalizing influence of Lawmaker Zero. Looking at these trends collectively, we can identify four underlying drivers of criminalization that cut across them:

1. *social stigma*, including HIV stigma, homophobia, and stigma against sex work;
2. *sensational media reports* of arrests of HIV-positive defendants and failed prosecutions;
3. *moral entrepreneurs* such as Lawmaker Zero who campaigned to label HIV as a criminal problem; and
4. *interest-group lobbying* by organizations such as police departments and ALEC.

Any one of these factors was not sufficient. Many states that did not pass HIV-specific criminal legislation presumably had legislators who held antigay attitudes, or prominent public officials who called for criminalization but did not find support in the legislature. In combination, however, the four factors frequently resulted in states enacting HIV-specific criminal laws.

Of course, the fact that homophobia and fear of sex work drove legislators to enact HIV-specific criminal laws does not mean that these laws went on to be used specifically against these groups. As the next two chapters reveal, the application of these laws has not followed predictable patterns. The factors that drove the epidemic of criminal legislation are not necessarily the same as those that drive how those laws are enforced.