Abstract

To date, there has been little research published about public health HIV surveillance, HIV testing, and HIV prevention. Accordingly, an exploratory project was undertaken, involving, firstly, a detailed review of local public health legislation and practice guidelines, and, secondly, the distribution of surveys about self-reported sexually transmitted infections (STI) and HIV testing/diagnosis, HIV testing practices, and sexual behaviours among gay, bisexual, and other men who have sex with men. A review of the public health law indicated that, in the local context, there is a pervasive public health surveillance apparatus that requires mandatory reporting of identified communicable diseases, including HIV. Results of the survey indicated that individuals who reported a preference for, or use of, anonymous HIV testing were more likely to have reported having: (a) been tested for, and diagnosed with, STIs; (b) prior STI/HIV diagnoses; and (c) a self-reported history of anal sex. These results highlighted that: (1) public health surveillance affects HIV testing and management practices; (2) that anonymous HIV testing is not truly anonymous; and (3) that HIV surveillance depends, in part, on individuals participating in the public health surveillance system. Accordingly, while knowing that one is HIV-positive can be beneficial (e.g., as a result of improved quantity and quality of life for people living with HIV), HIV testing is never free from surveillance. From this perspective, true avoidance of public health surveillance would require an absolute rejection of HIV testing.

Introduction

In the mid to late 1980s, in an effort (a) to understand HIV transmission, (b) to identify the groups burdened by HIV, and (c) to follow-up with persons who had come into contact with HIV, many public health units began collecting personal information—including the names and dates of birth—of persons diagnosed with HIV (UNAIDS 2000; CHALN and CAS 2001). In opposition to this practice, ‘advocates for people living with HIV, gay organizations, and many public health officials’ were concerned that this name-based reporting system could deter people from undergoing HIV testing, and, consequently, could compromise HIV prevention efforts that hinge on people knowing they are HIV-positive (UNAIDS 2000: 12). In some jurisdictions, the outcome of the tension surrounding named-based public health HIV surveillance was the development of a testing modality known as ‘anonymous HIV testing’, which required that only information on HIV exposure, and the sex and age of the person who tested positive for HIV, were transmitted to public health units using a unique identifier.

While some research exists on HIV testing, at present, the reporting, or surveillance, aspects of both name-based and anonymous HIV testing continue to be relatively unexplored. Overwhelmingly, academics, scholars, and other authors have not considered or examined HIV testing—whether done anonymously or through a person’s name—as a form of surveillance, when such testing is tracked with extreme detail and legal mandate in many places around the world. Indeed, the World Health Organization’s Declaration of Commitment on HIV/AIDS explicitly states that national health
organizations must monitor and report on HIV testing, diagnoses, and transmission in their respective jurisdictions, thus signalling that HIV testing and its associated reporting to public health units is a form of intense surveillance internationally (World Health Organization 2001; Public Health Agency of Canada [PHAC] 2011).

In light of this situation, a two-part research project was undertaken about HIV surveillance. The goal was to contribute toward what Lyon argued was a primary step in surveillance studies: ‘knowing something about the legal framework within which [public health surveillance] operates’ (2007: 21). In this project, this introductory knowledge development, firstly, included a detailed review of the public health legislation, practice standards, and HIV testing requisitions that exist in Ontario, Canada, and, secondly, it involved survey distribution to gay, bisexual, and other men who have sex with men (MSM) in one city within the same jurisdiction (Ottawa, Ontario). These surveys contained questions about participants’ sexual practices, and about their sexually transmitted infection (STI) and HIV testing and diagnosis histories. In short, this project did not explore the extant definitions and/or meanings of surveillance, but rather sought (a) to describe the system of public health HIV surveillance in Ontario, Canada, (b) to understand some persons’ self-reported perceptions of, and actions toward, this surveillance apparatus, and (c) to discuss these findings in relation to contemporary understandings of surveillance. Gay, bisexual, and other men who have sex with men were the targeted research population because in Ottawa, Ontario, Canada, and most Western countries, these men account for nearly half of all new and diagnosed HIV infections (Ottawa Public Health 2011; Remis et al. 2012; PHAC 2012).

Theoretically, we examined the results of this analysis using Hardt and Negri’s (2000) work on ‘Empire’ and Lupton’s writings about the ‘Imperative of Health’. These concepts, which explain the contemporary imperial model of population regulation, and the current social practice of observing one’s health status, respectively, were useful in understanding how public health HIV surveillance observes persons who believe they may be, or who are, HIV-positive. Hardt and Negri’s and Lupton’s work, in combination, was particularly useful for explaining how the public health HIV surveillance system maximally captures individuals within the purview of its surveillance mechanisms. Furthermore, to understand surveillance, we adopted David Lyon’s (2007) definition: while surveillance ‘is the focused, systematic and routine attention to personal details for purposes of influence, management, protection or direction’, this process of observation and classification ‘is not merely something exercised on us. … [Rather] it is a set of processes in which we are all involved, both as watched and as watchers’ (2007: 13-14). Surveillance, from this perspective, therefore, both exists to achieve specific goals, and occurs because people participate in its activities. Bearing this definition of surveillance and the work of Hardt and Negri and Lupton in mind, we thus examined public health HIV surveillance in Ontario.

The Extant Literature on Anonymous HIV Testing

Despite its longstanding existence and controversial history, there are few published research papers about anonymous HIV testing. Of those that do exist, the results indicate that anonymous HIV testing is used by a small group of individuals who, in the absence of such services, may not undergo HIV testing (Sasse et al. 2006; Bindman et al. 1998; Hoxworth et al. 1994; Meyer et al. 1994; Kegeles et al. 1990). For example, Meyer and colleagues (1994) noted that participants (n=75) who left their home state for anonymous HIV testing were more likely to test positive for HIV, when compared to individuals who accepted to do in-state non-anonymous testing. Similarly, in Sasse and colleagues’ (2006) 12-year review of HIV testing in Belgium, individuals who opted for anonymous HIV testing were more likely to test positive. Likewise, the annual HIV/AIDS surveillance reports for Ontario, Canada reveal that anonymous HIV testing continues to have the highest proportion of positive results among all HIV testing and reporting methods (Remis et al. 2012).
Kegeles and colleagues’ (1990) survey study involving 180 participants may shed some light on these trends: ‘Believing that one was infected with HIV was slightly associated with a decreased inclination to obtain testing under non-anonymous circumstances’ (1990: 585). While it is important to remember that HIV treatments were highly ineffective at the time of this study (UNAIDS 2000), newer research continues to demonstrate relatively consistent findings; for example, Charlebois and colleagues’ (2005) California-based study, which included one sample of 208 individuals about to undergo HIV testing, and one sample of 226 individuals who had just undergone HIV testing. This study found that participants preferred to know that, if they were to test positive, their name would not be reported to local health departments. The Public Health Agency of Canada (PHAC 2011) has taken these results to mean that, because anonymous HIV testing ‘offers the highest degree of confidentiality, it may encourage more people to come forward for HIV testing and counselling…especially those at high risk or those who would not volunteer for testing under nominal/name-based or non-nominal/non-identifying circumstances’.

Furthermore, other research has suggested that public health benefits may also be associated with anonymous testing. Indeed, Bindman and colleagues (1998), who reviewed both the CD4+ count (which is used as a measure of immune system status to determine treatment initiation) and time from HIV diagnosis to AIDS diagnosis of 835 persons newly diagnosed with HIV from four American States over 20 months, found that individuals who underwent anonymous testing were diagnosed with HIV earlier and accessed medical care more quickly than individuals who used other HIV testing modalities. Another study by Osmond and colleagues (1999), involving one sample of 2370 ‘persons at risk for HIV infection’ and another of 1913 ‘persons who had recently received a diagnosis of AIDS’, confirmed these findings: although small, there were higher follow-up rates with the partners of individuals who tested positive for HIV anonymously, and more timely access to care among individuals who used anonymous testing, when compared to persons who accessed non-anonymous testing services (1999: 776). Aligning with these results, the American Centers for Disease Control and Prevention (CDC) has since stated that anonymous HIV testing programs should be enhanced because this testing modality is associated with faster access to care (see Janssen et al. 2001).

**HIV Status Awareness and Decreased Transmission**

Currently available research demonstrates that being aware of one’s HIV-positive status typically corresponds with behaviour changes that decrease onward HIV transmission (Marks et al. 2005). Fox and colleagues (2009) confirmed this assertion by undertaking two interviews with 98 MSM whose HIV diagnosis indicated a recently acquired HIV infection: the first interview took place at the time of diagnosis; the second interview occurred three-months thereafter. The findings of Fox and others’ (2009) project, which sought to establish if some MSM change their sexual practices after receiving an HIV diagnosis and counselling about HIV transmission, revealed that 76% of the participants reported that they changed their behaviour after their HIV diagnosis; e.g., by increasing condom use and having fewer sexual partners. These results suggested that, in many cases, reduced probabilities of onward HIV transmission occurred after an HIV diagnosis. Additionally, this study highlighted that most of the participants reported disclosing their HIV-positive status to sexual partners.

Camoni and colleagues (2009) produced similar results in their survey-based study of 497 persons who had been diagnosed with HIV within the previous two years. Indeed, in determining if an HIV diagnosis corresponds with changes in sexual and drug-using practices, Camoni and others (2009) found that their participants reported the following changes after their HIV diagnosis: a significant decrease in their number of different sexual partners; a significant decrease in commercial sex (as client or worker); and a significant increase in condom use with both casual and regular sexual partners. Additionally, the participants reported a significant decrease in the use of all drugs following their HIV diagnoses (Camoni et al. 2009).
Lastly, a meta-analysis by Marks and colleagues (2005), which compared the sexual practices of HIV-positive persons aware of their serostatus and HIV-positive persons unaware of their status, yielded the same conclusions as the above-noted studies. The results of this meta-analysis, using between-group comparisons of HIV-positive individuals, aware and unaware of their HIV-positive status, suggested that most people eschew the practices that permit continued HIV transmission after being diagnosed with HIV (Marks et al. 2005). Marks and colleagues (2006) used these findings to substantiate their claims in a second paper that onward HIV transmission could be ‘lessened substantially by increasing the number of HIV-positive persons who are aware of their status’ (2006: 1447).

Furthermore, and most importantly, HIV status awareness can induce benefits for people living with HIV. For example, Girardi and colleagues (2007), in their review article, argued that early HIV diagnosis contributes to an improved quality of life for people living with HIV by decreasing morbidity and mortality due to HIV infection, and improved response to HIV therapies. In addition, the results of a collaborative study by Egger and colleagues (2002), involving 13 prospective studies and over 12,000 patients living with HIV, indicated that individuals who present at an advanced stage of immune suppression were more susceptible to opportunistic infections, such as pneumonia or toxoplasmosis, and were more likely to have a poorer response to HIV medications. These authors found that the CD4+ cell count at the start of treatment was the strongest prognostic factor: patients who started with fewer than 200 CD4+ cells/microL were at higher-risk for HIV progression than those with higher CD4+ counts (Egger et al. 2002). Palella, Delaney and Moorman (1998) have similarly found that HIV medications dramatically improve the quality and duration of life for people living with HIV.

Theoretical Underpinnings

The Imperial Imperative of Health

While the contemporary public health system emerged with a primary focus on dirt and disease, it has evolved to include many strategies which, in design and goal, help entire populations diminish the factors that contribute to morbidity and mortality (Last 2001; Lupton 1995). Underpinning such a focus is the often-unstated belief that health is an imperative, a universally desired outcome, which supersedes all other issues (Lupton 1995). This imperative of health, which Foucault (1984) summarized as the social expectation that optimizing health is both the ‘duty of each and objective of all’, corresponds with the contemporary socio-political environment wherein individuals, firstly, are enticed to engage only in practices that hegemonic dictates establish as healthy, and, secondly, are monitored to identify any and all occurrence of health outcomes that are deemed unwanted (1984: 277).

Although the public health system builds on this imperative of health, it nevertheless relies on individuals accepting its principles, programs, and practicalities. Indeed, for the public health mechanism to function, people must follow—or, at least, not reject or resist—its scope and practices. Because the contemporary public health apparatus, therefore, requires people to be included within both its interventions and its observations (i.e., with its surveillance), it is useful to turn to Hardt and Negri’s (2000) writings, wherein they describe the modern world as a globally pervasive empire that resembles Deleuze’s (1992) society of control. While much of Hardt and Negri’s (2000) work could be drawn from, it is specifically their work on the ‘triple imperative of empire’ that is used for the purposes of this analysis.

The first component of Hardt and Negri’s (2000) three-part sequence is inclusion, which situates, as the primary focus of imperial undertakings, the maximal incorporation of that which is deemed important, whether this item of significance is people, property, territory, or other. Inherent in inclusion is absolute capture, not ethical obligations to ensure equality of opportunity. The subsequent phase of Hardt and Negri’s sequence is differentiation, during which all items that were previously included are sorted and filtered. Differentiation is thereby the process of classification. Once differentiation is complete, management, as the third and final phase of Hardt and Negri’s imperial sequence, commences. For Hardt
and Negri (2000), this last step describes the execution of strategies which address and deal with the particular items, people, or places that were, first, included, and, second, differentiated (i.e., classified).

As a final note on these three phases, Hardt and Negri’s (2000) writings also suggest that each step in the ‘triple imperative of empire’ interacts with the others. Accordingly, imperialists must, Hardt and Negri note, ensure that each of their phases does not negatively affect a subsequent or preceding activity. For example, inclusion should not exceed differentiation capabilities, and management should not dissuade inclusion. Instead, in the most successful imperial undertakings, each phase synergistically contributes both to favourable outcomes during the other steps and to the overall success of the imperial process.

**Methodology**

**Document Review**
The first phase of this project was a review of public health HIV surveillance in Ontario, Canada. As part of this examination, the laws and practice standards that govern public health practice in this jurisdiction were explored. HIV requisitions, both confidential and anonymous, were similarly examined (see figures 1 and 2, at the end of the article, to review these HIV requisitions).

**Research and Survey Design**
The second phase of this project involved the distribution of surveys about people’s sexual practices and STI/HIV testing and diagnosis histories. These surveys also contained questions about whether or not the participants’ STI/HIV testing practices had been affected by criminal prosecutions for HIV-status nondisclosure (see Table 1 for a list of survey variables).

For this project, the survey was piloted with three different groups of men before distribution began. Participants were eligible to participate in the pilot if they identified as gay, bisexual, transsexual, two-spirited, queer, or questioning. The men who participated in the pilot all identified as either gay, bisexual, MSM, or transsexual. Questions were refined as needed based on the pilot feedback; e.g., the questions about HIV-status discussions were changed from a ‘yes/no’ answer to a Likert item. In addition, the survey underwent further revisions after the first distribution round to comprise the feedback received from survey participants.

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*Table 1: Relevant Survey Variables*
**Sampling and Recruitment**

Study participants were identified through a mix of convenience and snowball sampling methods. Convenience sampling involved the use of the most readily available individuals as participants. Accordingly, local bars, bathhouses, and an STI/HIV testing clinic that were frequented by gay, bisexual, and other MSM were selected as initial data collection sites. Snowball sampling, as the second method, involved asking participants to identify other data collection sites. The outcome of snowball sampling was the identification of additional parties, bars, clubs, and other ‘unofficial’ social events where potential participants could be found.

In total, this recruitment strategy was employed over a six-week period, during which surveys were distributed at two STI/HIV testing clinics that were frequented by gay, bisexual, and other MSM, one hospital-based infectious disease unit, two HIV organizations, three gay bars, one bathhouse, and four community events. Prior to survey distribution at these venues, bar owners, clinic managers, and community representatives were contacted, and permission to distribute surveys was obtained. Because the locations where recruitment took place were either exclusively Francophone/Anglophone or a mixture of the two, the survey was available in both French and English at all times. Furthermore, because the survey was self-directed, participants had to be able to read and understand one or both of these two languages. Being unable to read either English or French was an exclusion criterion for this project.

**Procedure and Ethics**

In each venue, patrons were informed about the study, assured of anonymity, and offered a questionnaire in either English or French. Individuals who agreed to participate were offered a clipboard, a book light, and reading glasses to facilitate survey completion. The participants were then instructed to complete the survey and to deposit it into a locked drop-box located at the venue at the time of recruitment. To assure participants that the researchers could not and would not immediately know their survey responses, the participants were further informed that the researchers would not open the drop-box until they had left an event. The Research Ethics Board at the University of Ottawa approved this research project.

**Data Analysis**

The survey data were inputted into SPSS 19. Socio-demographic indicators underwent descriptive analysis. The participants’ sex practices and testing behaviour were subject to \( x^2 \) analyses to determine relationships between variables. A \( p \)-value of \(<0.05\) was used to determine significance. This value was selected prior to the onset of analysis.

**Results**

**Public Health Surveillance**

In Ontario, the Health Protection and Promotion Act (HPPA), including the regulations established pursuant to the HPPA, impose legal duties, grant legal powers, and create, in law, public health institutions, and their frameworks for exercising the powers to fulfil statutory responsibilities, such as disease prevention and control. Indeed, according to Section 2 of the HPPA, the purpose of the Act includes the ‘prevention of the spread of disease and the promotion and protection of the health of the people in Ontario’. Regarding public health HIV surveillance in Ontario, it is Sections 1, 5, 7, 22, 25, 26, 27, 28, 29, 31, 32, 34, 100, 101, and 102 of the HPPA that are of central importance. These sections, including their related regulations and practice standards, are presented below.

**Classifications of Disease**

Section 1 of the HPPA details that diseases can be classified as ‘communicable’, ‘reportable’, and/or ‘virulent’. Diseases classified as ‘virulent’ are listed in Section 1 of the HPPA and Ontario Regulation 95/03, and include the sexually transmitted infections gonorrhoea and syphilis; Ontario Regulations 558/91 and 559/91, respectively, set out those diseases classified as communicable and reportable. At
present, Acquired Immunodeficiency Syndrome (AIDS) is listed as both communicable and reportable, but not virulent. HIV, however, is not listed explicitly in either of these documents, although, historically, this infection has been considered reportable because the HPPA mandates reporting for ‘agent[s] of communicable disease[s]’, and Ontario Regulation 569 describes reporting requirements when people ‘test positive for an agent of AIDS’. These documents, in combination with other governmental guidelines from the Ontario Advisory Committee on HIV/AIDS (1997), therefore establish that HIV is a reportable infection.

The Ministry of Health Guidelines
In understanding the public health HIV surveillance in Ontario, the next important part of the HPPA is Section 7, which indicates that public health units must comply with guidelines published by the Ministry of Health. For HIV, these documents are the Ontario Public Health Standards (2008), which ‘establish requirements for fundamental public health programs and services’ (2008: 1), and three subject-specific protocols, which provide direction about how public health units ‘must operationalize specific requirement(s) identified in the Ontario Public Health Standards’ (2008: 2). These protocols are as follows: the Infectious Diseases Protocol (2013), the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol (2013), and the Population Health Assessment and Surveillance Protocol (2008). The Surveillance Protocol indicates that public health units ‘shall conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health indicators, as required by the Health Promotion and Protection Act’ (Ontario Public Health Standards 2008: 16). The Infectious Diseases Protocol, meanwhile, provides case definitions for the reportable infections, and thereby details when reporting is required. This document, moreover, repeats that, even though it is not explicitly listed in the HPPA, HIV—as the causative agent of AIDS—is definitively a reportable infection.

Mandatory Reporting
In relation to the public health surveillance of HIV, the next sections of importance in the HPPA are Sections 25 to 29, which stipulate that an array of persons, e.g., nurses, physicians, hospital directors, and laboratory operators, have a legal duty to report the identification and/or diagnosis of diseases specified in Ontario Regulation 559/91 (Specification of Reportable Diseases) to local medical officers of health. For these named persons, mandatory reporting is required for both definitive test results and ‘form[ed] opinion[s] that [a] person has or may have a reportable disease’ (Section 25, subsection 1). In Ontario, there are approximately 70 diseases that require reporting pursuant to Section 25 of the HPPA (see Ontario Regulation 559/91 (Specification of Reportable Diseases) for a complete list of these diseases). An important caveat about mandatory reporting, however, is that, while named people must transmit information about reportable diseases to local public health units, Section 3 of Ontario Regulation 569 only specifies a time limit for such reporting for laboratory operators; these persons have 24 hours to transmit the identification of a reportable infection or its agent to local public health units. For clinicians, no such time frame is specified. Sections 25 to 29 specify that the reporting must be done ‘as soon as possible’, without any quantification of the parameters of this time period (Speakman 2008).

The purpose of mandatory reporting is three-part. Firstly, mandatory reporting provides public health units with up-to-date surveillance data about the state of communicable diseases in their communities, and, for HIV, must contain the following information: person’s name, address, and date of birth; date of diagnosis; exposure information, e.g., type of sexual contact, history of injection drug use, blood transfusion (Speakman 2008; Ontario Regulation 569). This surveillance data, therefore, not only identifies the number of persons diagnosed with reportable diseases, but also identifies the demographic and exposure characteristics of these individuals. Practically, public health units use this information to fulfill their mandate of health protection and promotion and disease prevention by allocating resources to address these communicable diseases (HPPA; Speakman 2008).
A second aim of mandatory reporting is to ensure that individuals who are diagnosed with communicable diseases—i.e., index cases—have access to medical care, counselling, and support. In Ontario, practice guidelines, which are put in place pursuant to Section 7 of the HPPA, indicate that public health departments must initiate contact with STI/HIV index cases ‘ideally within 2 business days of receipt of a laboratory test result’ (PIDAC 2009). In certain cases, to further enforce this two-day follow-up period, Public Health Accountability Agreements have been drafted to contractually compel this follow-up period.

Thirdly, according to the Provincial Infectious Disease Advisory Committee (PIDAC 2009), because local public health departments are notified about individuals with reportable infections, local medical officers of health have ‘ethical and legal responsibilities to warn known persons potentially exposed to a communicable disease’ (2009: 50). This aspect of mandatory reporting is, therefore, the process of ensuring that other persons who were potentially exposed to a communicable infection—i.e., contacts—receive timely notification of their exposure(s) (CHALN and CAS 2001). As stipulated in Section 5 of the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol (2013) (Revised), this public health activity, known as partner notification, can be done by the index case, by a public health department employee, typically a public health nurse, or by clinicians who work in community-based clinics. When the index case opts for the partner notification by the public health unit, public health nurses then attempt to contact all persons identified by the index case, and undertake this partner notification without divulging the index case’s name to the identified contacts. As is the situation for index case notification (described above), pursuant to Section 7 of the HPPA, the existence of Ministry of Health guidelines about contact notification means that local medical officers of health must ensure appropriate and timely execution of such follow-up (Ontario Public Health Standards 2008; CHALN and CAS 2001). Of particular importance, however, is that the HPPA does not require that public health units execute this follow-up. Rather, they must simply ensure that appropriate follow-up occurs; community physicians, nurse practitioners, or registered nurses could undertake such non-health unit follow-up for their own patients.

Moreover, as part of mandatory reporting, Section 31, subsection 1, requires that medical officers of health subsequently notify the Ministry of Health about reportable infections. Section 8 of Ontario Regulation 569 (Reports) further specifies two points. Firstly, reports to the Ministry of Health must be transmitted using a province-wide database known as the Integrated Public Health Information System (iPHIS), and, secondly, these reports must include the following information about index cases: name, date of birth, sex, date of onset for symptoms, and address. Local medical officers of health also use this last item to determine if an index case resides within the jurisdiction of the medical officer of health who was notified about a reportable disease. If the individual resides in another jurisdiction, Section 32 permits the transmission of the index case’s information to the health unit responsible for his/her area of residence without requiring the index case’s consent for this disclosure of information.

Circumventing Mandatory Reporting: Anonymous HIV Testing

An important caveat in the reporting requirements established in Ontario Regulation 569 (Reports) is that, pursuant to Section 5.1, subsection 2, physicians and nurses who work at one of 50 designated HIV testing sites, as listed in Schedule 1 of this regulation, can offer two types of HIV testing: (1) confidential testing, which can be either name-based (nominal) or code-based (non-nominal) testing, and (2) anonymous testing (Ontario Ministry of Health 2012). This exemption to mandatory public health reporting and surveillance stipulates, however, that anonymous HIV testing can only occur if ‘patient[s] receive counselling about preventing the transmission of HIV infection’. In other words, the testing physician or nurse must counsel patients about how to prevent HIV transmission before performing the test.

The outcome of this exemption is that, at HIV testing sites that offer anonymous testing, practitioners are allowed to perform HIV tests, while only collecting basic information, including year of birth, sex, HIV risk factors, and symptoms, if they exist, provided that they provide patients with the indicated
When an anonymous HIV test yields a positive result, therefore, only the basic demographic information that is collected on the anonymous HIV requisition (see figure 2) is reported to the local medical officer of health. This gives the local public health department information about the age, sex, and HIV exposure information of individuals who test positive for HIV, even when it does not identify who tested positive.

A comparison of figure 1 and figure 2 shows that the data recorded on the anonymous and non-anonymous requisitions in the local jurisdiction are similar. The difference is that, for anonymous HIV testing, a six-digit identifier replaces the person’s name. Accordingly, when a person undergoes anonymous HIV testing, the six-digit identification code is attached to pertinent specimens and paper work; e.g., tubes of blood, identification cards to enable the individual to access his/her test results at a later date, clinic-specific records for the test and its result, and/or point-of-care testing material.

It is also important to note, firstly, if the HIV testing process involves the collection and submission of a blood specimen to a local laboratory for analysis, the individual who presents for anonymous testing and provides a blood specimen must be given one of the identification stickers from the bottom of the requisition so that he/she can return to the testing site at a later date to obtain his/her test results. Because no identifying or contact information is obtained during anonymous testing, when specimens are submitted to laboratories, it is the prerogative of each person who undergoes anonymous HIV testing to return to the clinic where he/she was tested to receive his/her results. Second, HIV testing in a laboratory, rather than at the point-of-care using a ‘rapid HIV test’ (PHAC 2007), may occur when (a) an HIV test is undertaken in this manner, i.e., as a standard blood test, or (b) when a point-of-care, or ‘rapid HIV test’ yields a reactive result. Because point-of-care tests can yield false-positive results in approximately 5 out of 1000 cases, it is important that such reactive test results are confirmed using additional methods that are only available in laboratories certified to perform HIV testing (PHAC 2007).

**Mandating Behaviour: Section 22 Orders**

Because HIV is the causative agent of AIDS, this infection acquires the same classification as AIDS not only a reportable infection, but also a communicable disease. Due to this second classification as communicable, the HPPA grants additional powers to local medical officers to prevent its transmission. Section 22 of the HPPA, specifically, authorizes medical officers of health, in certain defined circumstances, to instruct designated persons who have, or may have, communicable diseases to take, or refrain from taking, specific actions to diminish communicable disease transmission; for example, these orders could proscribe the occurrence of certain practices, such as, unprotected sex. Section 22 orders can, furthermore, require a person to submit to examination to determine his/her communicable disease status, and to deliver the findings of this assessment to the local medical officer of health. Medical officers of health could thus use Section 22 orders to force a person who is known to have been exposed to HIV, but who refuses to undergo testing, to submit for assessment. Failure to comply with such orders can result in a fine up to $5,000 per day under sections 100 and 101(1) of this act.

Section 22 orders, however, can only be issued when, firstly, a medical officer of health has reasonable and probable grounds, i.e., he or she is of the ‘opinion that a person has or may have a communicable disease’, and, secondly, three conditions are satisfied: (1) a communicable disease exists or may exist; (2) the communicable disease presents a risk to the health of the community; and (3) the stipulations of the Section 22 order are necessary to decrease or eliminate the risk to health presented by the communicable disease. Satisfying the first criterion is simple; the communicable disease need only ‘likely’ be present. A positive test result easily satisfies this requirement. Indeed, the mandatory reporting of communicable diseases as per Section 25 of the HPPA gives the local medical officer of health proof that a communicable disease does in fact exist.
Extant public health and health care literature satisfies the second criterion of a Section 22 order. HIV, as a result of its incurable and chronically debilitating nature that typically leads to immune system deterioration and premature death without treatment, presents a risk to the health of both individuals and communities. In addition, as the HPPA is currently interpreted, HIV is considered the causative agent of AIDS, and thereby is understood to be a communicable disease that threatens the health of communities.

The third criterion, by comparison with the previous two, is the most variable because the actions specified in the order is necessary to decrease or eliminate the potential transmission of the communicable disease of interest. Accordingly, there must be clear evidence that the actions specified in the order will decrease transmission of the communicable disease of interest. As part of this, Section 22 orders may also be issued when an individual refuses to take a prescribed treatment that would cure or eliminate the infectiousness of a communicable disease; however, it is uncertain if Section 22 orders could be issued to impose the use of HIV medication. Local public health officials can become aware of such situations as a result of Section 34 of the HPPA, which stipulates that physicians and registered nurses (extended class) must notify local medical officers of health if a patient with a communicable disease fails to comply with treatment directives for said disease.

According to the Ontario Advisory Committee on HIV/AIDS (1997), there are four other scenarios when local public health authorities could become aware of, and thus consider Section 22 orders for, potential instances of HIV transmission by persons living with HIV. These are as follows: (a) When a person living with HIV contacts his/her local public health department to seek assistance in diminishing occurrences of potential HIV transmission; (b) When a physician or registered nurse (extended class) interprets that an HIV-positive patient’s continued engagement in practices that can transmit HIV constitute a refusal of ‘care and treatment’, and, consequently, report the occurrence of these behaviours to the local medical officer of health under Section 34 of the HPPA; (c) When the local public health department is notified about the diagnosis of a second reportable STI, subsequently identifies that the person who was diagnosed with the reportable STI had previously been diagnosed with HIV, and then interprets this second infection as evidence that the person with HIV has been engaging in practices that transmit HIV; or (d) When persons who were ‘affected by the risk behaviour’ initiate a call to the local public health department to lodge a complaint (Ontario Advisory Committee on HIV/AIDS 1997: 15). Accordingly, while debate continues about whether or not Section 34 actually necessitates the reporting of so-called ‘unsafe behaviour’ by physicians and extended class nurses, all of the foregoing situations constitute situations when local medical officers of health could become aware of potential instances of ongoing HIV transmission by people who know they are HIV-positive (Ontario Advisory Committee on HIV/AIDS 1997). These situations, therefore, constitute instances when medical officers could issue Section 22 orders.

**Breaching Section 22 Orders**

In addition to the above-noted powers inherent in Sections 100 and 101, according to Section 102, if a medical officer of health obtains evidence that a Section 22 order has been breached, the medical officer may apply to a judge of the Ontario Court of Justice and request that the courts ‘prohibit [the] continuation or repetition of contravention’ of a section 22 directive. During this application, the judge can ratify the Section 22 order as is, can modify it as he/she wishes, or can reject the motion. If the judge maintains the Section 22 order, Section 102, Subsection 2.1 of the HPPA states that ‘the order may be enforced in the same manner as any other order or judgment of the Superior Court of Justice’.

**Survey Findings**

In total, 721 surveys were collected. Of these, 86.8% (n=626) were completed in English; 97.2% (n=701) were completed by participants who reported being male; and 81.8% (n=590) were completed by individuals who identified as White. The respondents’ average age was 37.8 ± 12.1 years. Moreover, 81.9% (n=590) reported a College or University education, and 40.8% (n=294) noted a salary of $40,000-
$80,000 (CAD). In relation to testing practices, 85.6% (n=617) reported having previously undergone STI testing, with 39.0% (n=281) reporting a prior STI diagnosis. Previous HIV testing was similarly noted by 88.8% (n=640) of the participants, with 10.0% (n=72) having noted they had been diagnosed with HIV. Regarding HIV testing modalities, 91.3% (n=658) indicated they were aware of anonymous testing, and 55.2% (n=398) reported they had undergone such testing. A smaller, but still substantial, proportion (40.2%, n=290) noted that anonymous testing was their preferred testing method.

Exploration (by cross tabulation) of HIV testing modality and STI testing and diagnosis histories revealed a few significant findings. For one, when compared to those who did not report previous anonymous HIV testing, a greater proportion of individuals who reported previous anonymous HIV testing indicated they had undergone STI testing ($\chi^2=26.603$, $p<0.001$). In addition, more individuals who reported previous anonymous HIV testing, when compared to those who noted no such HIV testing, reported a previous STI diagnosis ($\chi^2=9.096$, $p=0.003$). By comparison, analyses of the participants’ reported awareness of, or preference for, anonymous HIV testing and their reported STI testing and diagnosis histories revealed no significant relationships. Thus, it was actual use of anonymous testing, not knowledge of or preference for this testing modality, which corresponded with increased testing and diagnosis.

Moreover, significant findings emerged between anonymous HIV testing and previous HIV testing. In comparison to those who reported never having undergone anonymous HIV testing, a significantly higher proportion of individuals who reported having undergone anonymous HIV testing reported previous HIV testing ($\chi^2=34.059$, $p<0.001$). Likewise, when compared to respondents who noted they had no preference for anonymous testing, more participants who noted they preferred anonymous HIV testing reported such testing ($\chi^2=62.701$, $p<0.001$). This demonstrated an association between stated preference and testing behaviour.

Lastly, some associations emerged indicating who reported using anonymous HIV testing. Firstly, among those who indicated they were unsure about their HIV-status or HIV-negative, in comparison to those who indicated they had never undergone anonymous HIV testing, more individuals who reported a history of anonymous testing reported that previous or current sexual partners were HIV-positive ($\chi^2=8.941$, $p=0.003$). Secondly, among all participants, in comparison to those who did not indicate previous anonymous HIV testing, more individuals who reported such testing noted they engaged in anal sex in the two months preceding survey distribution; this finding approached significance ($\chi^2=3.599$, $p=0.058$). A similar comparison for anonymous HIV testing and oral sex, both performing and receiving, within the same time period, revealed no significant associations ($p=0.700$, $p=0.764$, respectively).

**Discussion**

**Summary of Empirical Findings**

In summary, the survey findings revealed that the participants who reported using anonymous HIV testing were more likely to have noted: (a) previous STI/HIV testing, (b) prior STI diagnoses, (c) a preference for anonymous HIV testing, and (d) sexual histories involving anal sex and HIV-serodiscordant partners. These results suggest that the survey respondents who used anonymous HIV testing were most likely to engage in practices that—as per the Public Health Agency of Canada’s (2011) HIV transmission criteria—easily transmit HIV. These results correspond with current epidemiological data in Ontario, which indicate that, among all testing modalities, anonymous HIV testing has the greatest proportion of positive test results\(^1\) (Remis et al. 2012).

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\(^1\) It is important to note that this association between anonymous HIV testing and the elevated positivity rate may occur because: (1) persons who are more likely to test positive for HIV use this modality, which affects the numerator in the positivity rate, (2) persons who are unlikely to test positive for HIV do not use this modality, which affects the denominator in the positivity rate, or (3) some combination of both of the foregoing processes. In any case, the point remains: anonymous HIV testing, while utilized
The document review findings, which provided what useful information ‘about the legal framework within which [public health] surveillance operates’ (Lyon 2007: 21), meanwhile, suggested the presence of an extensive, pervasive, and legally-imposed system of surveillance, which mandates local public health authorities to track and follow-up with, firstly, people diagnosed with HIV (index cases), and, secondly, persons who may have been exposed to HIV (contacts). More specifically, in Ontario, public health legislation, known as the HPPA, gives authority to public health officials to obtain information about persons diagnosed with reportable diseases (Section 25), to ensure appropriate and timely follow-up with these index cases and their contacts (Sections 7 and 25), and to issue directives which proscribe actions that transmit communicable diseases (Section 22). The stated purpose of the HPPA is to decrease disease transmission and to promote and protect the health of people in Ontario (Section 2).

Amidst this environment of legally mandated public health surveillance, however, anonymous HIV testing allows persons to undergo HIV testing without having their names reported to public health authorities if they test positive for HIV. Anonymous HIV testing thus prevents public health officials from undertaking follow-up with index cases and their contacts pursuant to Sections 7 and 25 of the HPPA. In addition, without a person’s name, medical officers of health cannot issue Section 22 directives to force persons living with HIV to take, or refrain from taking, specific actions that should prevent the transmission of this virus.

Theorizing the Empirical Findings

When these results are examined using Hardt and Negri’s and Lupton’s work, in addition to simply detailing the public health HIV surveillance system, two noteworthy points about surveillance arise: (1) HIV surveillance occurs both formally and informally, and (2) HIV surveillance is self-limiting and cannot achieve total observation.

Formal and Informal HIV Surveillance

The first point of interest is that public health HIV surveillance occurs in two ways. The formal aspect of this surveillance system is the legally mandated public health reporting and follow-up that occurs when a person is identified as having a reportable infection. This formal system, moreover, includes the systematic tracking of the demographics and exposure characteristics of people both who undergo HIV testing and who are diagnosed with HIV. Involved in the formal public health surveillance apparatus, therefore, is: (1) the detailed tracking of the names and personal details of individuals who test positive for HIV after having undergone such testing using their names, and (2) the careful examination of the characteristics of persons who undergo anonymous HIV testing both nominally and anonymously.

Surveillance of the demographic and exposure characteristics of people who are diagnosed with HIV highlights that anonymous HIV testing is not entirely anonymous. While an anonymous HIV test may not include a person’s name, practitioners and laboratories still submit, to local public health units, information about the age, sex, and exposure practices of persons who test positive for HIV (see figure 2). Persons who undergo anonymous HIV testing are thereby subject to indirect, but nevertheless, formal public health surveillance because public health officials use the information they receive from both anonymous and nominal HIV test requisitions to generate an overall understanding about the type (profile) of person who tests positive for HIV, and, thereafter, use these surveillance data to target prevention initiatives at identifiable profiles. In other words, because public health officials obtain surveillance data that describe the persons who access, and test positive using, anonymous HIV testing, public health officials compile this information with the data from the nominal HIV test results and implement HIV prevention strategies that target the groups which yield the greatest number of positive HIV results.
People who undergo anonymous HIV testing, accordingly, do not avoid surveillance. While their names are not reported, they, and the members of their surveillance groups, nonetheless become the focus of public health initiatives.

The outcome of this process is similar to, but distinct from, the creation of data doubles, which describe a single identifiable case (Haggerty and Ericson 2000). Although nominal HIV testing produces data doubles for positive test results, the data from anonymous test results cannot. Instead, these data are combined with the nominal HIV testing data to yield two other surveillance outcomes, which are the construction and prioritization of specific profiles; e.g., men who have sex with men, or persons who inject drugs. Of interest, using public health HIV surveillance data in this way resembles Bigo’s (2006) descriptions about how border surveillance initiatives repudiate accusations of racism by hiding behind the alleged objectivity and neutrality of their surveillance data. In the same way, because public health surveillance groupings purportedly describe behaviour, rather than disenfranchised subpopulations, public health officials are able to focus on the practices of many historically-marginalized people, such as, gay men, sex trade workers, persons who inject drugs, etc., without appearing to do so for ulterior reasons. Lyon (2007), however, aptly reminds us that this four-part process of surveillance, profiling, prioritization, and subsequent intervention nevertheless constitutes a form of policing: it is the use of surveillance data to inform people’s decisions about how to avert allegedly unwanted outcomes through a data-informed calculus of risk.

Such formal surveillance, and its relation to risk calculation, however, is only part of the public health HIV surveillance system. In addition, the results of this research suggest that informal surveillance, which is a form of auto or self-surveillance, also occurs. This highlights that the public health officials who execute public health surveillance, the group that can be called ‘the watchers’ based on Lyon’s (2007) work, are not alone in the surveillance process. Lyon’s concomitant group, ‘the watched’, also contribute to HIV surveillance by self-selecting to access care and undergo testing. To explain further, public health HIV surveillance, on the whole, cannot occur without the active participation of those who are monitored; i.e., ‘the watched’. In the absence of the aforementioned Section 22 order—which can mandate HIV testing in some cases—individuals in Ontario undergo HIV testing only when they voluntarily submit their bodies, tissues, and substances for examination. People are not supposed to be forced, coerced, or fraudulently persuaded to undergo testing, and they should likewise be informed when HIV testing is performed (PHAC 2012; World Health Organization 2007). Consequently, in the absence of a Section 22 issuance, individuals cannot be compelled to undergo HIV testing, to notify their previous partners of the HIV diagnosis, or to make efforts to decrease onward HIV transmission.

This voluntary participation in HIV surveillance signals that the informal component of public health surveillance manifests when individuals, often in the absence of any HIV-specific or otherwise debilitating symptoms, undergo HIV testing, whether nominally or anonymously, then become aware they are HIV-positive and, as noted in the extant literature about the effects of an HIV diagnosis, both eliminate practices that transmit HIV and notify previous partners about their potential exposure(s) to HIV. Indeed, as noted in previous research, after an HIV diagnosis, many persons forego practices that transmit HIV and become less infectious as a result of medication (Sasse et al. 2006; Charlebois et al. 2005; Fox et al. 2009; Camoni et al. 2009; Marks et al. 2006). While the association between HIV-positive status awareness and decreased HIV transmission has led some authors to argue that HIV testing services should be as inclusive as possible, it is important to emphasize that the behaviour changes which occur after an HIV diagnosis are similar when HIV testing is done anonymously or with people’s names (Marks et al. 2005, 2006; Sasse et al. 2006; Charlebois et al. 2005; Osmond et al. 1999; Fox et al. 2009; Camoni et al. 2009). The group that Lyon (2007) called ‘the watched’ thus actively participates in their own surveillance by voluntarily seeking out, and subsequently undergoing, HIV testing, and then by reducing the possibility of onward HIV transmission through behaviour change and viral load suppression.
Lupton’s (1995) writings about the ‘Imperative of Health’ can be used to suggest that ‘the watched’ group’s contribution to public health surveillance is the manifestation of an internalized form of self-regulation and self-surveillance. Lupton thus adds further insight to current understandings of Lyon’s (2007) comments about ‘the watchers’ and ‘the watched’: while public health officials undertake formalized systems of HIV surveillance, everyday citizens submit themselves to such tracking and observation without external compulsion to do so.

**HIV Surveillance as a Self-Limiting Process**

The second item for discussion is that public health HIV surveillance appears to be self-limiting, in that this surveillance seems to deter some people from accessing the health service, i.e., HIV testing, which initiates the entire public health surveillance apparatus. This raises interesting questions about how surveillance functions when the goal is to achieve total observation of a specific occurrence within society at large, not among confined groups. To explore this point, which suggests that public health surveillance may affect people’s HIV testing practices, one can use Hardt and Negri’s (2000) ‘triple imperative of empire’, which helps ensure that HIV surveillance is understood as inextricable from testing, diagnosis, and follow-up.

Indeed, in relation to HIV surveillance, of the many interactions that occur within Hardt and Negri’s (2000) include-differentiate-manage sequence, one of interest is that, while HIV testing, i.e., differentiation, induces many beneficial outcomes, e.g., improved quality and quantity of life for people living with HIV and decreased onward HIV transmission, surveillance, as an HIV ‘management’ strategy, affects inclusion, which is people’s willingness to undergo testing in the first place. In using Hardt and Negri’s (2000) language, therefore, one can suggest that anonymous testing: (a) is a differentiation technique that (b) corresponds with varying HIV management outcomes, e.g., prevention, treatment, follow-up, and which (c) influences some persons’ willingness to be included within the group who know they are HIV-positive.

Hardt and Negri’s (2000) work thereby helps identify the cyclical interactions between public health surveillance and HIV testing. For the most part, due to stipulations in the HPPA, HIV treatment, which can decrease transmission, requires surveillance, while surveillance deters some persons from undergoing testing, learning they are HIV-positive, and initiating treatment and preventing onward transmission. Public health surveillance, therefore, is not independent from testing. Rather, as Hardt and Negri’s (2000) ‘triple imperative of empire’ helps us to articulate, surveillance, testing, and treatment are linked.

Indeed, in the local jurisdiction, HPPA-mandated public health surveillance makes it difficult, if not impossible, for most persons to access HIV treatment if they have only undergone anonymous HIV testing. A name-based test, which triggers surveillance, is required in almost all cases for treatment to begin. Therefore, while most people eschew practices that transmit HIV after an HIV diagnosis regardless of the testing modality, HIV treatment is only available to people who test positive using their names; that is, to individuals who yield to surveillance. Problematically, current research highlights that some persons who use anonymous HIV testing have noted that they would forego HIV testing if anonymous HIV testing were not available (Sasse et al. 2006; Osmond et al. 1999). These individuals would thus remain unaware that they are HIV-positive as a result of public health surveillance. Nevertheless, the requirement of name-based testing for access to HIV treatments highlights another way by which anonymous HIV testing is not truly anonymous. If, to benefit from treatment, people must undergo name-based testing, then, while an initial HIV diagnosis (differentiation) may be anonymous, it will not remain as such if people wish to access medication. Although it appears as though surveillance can be avoided, public health involvement occurs in almost all instances.

The results presented above, in combination with the extant literature, suggest that arguments about partner follow-up with persons who might have been exposed to HIV do not justify name-based HIV
surveillance. Instead, in opposition to Lyon’s (2007) assertion that surveillance occurs to achieve secondary ends, with these outcomes being decreased HIV transmission and an improved quality and quantity of life for persons living with HIV, in this context public health HIV surveillance appears to have become its own ends. It is surveillance for the sake of surveillance. While the HIV surveillance regulations established in the HPPA are, according to Section 2 of this Act, supposed to prevent the spread of disease, requirements for name-based surveillance may actually undermine HIV prevention efforts and compromise the health status of people living with HIV. Indeed, preventing access to HIV treatment until a person undergoes testing using his/her name negates two benefits associated with these medications: HIV treatments both improve the quality and quantity of life for people living with HIV and they decrease future HIV transmission (Miller et al. 2010; Granich et al. 2010; Hamlyn et al. 2010; Pinkerton, Holtgrave and Galletly 2009; Crepaz et al. 2009). Considering public health surveillance as an activity that is, in and of itself, a worthwhile and sufficiently justifiable activity sheds further light on the scope and nature of surveillance in contemporary society: in addition to being pervasive, surveillance appears to be accepted not as a mechanism to induce secondary outcomes, but rather, simply as a natural aspect of social life. Surveillance occurs without question, compromise, or discussion. Such findings identify the need for further theoretical and empirical investigation of surveillance and its role in modern society.

Final Remarks

This project highlighted, firstly, that a distinct group of people access anonymous HIV testing, and, second, that a pervasive and legally mandated public health surveillance system monitors HIV in Ontario, Canada. When these findings were examined using the combined works of Lupton and Hardt and Negri, they suggested that public health HIV surveillance should not be understood simply as a top-down patriarchal system of formal observation and control, but rather as a complex and non-linear set of formal and informal interactions of inclusion, differentiation, and management, which occur between ‘the watchers’ and ‘the watched’, i.e., between public health officials and individuals who undergo HIV testing. Within this multifaceted system of observation, the formal surveillance mechanisms involved notifying people they are or could be HIV-positive, reporting diagnoses to public health authorities, and constructing and targeting groups that account for the majority of new HIV diagnoses. The informal surveillance mechanisms, meanwhile, related to the access to testing that was sought by individuals who engaged in practices that, according to public health definitions, rendered them particularly susceptible to HIV acquisition. Furthermore, the distinct characteristics of the persons who reported using anonymous HIV testing suggested that public health HIV surveillance is self-limiting. While the law indicated that this surveillance system emerged to prevent infection and disease transmission, these results, when reviewed in light of previous empirical data about anonymous HIV testing, indicated that public health HIV surveillance may, conversely, impede HIV prevention by limiting access to treatment and other effective HIV prevention interventions.

These results thus highlight that one must appreciate the dual and potentially conflicting nature of anonymous testing. On the one hand, it is possible that an absolute avoidance of the public health surveillance system would require an outright rejection of all forms of HIV testing. One would need to remain absolutely ignorant about whether one is, or could be, HIV-positive. To avoid public health surveillance, one would need to resist not only the overt and direct forms of public health surveillance that are legally mandated, but also the subtle and informal methods of self-surveillance that incite voluntary inclusion within the HIV testing system in the absence of symptoms and feelings of ill-health. To circumvent observation, therefore, the simple option is to avoid all inclusion within the differentiation and management system of testing and follow-up.

Notwithstanding these criticisms of anonymous HIV testing and public health surveillance, however, one must acknowledge on the other hand that benefits can, and typically do, arise from knowing one’s HIV-positive status. Indeed, this information most often corresponds with decreased HIV transmission to
others, and, more importantly, improved quantity and quality of life for people who know they are HIV-positive. Moreover, one must acknowledge that public health surveillance does inform health professionals about which groups are disproportionately affected by this infection, and, subsequently, how scarce resources can be distributed to alleviate this burden. Therefore, while it is evident that anonymous HIV testing is a component of public health surveillance, it is equally apparent that for some individuals and populations such testing produces benefits.

As a final note, from a Surveillance Studies perspective, the findings of this research, which highlighted the self-initiated contributions of ‘the watched’ to public health surveillance, leads to the assertion that future explorations of public health surveillance must consider both (a) the overt legal mechanisms which mandate the reporting of specific diseases and follow-up with individuals who may have been exposed to these disease, and (b) the self-surveillance that entices individuals to willingly submit their bodies to examination, and subsequently to change their practices in their test result, yields a positive result (O’Byrne and Holmes 2009). Indeed, the aforementioned results highlight that researchers and authors who discuss surveillance must acknowledge Lyon’s (2007) arguments that surveillance is not simply a top-down system that is imposed on passive bodies. It is, instead, a complex system of imposition and resistance, an intricate mechanism of support and confinement. Surveillance, therefore, results from a series of synergistic and oppositional interactions between ‘the watchers’ and ‘the watched’, or, at least, this appears to be the case regarding the public health surveillance of HIV in Ontario, Canada.

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Figure 1: Ontario HIV Serology Test Requisition.
Figure 2: Ontario Anonymous HIV Serology Requisition