ABSTRACT

Title of Dissertation:	BLACK SURVIVAL POLITICS: ORGANIZED MOBILIZATION STRATEGIES IN AFRICAN AMERICAN COMMUNITIES TO END THE HIV/AIDS EPIDEMIC
	Michelle A. Beadle Holder, Doctor of Philosophy, 2016
Dissertation directed by:	Professor, Patricia Hill Collins, Department of Sociology

The purpose of this study is to examine organizational patterns of African American activism in response the HIV/AIDS epidemic. Given their political, economic, and social disenfranchisement, African Americans have historically developed protest and survival strategies to respond to the devaluation of their lives, health, and well-being. While Black protest strategies are typically regarded as oppositional and transformative, Black survival strategies have generally been conceptualized as accepting inequality. In the case of HIV/AIDS, African American religious and non-religious organizations were less likely to deploy protest strategies to ensure the survival and well-being of groups most at risk for HIV/AIDS—such as African American gay men and substance abusers.

This study employs a multiple qualitative case study analysis of four African American organizations that were among the early mobilizers to respond to

HIV/AIDS in Washington D.C. These organizations include two secular or community-based organizations and two Black churches or faith-based organizations. Given the association of HIV/AIDS with sexual sin and social deviance, I postulated that Black community-based organizations would be more responsive to the HIV/AIDS-related needs and interests of African Americans than their religious counterparts. More specifically, I expected that Black churches would be more conservative (i.e. maintain paternalistic heteronormative sexual standards) than the community-based organizations. Yet findings indicate that the Black churches in this study were more similar than different than the community-based organizations in their strategic responses to HIV/AIDS.

Both the community-based organizations and Black churches drew upon three main strategies in ways that politicalize the struggle for Black survival—or what I regard as Black survival politics. First, Black survival strategies for HIV/AIDS include coalition building at the intersection of multiple systems of inequality, as well as on the levels of identity and community. Second, Black survival politics include altering aspects of religious norms and practices related to sex and sexuality. Third, Black survival politics relies on the resources of the government to provide HIV/AIDS related programs and initiatives that are, in large part, based on the gains made from collective action.

BLACK SURVIVAL POLITICS: MOBILIZATION STRATEGIES IN AFRICAN AMERICAN COMMUNITIES TO END THE HIV/AIDS EPIDEMIC

by

Michelle A. Beadle Holder

Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2016

Advisory Committee:
Professor Patricia Hill Collins, Chair
Professor Roberto Patricio Korzeniewicz
Associate Professor Sangeetha Madhavan
Associate Professor Rashawn Ray
Professor Stephen B. Thomas

Dedication

I dedicate this dissertation to my parents Clover and Michael Beadle. Words are not enough to let you know how much I appreciate all the sacrifices you have made to ensure that we all had opportunities to become educated and to pursue knowledge at the highest level. I love you.

Acknowledgements

First I would like to take the time to thank all the respondents who participated in this study. Thank you for taking the time to share your stories and experiences. To my dissertation committee, Dr. Patricia Hill Collins, Dr. Sangeetha Madhavan, Dr. Roberto Patricio Korzeniewicz, Dr. Rashawn Ray, and Dr. Stephen Thomas, thank you for all your feedback and support throughout the process.

This dissertation would not have been possible without the support and commitment of my academic community. To the members of my dissertation writing group—Dr. Aleia Clark Fobia, Dr. Kendra Barber and Dr. Kathryn Buford—we kept our promise. Five years ago, we made the commitment to meet weekly and to provide scholarly and emotional support to each other. The process of writing this dissertation would have been incredibly lonely and isolating without you. Each of you have taught me the importance of sisterhood in the academy. To PROMISE, Maryland's Alliance for Graduate Education and the Professoriate, since the beginning of my tenure at the University of Maryland you have been like a family to me. Special thanks to Dr. Renetta Tull and Dr. Wendy Carter-Veale, you both embody what it means to lift as you climb. I am so appreciative of your dedication to helping students like me achieve our academic goals.

Finally, I would like to thank my family who have been there with me through all the ups and downs. To my husband Dr. Robert Holder, I still can't believe that we did it together. This PhD journey was worth it all having you by my side. Thank you for all the words of encouragement and for being there for me. I look forward to seeing you get your degree. To my younger twin sisters Dania and Deidre Beadle.

Dania congratulations on receiving your M.S. I am so proud of you. Deidre I know that several years have transpired since you received your PhD, but I would like to take the time to tell you congratulations on your great achievement. To my brother Michael and my nephew Makai, I appreciate all the times that you made my smile. Mrs. Juanita Jones, my GM, thanks for all the prayers and inspiring words.

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Chapter 1: Saving Black Lives: Organized Struggles for Justice and Health

Threats to African American lives gained national attention with mass uprisings in response to the killing of Trayvon Martin and others in the criminal justice system.[1] Groups that were morally outraged by violent attacks and deaths at the hands of the police organized under the Black Lives Matter movement by mobilizing their voices, bodies, and resources to demand that the nation values the lives, rights, and dignity of African Americans. Some of the strategies and tactics of the movement include: lawsuits, protests and demonstrations, community surveillance of police actions, and die-ins. Moreover, leaders of Black Lives Matter stress the importance of valuing all Black lives, not only Black men and boys, but other groups such as the lives of Black women, Black LGBT, and Black people with undocumented immigration status. In light of these public mass mobilizations, it is important that sociologists and other scholars consider the multiple ways in which African Americans have organized to save their lives. In addition, it is important that scholars examine the actions of less visible forms of organized struggles for survival—particularly struggles in the realm of public health to address health disparities associated with HIV/AIDS. This dissertation investigates African American responses to the HIV/AIDS epidemic by connecting it to the community's long struggle for and tradition of survival.

Although this dissertation began before the emergence of Black Lives Matter in 2012, the history of Black protest and organized mobilization serves as one of the

[1] The terms African American and Black are used interchangeably throughout this paper.

primary motivations for its undertaking. To illustrate, Aldon Morris (1984:1), sociologist and scholar of Black social movements, argues that African Americans' historical experience of economic, political, and social marginalization has helped to develop a Black protest tradition. This protest tradition includes the mobilization of institutional and cultural resources to combat systemic forms of racial oppression. Morris contends that the Black protest tradition has been transferred across generations through religious, academic, and political organizations. In addition to his analysis of Black protest tradition, Morris explores the significance of Black survival traditions.

One of the main contributions of this study is to focus on the political or oppositional aspects of Black survival. Social scientists have examined the survival traditions or strategies of African Americans (Lincoln and Mamiya 1990; Morris 1984). These survival traditions often include efforts to address the basic human needs of African Americans such as food, housing, and shelter, as well as support in sickness and death (Barnes 2004, 2011; Lincoln and Mamiya 1990). Although Black survival is often regarded as being essential to the continued existence of African Americans, scholarly framing of the term typically viewed it in contrast to the Black protest tradition (Barnes 2011; Morris 1984). In sociological scholarship, Black survival strategies have rarely been discussed as revolutionary, liberating, or transformative justice. Rather, analyses of Black survival strategies have been framed as accommodating, assimilating, and conservative (Barnes 2011; Lincoln and Mamiya 1990; Morris and Braine 2001). Yet intersectional scholars argue that while Black survival may not be transformative, it is important to think more robustly about

African American strategies of survival (Collins 2000; Crenshaw 1999; Spade 2013). Moreover, Collins (2000) argues that an emphasis on protest traditions may divert attention from groups such as African American women whose needs, interests, and concerns are typically ignored and suppressed by larger social movement organizations.

For the last three decades, HIV/AIDS has threatened the lives and well-being of many African Americans.[1] This disease thrives in African American communities that experience numerous inequalities such as poverty and limited access to health services. Moreover, the lives and experiences of those most vulnerable to HIV/AIDS are situated at the intersections of homophobia, racism, sexism, and classism (Cohen 1999; Stockdill 2003). From this perspective, one needs to consider the ways in which organized strategies—whether protest or survival—to address HIV/AIDS are shaped by race as well as sexual, class, and gender inequalities.

This chapter is organized into five sections. In the first section, I provide an overview of the state of African American survival as it relates to HIV/AIDS. There I show that, while African Americans as a group are disproportionately impacted by HIV/AIDS, the lives of some segments within African American communities are especially vulnerable, namely, African American women and girls as well as African American gay men and boys. In the second section, I provide a brief overview of the different responses of the U.S. public health institutions to HIV/AIDS. The third section includes a brief historical review of African American experiences of health disparities, organized public health activism, and early organized mobilization to address HIV/AIDS. Fourth, in the section on organization of the study, I provide a

brief overview of the study's purpose, research question, and methods, as well as discuss some of its underlying assumptions. Finally, section five includes a summary of the chapters that follow in this dissertation.

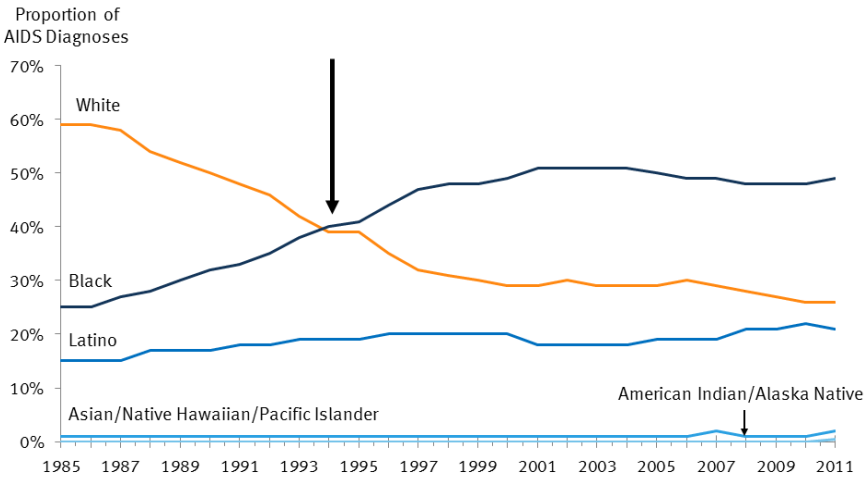
The sections below provide an overview of HIV/AIDS to give the reader an understanding of the public health challenges that African Americans face in the United States. I am hoping to give the reader a sense of the impact of the disease on the general African American population as well as a view of how the HIV/AIDS epidemic is unequally distributed even among African Americans. HIV/AIDS affects groups who are among the least privileged members of the society—African American women and African American gay men. Since all nations claim to have a vested interest in preserving the health and well-being of the members, it is important to also consider the history of the U.S. government response to HIV/AIDS. As I show below, the government response to HIV/AIDS has historically been uneven in terms of which groups have been regarded as more or less deserving of public resources to preserve their health and well-being. In other words, some groups have been granted first-class health citizenship status while others were regulated to second-class status. Initially, throughout the history of the U.S., African Americans lives have been regarded as less deserving of public resources as it relates to health (DuBois 1899 [2007]; Gamble 2010; Smith 1995). They have not only experienced greater burdens of disease and threat to their health, but they have been in many ways second-class health citizens. Yet throughout this history, African Americans have mobilized around health. However, this mobilization was slow to emerge around HIV/AIDS

because the disease impacts those groups that have historically being marginalized in other movements.

1.1 HIV/AIDS and African American Chances of Survival

African Americans have been impacted by HIV/AIDS since the official recognition of the disease in the United States in 1981. Yet the magnitude of the epidemic and threat to African American lives was not fully recognized until 1993, more than a decade after its discovery (see Figure 1.1.1). According to political scientist Cathy Cohen (1999), the rates of HIV infection among African Americans were severely undercounted by major public health organizations such as the Centers for Disease Control and Prevention (CDC). In 1985, approximately four years after the disease was officially identified as a public health threat, Blacks represented approximately 25% of the epidemic and Whites nearly 60% (see Figure 1.1.1 Kaiser Family Foundation 2013). However, with better HIV/AIDS surveillance public health officials observed a dramatic shift in reported cases of the disease in 1993. Public health data indicated that Whites experienced nearly a reverse trend of approximately a 20% decline, while Blacks seemed to have experienced an approximately 15% increase in AIDS diagnosis in 1993 (see Figure 1.1.1). This racial gap in HIV/AIDS diagnosis would continue to widen. Current epidemiological reports of the rates of AIDS diagnosis suggest that in 2014, African Americans accounted for nearly half, or 44%, of the new cases of HIV infection even though they represent 12% of the overall U.S. population (CDC 2016a).

Figure 1.1.1: Proportion of AIDS Diagnoses, by Race/Ethnicity in the United States, 1985-2011



Note: Data are estimates and respresent AIDS diagnoses by year
Sources: Kaiser Family Foundation, based on CDC, Data Resquest; 2006. CDC, HIV Suveillance Report, Vol 23; Feburary 2013.

Racial health disparities are also observed in HIV/AIDS-related mortality rates. African Americans continue to die at higher rates than their White counterparts. "From 1990 through 2010, the percentage of Blacks/African Americans […] who died of HIV infection increased from 29% to 56%, while the percentage of Whites decreased from 53% to 28%" (CDC 2013:17). Such disparities remain despite the widespread availability of antiretroviral therapy. In 1993, highly active antiretroviral treatment (HAART) became available to treat HIV/AIDS in the United States. While all groups experienced dramatic declines in death rates in between 1993 and 1995, African Americans benefited the least from such biomedical interventions (CDC 2013).

Whereas HIV/AIDS health disparities are due to many factors, racial and socioeconomic inequalities are fundamental. For example, African Americans have unequal access to high quality HIV/AIDS medical treatment and care. Studies indicate that given the continued history of racial apartheid, African Americans tend to reside in segregated neighborhoods with fewer medical specialists and facilities to diagnoses disease and illnesses relative to White neighborhoods (Smedly, Stith and Nelson 2003; Williams and Sternthal 2010; Williams and Wyatt 2015). The issue of medical distrust is also noted in the research as a major barrier to HIV/AIDS care due to the legacy of medical abuse in the health care system (Bucher, Hood and Jordon 2005; Thomas and Quinn 1991). Socioeconomic factors also contribute to unequal diagnosis and access to medical care. African Americans tend to have lower educational attainment and income levels, as well as higher rates of unemployment, underemployment, and incarceration, which impact their level of access to jobs that provide health insurance (Fullilove 2006; McCree and Hogben 2010). While racial and economic inequalities contribute to HIV/AIDS health disparities, gender and sexuality are also important factors.

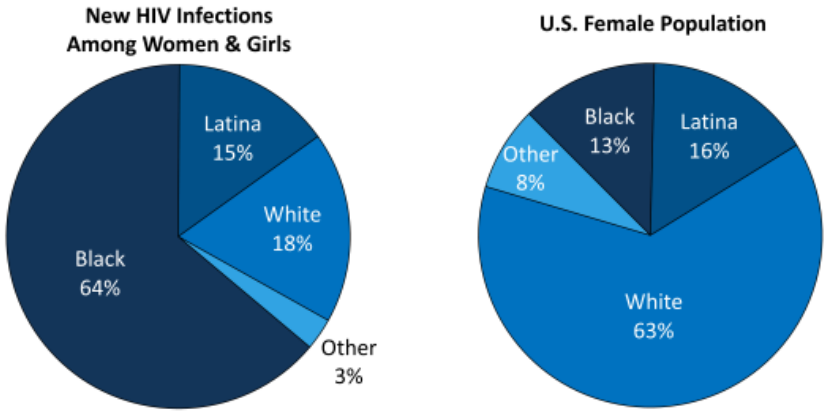
1.1.1 African American Women and HIV/AIDS

As a group, women were largely invisible in early public health responses to HIV/AIDS. Since the epidemic was initially framed as White male and gay disease, the epidemic was not considered to be a major public health threat to the lives of women and girls (Campbell 1999; Patton 1994). The early failure of the nation to prioritize and attend to the health needs of women and girls had medical, political, and social consequences. To illustrate, women were less likely to be diagnosed with

HIV and they also had limited access to health care and other social services (Higgins, Hoffman and Dworkin 2010; Patton 1994). These health inequalities were particularly devastating for African American women.

The HIV/AIDS epidemic among African American women far exceeds the rates of all women in the United States. In 2010 African American women made up 64% of the estimated cases of new HIV infections, while White women only accounted for 18% (Kaiser Family Foundation 2014; See Figure 1.1.2). Studies highlight the ways in which gender inequality contributes to the elevated rates of HIV/AIDS among African American women. For example, prevailing gender norms which support or encourage women's submission in sexual relationships also contribute to increased risk (Wingood and DiClemente 2010). African American women, like other women, face the risk of domestic and sexual violence, a phenomenon which has been found to be associated with increased vulnerability to HIV/AIDS (Campbell 1999). Gender inequality is also compounded by racial and economic factors (Gilbert and Wright 2003; Hammonds 1995; Wingood and DiClemente 2010).

Figure 1.1.2: New HIV Infections Among Women and Girls and U.S. Female Population, by Race/Ethnicity, 2010

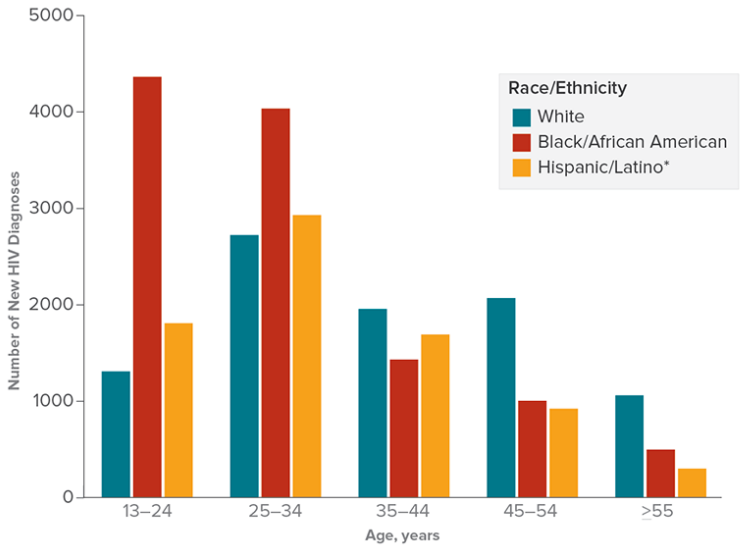


Source: Kaiser Family Foundation. 2014. Women and HIV/AIDS in the United States

1.1.2 African American Gay Men and HIV/AIDS

When compared to other gay and bisexual men, the CDC (2016b) reports that Black gay and bisexual men account for the highest rates and number of people diagnosed with HIV (38%, 11,201). Young Black gay and bisexual men ages 13-24 are two times more likely to be newly infected by HIV/AIDS than their White and Hispanic counterparts (CDC 2016b; See Table 1.1.3). Like African American women, Black gay men face issues related to racial and socioeconomic inequalities. However, the issue of homophobia both within the larger society and, more specifically, within Black communities contribute to heightened HIV/AIDS risk partly linked to marginalization from health resources and support.

Figure 1.1.3: Estimated Incidence of HIV Infection Among Men Who Have Sex with Men, by Race/Ethnicity and Age at Infection, 2014—United States



Source: CDC 2016b. HIV/AIDS Among African American Gay and Bisexual Men

In summary, HIV/AIDS remains a major public health issue that disproportionately impacts African Americans. Yet the issue is more devastating for African American women and African American gay men who tend to occupy lower social status and experience higher vulnerability to abuse and oppression. The physician and medical anthropologist Paul Farmer (2005) uses the term *hierarchy of suffering* in his analysis of HIV/AIDS and other health issues. Farmer uses the concept to highlight the ways in which some groups experience greater suffering, violence, and neglect in society. For Farmer (2005:31), suffering is rarely "effectively conveyed by statistics and graphs." Rather, Farmer (2005:40) states that it is important to consider the historical and socioeconomic "processes and forces that conspire—whether through routine, ritual, or, as is more commonly the case, the hard surfaces of life—to constrain agency." These forces include systemic racism, sexism,

poverty, and sexual inequality that shape and limit the life chances and agency of some groups such as African Americans.

1.2 U.S. Public Health Organizations and HIV/AIDS

To ensure its survival and continuity, the U.S. has invested in some aspects of public health—such as the establishment of health institutions – and neglected others. According to Riegelman (2010), public health institutions serve three main functions: (1) to provide information about what makes us ill; (2) to recommend and enforce strategies to maintain health and avoid sickness and; (3) to mobilize individuals, groups, institutions, and organizations to promote and maintain population health. Through various mechanisms and processes, U.S. public health institutions are tasked with the responsibility of providing health information, services, and resources to the public. Some of the most well-known public health organizations include the CDC, the Department of Health and Human Services (DHHS), the National Institutes of Health (NIH), and the Food and Drugs Administration (FDA). Other public health institutions include the Substance Abuse and Mental Health Services Administration (SAMHSA), public hospitals, and clinics. These and other health organizations have been central to public health response to HIV/AIDS.

Public health institutions are governed by a set of ideals, norms, practices, laws, and policies related to concerns for the survival and welfare of society. Experts are trained in multiple fields to identify, categorize, treat, prevent, and help people cope with threats of disease and illnesses (Lupton 1995). In addition, the public or members of the society are tasked with the responsibility, both as individuals and as a part of a collective, to adhere to the prevailing health norms, practices, laws, and

policies (Dew 2012). For this reason, some regard public health as a site of institutional and cultural power.

The authority of public health includes efforts to foster ideals and practices that are both empowering and restrictive. For example, one of the most positive ideals of public health is grounded in constructions of community—a belief in a collective "us" or "imagined community" —where people come to see their lives, health, and well-being as being connected to the lives of millions of unknown people (Morone 1997). As Hahn and Inhorn (2009:4) assert, the foundation of "[p]ublic health rests on a moral assumption that [the] response to the perceived suffering of others is a worthy action, deserving commitment of resources and effort." Yet there are those who stand outside of community, namely, groups labeled "them" or "others" that are not considered to be a part of the group or community. These groups tend to occupy second-class status and are often regarded as undeserving of public health resources and more deserving of control, restriction, and punishment. Moreover, Morone (2005) contends that the treatment of the groups regarded as the undeserving other is often informed by Judeo-Christian traditions, for example, Puritan Protestant perspectives which emphasize individual sin. Public health traditions reflect these ideas about community and belonging.

In the following sections, I provide a brief overview of public health responses to HIV/AIDS. First I discuss the ways in which United States public health response to the epidemic privileged the lives and well being of some groups, particularly those deemed innocent victims of HIV/AIDS. This is followed by a brief overview of public health responses to those regarded at the undeserving victims of

HIV/AIDS. Understanding the public health responses to health and disease is important for examining African American responses to HIV/AIDS.

1.2.1 To Let Live: Innocent Victims of HIV/AIDS

Since the 1980s, the U.S. government and its health institutions have deployed and maintained public health resources for groups considered the innocent victims of HIV/AIDS. I will discuss three such groups: hemophiliacs, babies, and women.

One example of an innocent victim group includes hemophiliacs who became vulnerable to HIV/AIDS through blood transfusions. Between 1981 and 1984 more than half the population of HIV-positive hemophiliacs contracted HIV through blood transfusion (Evatt 2006; White 2010). To prevent transmission among this group, institutions such as the FDA imposed public health laws and practices to screen and regulate blood donation (Farrell 2012; FDA 2015). These practices led to zero new infections of hemophilic patients born in the U.S. after 1985 (Evatt 2006). In addition, the government provided reparations through the Ricky Ray Bill, which compensated hemophiliacs for the biological harm and social suffering they incurred as victims of the medical system (Shaw 1996). Broader government policies such as the Ryan White Care Act, which made federal funding available to HIV/AIDS patients unable to afford care and other services, were initially informed by the threat of HIV/AIDS among hemophiliacs (Donovan 2001; Evatt 2006). Both the Ricky Ray Bill and the Ryan White Care Act were named in honor of hemophiliacs who were White, young and male.

As another designated innocent victim group, fetuses and babies have historically occupied a privileged status in United States public health systems. This

preferential status continued with discovery of HIV/AIDS because these two groups were deemed innocent victims of the epidemic. Since the 1980s, the U.S. government and medical institutions have allocated public health resources to the health and survival of babies with HIV/AIDS. Public health institutions such as the hospitals, National Institute of Health (NIH), the Food and Drug Administration (FDA), and the Department of Health and Human Services (DHHS) made concerted efforts towards prevention by making antiretroviral drugs available to pregnant women diagnosed with HIV/AIDS (McGovern 1997). Studies document public health success as the U.S. pediatric epidemic decreased by 95% between 1992 and 2005 (Burr et al 2007; CDC 2016c). In 2011, only 53 babies were born with HIV/AIDS (CDC 2016c).

As a health category, women have occupied but a privileged and second-class status in public health policies when it comes to HIV/AIDS. Feminist scholarship on HIV/AIDS suggests that their privilege has historically being tied to their roles as mothers (Campbell 1999; McGovern 1997). To illustrate, women only became beneficiaries of public health resources and services such as HIV/AIDS treatment through NIH clinical trials for drug development. In addition, during the early years of the epidemic, most women did not become aware of their diagnosis until they were pregnant.

1.2.2 To Let Die: The Undeserving Victims of HIV/AIDS

In contrast to the treatment of hemophiliacs, fetuses and babies, and women, public health responses to HIV/AIDS provided unequal distribution of resources for groups deemed undeserving of public health resources, namely, those viewed as being responsible for their own illness. This included groups that have historically

held second-class citizenship status—gay men, people with history of substance abuse, sex workers, Haitians and African immigrants (Lune 2007; Patton 1990). Coercive responses included the treatment of these groups in the regulatory laws and practices of HIV/AIDS. For example, the regulatory standards and policies used by the FDA to protect the blood supply from HIV/AIDS involved broad-scale discrimination against gay men, sex workers, intravenous drug users, Haitians and African immigrants (Farrell 2012; FDA 2015). These groups have been restricted from donating blood due to fear that they as a group posed a threat or risk of contaminate the blood supply. Other unequal responses included disinvestments of public health funding for drug treatment programs and an investment in the criminalization of drugs both prior to and since the discovery of HIV/AIDS (Cohen 1999; Donovan 2001). In addition, state-imposed laws and policies have restricted broad-scale access to sexual health information and prevention technologies. This has been particularly the case under Republican administrations, which tended to emphasize abstinence-only interventions, a public policy outcome which has historically been informed by Judeo-Christian beliefs (Brier 2009).

These responses to HIV/AIDS foster practices that have contributed to the deaths of groups that have historically had lower political, social, and moral status in the U.S. To illustrate, HIV/AIDS was discovered in 1981, under the political rule of President Reagan who was elected on the political platform of 'moral deviance' and conservative race and politics (Gould 2009; Smith and Siplon 2006). The Reagan administration pursued the economic politics of 'supply side economics', which justified decreased funding to employment and training programs, food, housing, and

many other programs. This had devastating impact in poor Black communities in urban areas like Washington D.C. (Cohen 1999; Marable 2002). Such practices were expanded to HIV/AIDS, where the government failed to provide the necessary public health resources to save the lives of those disproportionately impacted (Brier 2009; Shilts 1987).

Public health neglect around HIV/AIDS has also inspired uneven collective action. For example, although health has been a core component of the women movement in the U.S., this movement failed to deploy resources to address HIV/AIDS, an issue that disproportionately affects women—specifically African American women (Farmer 2010; Treichler 1999). Although an HIV/AIDS movement emerged in the United States in the 1980s and 1990s, the activism tended to focus on the needs and interests of White middle-class gay men (Epstein 1996; Smith and Siplon 2006).

In the following section, I provide a brief history of African American experience of health disparities in the U.S. and their history of collective action. This summary provides an overview of the legacy of influence of public health neglect on African American communities. It also provides an interpretive context for understanding African American agency in response to these historical patterns of neglect. African American responses to health inequalities have included the mobilization of community resources to develop a Black health infrastructure and effort to challenge dominant beliefs that American Americans were underserving of health resources.

1.3 African American Health: History of Disparities and Activism

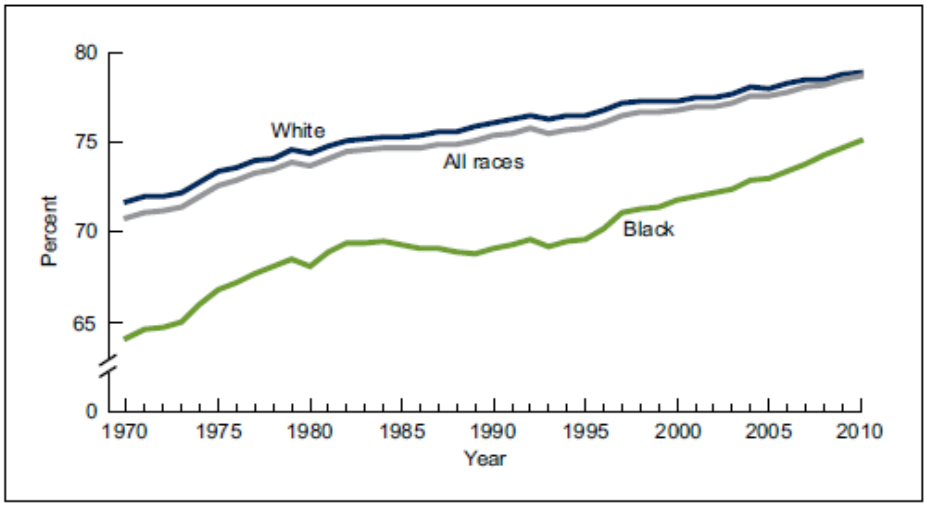
The history of health disparities in African American communities is well documented. To illustrate, at the turn of the twentieth century the United States and other European nations experienced dramatic improvements in health—mortality rates declined "by 40% from 1900 to 1940" (Cutler and Miller 2005:1). Many note that such improvements in health were due to non-medical advances such as improved sanitation, nutrition, living, and work conditions (McKeown 1979; McKinlay and McKinlay 1977; Szeter 1988). Other scholars argue that improvements in health were due to the development and improved access to medical care, specifically treatment for diseases such as polio, tuberculosis, and other infectious diseases (Rosen 1993). Though there are disagreements in the literature regarding whether medical or non-medical factors were the primary cause of improvements in life expectancy and overall population health, many agree that both were influential. Yet African Americans failed to fully benefit from these advances. In fact, in his classic 1899 text *The Philadelphia Negro,* W.E.B Du Bois (1899 [2007]:116) spoke about the "peculiar indifference" the nation had toward the health and suffering of Black people.

Analyses of African American health reveal a history of unequal life chances. In the early 1900s, public health reports revealed that African Americans experienced higher mortality and morbidity rates than their White counterparts (Gamble 2010). Public health surveillance conducted by the Atlanta Board of Health indicated that the death rates for Blacks were 69% higher than that of Whites in 1900 (Galishoff 1985). Du Bois (1906) documented cases in which African American deaths from diseases

such as tuberculosis, diarrhea, and pneumonia were twice or sometime three times the rates as Whites.

In the twenty-first century, African Americans continue to experience poorer health outcomes than their White counterparts. For example, though the racial health gap for life expectancy narrowed between the years of 1970 to 2010, White Americans continue to outlive African Americans (See Figure 1.1.4). Research by Kochanek, Arias, and Anderson (2015) suggest that White Americans lived an overall 3.6 years longer than African Americans in 2010. Even among the highly educated and higher income, Blacks experience higher incidence of heart disease and other illnesses than their White peers (Williams and Sternthal 2010).

Figure 1.1.4 Life Expectance by Race: United States, 1970-2010



Source: Kochanek, Arias, and Anderson (2015)

1.3.1 African American Public Health Organizations and Activism

African Americans have a long history of mobilization in response to racial health disparities. Like mobilizations against educational inequality, such as the protracted struggle against racial segregation in schools, health mobilization was also forged in response to the institutional neglect, mistreatment, and discrimination that

African Americans experience in predominantly White health institutions (Byrd and Clayton 2002; Thomas et al. 2011). The response to inequality often entailed the deployment of resources to establish health organizations. These African American public health organizations took different forms, can be traced as far back as slavery, and became formalized in the years following the Civil War (Byrd and Clayton 2002; Gamble 1997). For example, freed African Americans lobbied with White allies to pressure the federal government to develop agencies such as the Freedman's Bureau to invest public resources to establish Black public institutions that provided access to education and health beginning in 1865 (Downs 2012; Smith 1995). In the face of racial backlash and public disinvestment during the period of Jim Crow, African Americans established their own hospitals and clinics to improve and maintain community access to medical care (Byrd and Clayton 2002; Gamble 1997). Other organized efforts included health research conferences, journals, and centers in Historically Black Colleges and Universities such as Atlanta University and the Tuskegee Institute (Byrd and Clayton 2002; Thomas et al. 2011). For example, while at Atlanta University, Du Bois organized numerous conferences and research projects with other Black scholars and physician to challenge scientific racists claims which tied health disparities to biology or heredity instead of systemic racial inequality (Williams and Sternthal 2010).

African American mobilization for health and survival has primarily occurred through both secular political organizations and faith-based religious organizations. During the early twentieth century, established civil rights organizations such as the National Association for the Advancement of Colored People (NAACP), the Urban

League, as well as Black churches have participated in large-scale efforts to preserve and protect Black public health. According to Quinn and Thomas (2001:1047), secular and faith-based organizations participated in the National Negro Health Week, a 35-year community health mobilization effort that began in 1915 and focused on "community development, health education, professional training, and health policy initiatives, all designed to improve Black health status." In the early half of the twentieth century, racial health disparities were viewed as a detriment to racial and economic progress. Smith (1995) asserts that while Black leaders and institutions were unable to change the racial and economic structures of society to improve their health, early organized mobilization included efforts to cope or survive in the existing systems. Mobilization for health equity was situated within the larger racial-uplift movement of the time where members of the Black middle-class deployed political and health resources to fight for the preservation of African American life (Gamble 1997; Smith 1995). Given the continued presence of racial health disparities, public health scholars, such as Thomas and colleagues (2011), draw attention to the persistence of the color line in health. They also call for renewed mobilization for health equity. However, the Black health movement of the early twentieth century was rooted in the identity politics that developed in a period when all African Americans, despite their class, gender, and sexual background, all experienced the discrimination and indignities of the legally segregated and unequal health care system (Gamble 1997, 2010). In contrast, in the late twentieth century, health issues like HIV/AIDS draw attention to the gender, class, and sexual divisions within

African American communities, which has historically been considered less worthy of community resources and activism (Cohen 1999; Stockdill 2003).

1.3.2 Women-Centered African American Public Health Organizations

African American historical and contemporary organizational mobilization has not only been shaped by persistent racism but also gender inequality (Davis 1983, 1994; Smith 1995). While men have historically had poorer health outcomes relative to women, men tend to have greater control, particularly over their sexual and reproductive health (Gordon 2002). To illustrate, a key gender distinction problematized by the women's health movements is the way in which women's mortality is tied to their reproductive health. A very clear example is the risk of a woman's death during childbirth. However, other examples are the cases in which multiple institutions, such as the church, family, schools, medicine, and government, have played a role in censoring and regulating women's access to comprehensive sexual health and reproductive health services (Rohlinger 2015; Gordon 2002).

Black public health organizations fought to expand largely White-dominated women's health organizations to include the needs and interests of African American women and girls (Avery 1994; Smith 1995). While some organizations mobilized in ways that reinforced prevailing paternalistic and heterosexual moral norms that regulated the sexual and reproductive health practices of women and girls, other organizations provided spaces and opportunities to contest them (Avery 1994; Simmons 1993). For example, the Black church has historically served as a mechanism for the control of Black sexuality—particularly for women and girls (Frazier 2003; West 1999). Moreover, organizations such as those led by African

American women, and organized through the women's club movement, also maintained these prevailing ideals that the sexual behavior of Black of particularly poor women and girl needed to be controlled (Simmons 1993; Smith 1995). African American women organized to contest the discriminatory practices of the Young Women Christian Association (YWCA) when they failed to provide room and protection for Black girls (Smith 1995). Activism included both women and men. An illustration of this includes organizational efforts to increase the access that African Americans had to sexual health education through the YWCA and the YMCA during the height of the syphilis epidemic in late 1800s and early 1900s (Jenson 2010). Women such as Ida B. Wells Barnett organized through institutions such as the NAACP and the Black women's club movement to problematize and contest the racist ideologies that hypersexualized Black men and framed them as the rapists of White women (James 1997). Although these movements contested stigmatizing racial conceptions of Black sexuality, efforts were also made to regulate, in particular, the sexual behaviors of African American women (Collins 2005). In other words, the sexuality of Black women and girls has historically been heavily policed in ways that reinforce models of sexual chastity, purity, and subordination (Harris-Perry 2011). Women who failed to conform to these narrow gender norms were often publically criticized and regarded as undeserving of community resources and help (Collins 2005; Harris-Perry 2011). Since HIV/AIDS is typically associated with sexual deviance, the legacy of women-centered African American public health organizations has limited the extent to which the larger community response to HIV/AIDS among women in ways that resist the dominant feminine normalization

about sex (Collins 2005; Hammonds 1997, 1999). In this way, African American women have been part of this tradition of African American health activism. While African American health activism included mobilization related to race, class and gender, HIV/AIDS added another layer of issue for which the community failed to address—homosexuality.

Although the African American community as a whole and African American women in particular are disproportionately impacted by HIV/AIDS, the disease also threatens the lives and overall well-being of African American gay men. As a group, African American gay men have been able to benefit from the resources of the larger Black community based on their race and gender status (Cohen 1999). However, they are marginalized based on their sexuality. This marginalization has taken place in both traditional organizations such as the NAACP as well as the Black church (Cohen 1999). Thus, in order to address the epidemic crisis of HIV/AIDS, African Americans are faced with multiple inequalities that have made organizing around a single identity politics insufficient to preserve and protect the lives of people who experience multiple forms of oppression.

Summing up key points of the chapter thus far, the history of African American organizational activism in response to African American public health disparities emphasizes persistent struggles for community survival (Gamble 1997; Quinn and Thomas 2001; Smith 1995). An important component of these struggles includes the formation of a Black health infrastructure, specifically, hospitals, clinics, and organizations in Black civil society that provided African Americans with access to health care services and information. The intent of this infrastructure was to

empower African Americans with medical knowledge, practices, and technologies that were denied in the broader public health sector.

The experience of racial discrimination in the health care system forced community members to mobilize resources by drawing of upon self-help traditions, especially those that emphasize survival. The mobilization for survival not only involved efforts to escape the violence and murder at the hands of White mobs but also to respond to the overall neglect and indifference to Black health mentioned by DuBois at the turn of the twentieth century (Thomas 2001). This overall repression and lack of value for African American lives continues in the twenty-first century (Hinkson 2015). Examples of this devaluation include police brutality and homicides (Gilbert and Ray 2015). Yet African Americans have been able to deploy the resources of Black organizations such as the NAACP, the Urban League, Black hospitals, and clinics like those developed during Reconstruction, the Civil Rights and Black Power Movement (Gamble 1997; Nelson 2011; Quinn and Thomas 2001). Throughout this history the Black church has played an instrumental role in African American health mobilizations, often serving as places for people to gain access to health information, services, and support.

As shown above, organized public health responses of African Americans are shaped by the influence of racial as well as gender inequality. These organized struggles for Black women's health rights provide insights to efforts which both contested and maintained dominant heterosexual norms and practices in addressing the sexual and reproductive health care needs of Black women (Avery 1994; Simmons 1993). Given the continuity of gender inequality in African American

communities, the activism to save Black women's lives has been somewhat less politicized than can be seen for particularly Black men (Crenshaw 2015). This can be seen in the case of violence against women (Brown 2012; Crenshaw 1991). Despite this, African Americans have established women-centered health initiatives and programs through the YWCA, NAACP, women's club organizations, and the National Women's Health Project (Simmons 1993; Smith 1995). Although women occupy second-class status in the Black church, this religious institution has served as a site for women to gain information related to reproductive health, breast cancer, and other diseases (Bowie et al. 2008; Smith 1995). Yet the issue of HIV/AIDS presents a greater challenge for African American health activism, as it is not only shaped by race and gender inequality, but also heteronormativity.

1.4 Organization of the Study

1.4.1 Purpose of this Study

The purpose of this study is to examine organizational patterns of African American activism in response to the HIV/AIDS epidemic. Previous sociological research has focused on HIV/AIDS activism in the U.S. and notes the significance of organizations such as the AIDS Coalition to Unleash Power (ACT-UP), the Gay Men's Health Crisis, and the San Francisco AIDS Foundation (Brier 2009; Epstein 1996; Gould 2009; Smith and Siplon 2006). These organizations were established in response to a need to save the lives of people living with HIV/AIDS, who as a group were largely considered to be unworthy of public resources, compassion, services, and care. Although these organizations were instrumental in pressuring the government and other health organizations to address the health, social, financial, and

basic human needs of people living with HIV/AIDS, organizational mobilization prioritized the lives of White middle-class gay men (Brier 2009; Cohen 1998; Smith and Siplon 2006). Studies exploring the actions of these organizations note the efforts of African Americans to change predominant White controlled AIDS organizations (Brier 2009; Lune 2007).

Other sociological analyses focus on the responses of the Black church to HIV/AIDS. For example, Barnes (2013) examines the ways in which Black megachurches alter and maintain conservative religious ideologies to address HIV/AIDS. Barnes challenges the prevailing view that Black churches were non-responsive or conservative in their response to HIV/AIDS. Social scientific studies of Black organizational responses to HIV/AIDS during the 1980s and 1990s note the slow and morally repressive responses of Black churches (Cohen 1999, 1996; Quimby and Freidman 1989). These studies indicate that the church contributed to the problem of HIV/AIDS-related stigma and often failed to mobilize its resources to help save the lives of those most vulnerable to contracting the virus. Cohen (1996) argues that the failure to mobilize is in large part due to the belief that HIV/AIDS was divine retribution for homosexuality.

A handful of studies explore Black women's efforts to mobilize Black churches to address the impact of HIV/AIDS in Black communities (Harris 2010; Gilbert 2003). For example, Harris (2010) examines the actions of The Balm in Gilead—a national faith-based AIDS organization founded by an African American woman. Harris analyses the ways in which the leader and staff of The Balm in Gilead use cultural ideologies, symbols, and practices within the Black church to

strategically mobilize Black religious institutions to respond to HIV/AIDS and, most importantly, contributed to the formation of AIDS ministries in Black churches. Though Harris provides insights to the significance of Black women's religious mobilization to address HIV/AIDS, she offers little analysis of how Black gay men also mobilized in these religious institutions. To fill this gap, a few studies analyze the actions of less mainstream religious institutions, such as the formation of new open and affirming Black churches, including Unity Fellowship which was established by an openly gay Black pastor to respond to HIV/AIDS and religious homophobia (Leong 2006; McQueeney 2009).

These studies provide important insights regarding the actions of Black AIDS organizations, yet their emphasis on Black churches or faith-based organizations alone obscures the ways in which secular or community-based organizations mobilize institutional and cultural resources to address AIDS. Several scholars note the significance of secular organizations for Black women and men who do not conform to the heteronormative standard of sexual morality (Battle and Bennett 2005; Davis 1998). Organizations such as the Juke Joint, dance clubs, and gay bars have stood outside of the regulative and moral control of the church (Davis 1998; West 1999; Wilson 2008). Moreover, Taylor (2005) found that the Black church is not always the most significant space for mobilization. Other organizations such as Black universities or colleges have also mobilized for the interests of African Americans.

Since African American organized activism has historically involved the deployment of both religious and secular organizations, it is important to study the responses of those mobilized both within and outside the church. This study examines

the organizational practices of four African American organizations in the Washington, D.C. area in 2012 and the beginning of 2013. Through a case study analysis that includes both Black church and community-based organizations, this dissertation provides a unique point of comparison.

1.4.2 Research Questions, Methods and Assumption

The primary research question guiding this study is: *How do Black organizations respond to the multiple experiences, needs, and interests of groups impacted by HIV/AIDS in Black communities?* Given the centrality of religion in Black communities, this study also seeks to answer the following sub-question: *To what extent does religion, specifically Black religious traditions, directly or indirectly impact the actions of these organizations?*

This research utilized a qualitative case study research design. The case or unit of observation used for this study was Black organizations. Two types of Black AIDS organizations were selected for this study: (1) faith-based and (2) secular AIDS organizations. A total of four organizations were examined for this dissertation. Of the four organizations, two were Black churches with AIDS Ministries or programs. The other two organizations were community-based organizations that provided HIV/AIDS-related services to African Americans. The data gathered from these organizations included participant observation, organizational documents, and 28 semi-structured interviews.

One main assumption informed this study. This assumption is grounded in the literature and was formulated before conducting the research. *I postulated that Black community-based organizations would be more responsive to the HIV/AIDS-related*

needs and interests of African Americans than their religious counterparts. More specifically, I expected that Black churches would be more conservative (i.e. maintain paternalistic heteronormative sexual standards) than the community-based organizations. The rationale for my assumption will be addressed in chapter 3. In the following section, I provide an overview of the chapters in this dissertation.

1.5 Chapter Summaries

This dissertation includes six chapters. In Chapter 2, "Black Protest and Survival in the Context of HIV/AIDS," I provide a review of the analytical frameworks that guide this study—the significance of social movement theory to explain Black protest and organizational traditions; how intersectional frameworks provide understandings of race, gender and sexuality; and importance of the sociology of religion for examining the Black church. While these literatures overlap in important ways, each offers unique contributions to the ways in which marginalized groups establish organizations to respond to social problems. Moreover, bringing these literatures together provides important insights about Black survival politics, specifically the ways in which most analyses regard Black survival as merely accommodating the larger power structure and reifying social and sexual deviance rather than opposing it.

Chapter 3 provides an overview of the methods used to explore the actions of these organizations. In this chapter I review the procedures used to select the cases for this study, as well as an overview of the data collection and analysis procedures as well as the challenges and limitations of the study. I also discuss my role as a researcher, especially the challenges I faced in doing research on this sensitive

subject. I also provide organizational profiles of New Hope Baptist and Greater Faith Ministries, the two faith-based organizations in this study; and Community Alliance and Brothers United, the two secular organizations. These organizational profiles provide background information for the two results chapters that follow.

Chapter 4, "The Black Survival Politics of HIV/AIDS," analyzes the strategies used by the four organizations included in this study to advance the health-based political interests of their constituents living with or at risk for HIV/AIDS. Both the community-based organizations and the Black churches in the study mobilized to secure resources from public health institutions and other institutional actors that were needed for the health, well-being, and survival of different groups of African Americans. Despite this shared goal, I explore the similarities and differences between the community-based organizations and the Black churches in how they implemented this overarching goal.

In Chapter 5, "Access to Life Saving Technologies of HIV/AIDS," I analyze the ways in which the organizations in the study work to improve access to rapid HIV tests and condoms. By providing access to rapid HIV testing services, I found that the community-based organizations, in particular, acted as a single-service medical provider to groups of African Americans that have historically been regarded as medically non-compliant or deviant. While the Black churches occasionally provide access to HIV tests, I found that they are more likely to engage in providing access to HIV prevention tools such as condoms. Through the provision of sexual health service, the churches work to save lives of African Americans in ways that contest

aspects of religious conservativism and normative beliefs about Black sexuality for women and/or homosexual men.

In chapter 6, “The Right to Life,” I discuss the findings of the study in relation to the historical and continued legacy of African American struggle for survival from the perspective of health.

Chapter 2: Black Protest and Survival in the Context of HIV/AIDS: Social Movements, Intersectionality and the Black Church

Given that African Americans are more likely to die from HIV/AIDS compared to other groups, it is important to consider the political aspects of Black survival—what I regard as Black survival politics—when exploring African American organized responses to the HIV/AIDS. I argue that scholarship in social movements, intersectionality, and sociology of religion provide important insights about Black survival politics through their analyses of Black protest traditions.

When analyzed in relation to Black protest traditions, Black survival is typically discussed in two main ways in the literature. First, Black survival is often framed as accommodating to rather than oppositional against repressive laws, policies, and practices in the political economic power structure (Collins 2000; McAdam 1999; Morris and Braine 2001). Second, it is often regarded as the reification of social and sexual deviance instead of a resistance of normalization (Collins 2005; Harris 2012). In many respects, these framings of Black survival provide important insights about African Americans' slow response to HIV/AIDS since the disease disproportionately affects intravenous drug users, gay men and women—groups historically regarded as socially and sexually deviant. Moreover, these groups have been considered unworthy of the resources needed for collective action and protest (Cohen 1999). While useful to understand the failure of the emergence of broad scale movements for HIV/AIDS, I argue that these main framings of Black survival often obscure understandings of African American oppositional struggles to stay alive and to thrive.

This chapter draws upon the analytical tools of three sets of literatures—social movement theory, intersectionality, and sociology of religion – to shed light on this theme of Black survival politics. Though overlapping in many ways, these literatures each provides unique perspectives to explore how African Americans have historically organized to respond to a variety of social problems—such as educational inequality, domestic violence, as well as the criminalization and hypersexualization of Black bodies. In addition, each literature offers insights into different aspects of African American organized mobilization for equality and justice.

This chapter is organized into three main sections. The first section provides an overview of social movements with a specific focus on Black protest traditions like the Civil Rights and Welfare Rights Movements. I argue that analyses of these movements focuses on Black survival from the perspectives of the birth and decline of Black social movements in the context of repressive race and class power structures (Morris 1984; Piven and Cloward 1979, 1993). These analyses allow us to make important connections and inferences about HIV/AIDS within the broader context of urban economic decline as well as state disinvestment in substance abuse treatment and the criminalization of poor African American communities.

The second section of this chapter focuses on intersectionality. Like social movements theorists, scholars using an intersectionality framework have studied Black protest and survival from the perspective of the birth and death cycles of Black social movements. However, unlike social movement scholarship which primarily focuses on activism in relation to class and race, intersectional scholarship draws attention to the mutually constituting forces of race, class, gender, and sexual

inequality. In so doing it analyze the ways in which the needs and interests of African American women as well as African American gay men have been largely ignored and dismissed not only by the leaders of Black freedom struggles but also White women and LGBT protest movements. Although some scholars have noted the legacy of the activism of Black women and Black gay men, relatively few scholars have explored the changing dynamics of religion in relation to Black survival and HIV/AIDS.

Finally, the third section draws upon the sociology of religion to provide analytical tools for studying the Black church. Like social movements theory and intersectionality, sociologists studying Black religious traditions note the centrality of the Black church to the community's traditions of protest and survival. Yet scholars have also noted its repressive aspects in terms of gender and sexuality (Grant 1995; Tucker-Worg 2011) Given its general focus on regulating social and sexual deviance, the church has been regarded as one of the most repressive institutions and barriers for broad scale movement to end the HIV/AIDS epidemic (Douglas 1999; West 1999). However, an analysis of religious structures in relation to broader social crises and changes in society that focuses on the changing dynamics of Black religious traditions is useful to develop a framework of Black survival which is both repressive and progressive in terms of gender and sexuality.

2.1 Social Movements: Black Rights, Welfare, and Survival

Social movements scholarship provides multiple perspectives on collective action (Edelman 2001). For example, some scholars focus on disruptive actions such as riots (Olzak and Shanahan 1996; Useem 1996). Others examine the ways in which

marginalized groups mobilize the resources of formal organizations and loose networks of social movement (Cress and Snow 1998; Pichardo 1988; Tilly 1978). In addition, scholars study the identity politics of primarily middle-class groups, what some regard as new social movements (Jenkins and Form 2005; Larana, Johnson, Gusfield 1994). Still others study the activism of the poor (Kornbluh 2007; Piven and Cloward 1979). While there are different perspectives on collective action, most regard social movements as the efforts to achieve social change through the redistribution of power (Jenkins and Form 2005; Tarrow 1996).

Two of the most utilized models of power include analysis of political and economic structures (Fraser and Gordon 1994). Analyses of the political structure focus on issues related to the state and citizenship (McAdam 1999; Tarrow 2011). Thus those examining issues related to Black disenfranchisement have focused on the denial of representation in the state and other governing institutions, as well as the deployment of repressive laws and policies to maintain the racial order (Harris 2012; McAdam 1999; Morris 1984). Scholars utilizing the economic model of power draw upon a Marxist framework and explore the exploitation and stratification of African Americans in the labor market (Marable 2000; Piven and Cloward 1979; Wacquant 2008). Both frameworks of power provide insights to the birth and death cycles of Black protest traditions which offers some insights into the legacy of Black struggles to survive.

In the following sections I provide an overview of two main protest traditions that are prominently featured in social movement scholarship. The first includes the mobilization for the Civil Rights Movement, largely advanced by a well-resourced

Black middle-class. The second includes a protest tradition based on the Welfare Rights Movement of the 1960s that emerged from the Black urban poor who failed to reap the benefits of the advances made by the Civil Rights Movement. I argue that both provide insights about Black survival politics. However, it is the Welfare Rights movement that is most useful to consider Black survival as oppositional.

2.1.1 Black Protest Traditions: The Civil Rights Movement

Historically, the U.S. government has prioritized the needs and interests of White Americans and neglected those of African Americans (Marable 2002; Marx 1998). While the nation was built to protect the rights of White Protestant property owning men, citizenship would eventually be extended to immigrant Europeans (Calhoun 2012; Fraser and Gordon 1994). Under state law, Whiteness and White privilege were granted to people of European working-class descent. Those bestowed with White identity could then legitimately make claims to the state (Goldberg 2002; Omi and Winant 2015). Moreover, the political and legal system helped to maintain White privilege through repressive and exclusionary laws. Given their exclusion from the rights and benefits of the nation, African Americans were forced to build a broad scale movement to obtain full citizenship in the United States (McAdam 1999; Morris 1984).

The Civil Rights Movement constitutes one of the most studied and well-known African American social movements that aimed to address racial inequality.[2] In the late twentieth century, the Civil Rights Movement was largely led and controlled by the Black middle class, who had the financial, human and, organizational resources to wage and sustain a broad based movement against racial

inequality. The Black middle class included members of the community who had access to higher education, were more economically privileged, and held leadership roles in education, business, and other institutions (Marable 2000; Piven and Cloward 1979; Wacquant 2002). However, under Jim Crow, this group along with the Black masses was largely excluded from White public and private institutions.

Studies of the Civil Rights Movement analyze the innovative strategies and tactics employed by African American organizations to challenge institutionalized racism (Lawson and Payne 1998; McAdam 1999; Morris 1984). These strategies included legislative actions championed by the National Association for the Advancement of Colored People (NAACP). Activism also involved the non-violent direct actions of organizations such as the Student Nonviolent Coordinating Committee (SNCC) (Morris 1984). Individuals with expertise in collective action trained people at the grassroots level in non-violent direct action—such as sit-ins, pray-ins, and boycotts—to risk violence and imprisonment in order to contest the separate and unequal practices of the nation's economic, political and social institutions. Progressive Black churches and Black religious leaders played a central role in this movement (Morris 1984; Morris and Staggenborg 2007).[3] While social movement scholars note the development of Black protest traditions such as those observed during the Civil Rights Movement, they have also examined the ways in which the benefits of this movement were unequally distributed and failed to benefit groups of African Americans disproportionately impacted by HIV/AIDS—such as the Black urban poor.[4]

2.1.2 Advanced Marginality: The Welfare Rights Movement

The term "advanced marginality" has been used to describe the experiences of poor African Americans living in urban cities following the Civil Rights Movement (Wacquant 2002, 2008). In *Urban Outcast*, Wacquant (2008:2) describes advanced marginality as those highly stigmatized places or 'hyperghetto' that emerged "as a result of the uneven development of the capitalist economies and the recoiling of welfare states." Prior to the 1960s Black urban communities served as spaces of shared resources for which African Americans could collective mobilize (Harris 2012; McAdam 1999). However, following the Civil Rights Movement the masses of poor Blacks were regulated and contained in urban communities, which had few labor market opportunities that was in part fueled by White and Black flight to the suburbs (Wacquat 2002). According to Piven and Cloward (1979), the Black urban poor failed to benefit from the educational, economic, and political benefits that were available to the Black middle class (Piven and Cloward 1979; Wacquant 2002). They also lacked the resources necessary to pressure the conventional political system. Although poor African Americans experienced advanced marginality and had limited resources, they were not without agency.

Social movement scholars identify two main types of activism by African Americans relegated to the poor urban enclaves of the United States. The first includes riots or use of violence (Piven and Cloward 1979; Useem 1998; Wacquant 2002). Poor and other marginalized groups have used riots and violence to garner concessions from the state and elite groups (Till 1978; Useem 1998). For example, following the murder of civil rights leaders and outraged by the lack of job and

income opportunities in their communities, poor African Americans revolted. This strategy has been viewed as particularly effective given the lack of resources to advance their interests (Piven and Cloward 1979).

The second type of activism is organized activism that is directed at changing state policies. The movement for welfare rights organized by poor African Americans illustrates this form of activism (Kornbluh 2007; Piven and Cloward 1979). Piven and Cloward note that in the 1960s and 1970s, African Americans living in poor urban communities developed strategies to gain access to subsistence products through welfare agencies. In the face of economic strain that resulted from urban unemployment and displacement from the agricultural economy, activists formed the National Welfare Rights Organization (NWRO) to disrupt the welfare system by demanding access to food, clothes, housing and other social services (Kornbluh 2007). Strategies included mass education about relief programs and qualification, and developing an ethic of entitlement rather than shame to receive social benefits and legal services to fight against discrimination (Kornbluh 2007; Piven and Cloward 1979).

Like the Civil Rights and Black Power Movements, poor African Americans experienced gains in the public sphere. They gained access to public housing, clothes for children, economic relief for food and other social services (Kornbluh 2007). Yet these gains were largely attacked and dismantled by a particularly powerful conservative Republican Party that represented White elite and middle class interests (Piven and Cloward 1993). Those benefiting from welfare rights were also among the groups most impacted by HIV/AIDS (Cohen 1999; Fullilove 1995). However, few

scholars make the connection about the ways in which the Welfare Rights Movement could help develop understanding of Black survival as political.

2.1.3 Black Survival and HIV/AIDS

In their analyses of the rise and fall of social movements, for example, the varying visibility of the Civil Rights movement and the Welfare Rights movement, social movement scholars allow us to make inferences about Black survival. For example, some argue that social movements fail to emerge due to the presence of repression or structural violence exercised by the state and other governing institutions (Morris and Braine 2001). Under Jim Crow, racial order was maintained not only through exclusionary laws and policies but based on the legal authority of White ruling elites to kill (Morris 1984). An example of this includes the lynching of African Americans who openly contested the White power structure. Others note the deployment of state violence such as the use of mass incarceration and the killings of Black men by the police to deal with low employment opportunities in poor urban communities (Alexander 2010; Wacquant 2002). Thus Black survival can be regarded as efforts to avoid death that may result from structural violence.

Repressive power can also take the form of cultural hegemony that shapes the development of Black survival traditions. Groups benefitting from systems of racial and class oppression often create and disseminate hegemonic culture—ideas, values, and norms—that legitimatize and reinforce notions of superiority and subordination as well as deserving and undeservedness (Gramci 1971; Marable 2002; Piven and Cloward 1993). Thus, in a particularly repressive society, such as could be observed under Jim Crow, Morris and Braine (2001:22) note that African Americans developed

a “culture of subordination” which reinforced dominant views of racial inferiority rather than contesting the existing systems of inequality. Black religious, educational, economic and social institutions have been identified as perpetuating cultures of subordination. For example, rather than promoting resistance, scholars note that accommodating Black churches tended to emphasized liberation in the afterlife rather than the here and now (McAdam 1999, Morris and Braine 2001, Morris 1984). Others note that Booker T. Washington’s Tuskegee Institute was accommodationist, as it encouraged African Americans to pursue careers in agricultural, vocational and other service related fields and to be content with racial segregation (Harris 2012; Morris 2015). Institutions emphasizing cultures of subordination also tend to emphasize self-help and individualism and the correction of behaviors that are considered to be bad or immoral (Harris 2012). Overall whether religious or secular, the Black survival tradition of these organizations has been regarded as a barrier to social movements and resistance to oppression. Fullilove (1995) argues that these historical and contemporary forms of Black accommodation to racial and class inequality has implications for the development of a Black HIV/AIDS movement.

HIV/AIDS emerged in the early 1980s, a time when African Americans were experiencing great political, economic and cultural repression. This was during the rule of the Reagan and Bush administrations, which expanded the repressive War on Drugs policies that had detrimental effects in African American communities by reversing gains made by the Civil Rights as well as the Welfare Rights Movements (Alexander 2010). African Americans in poor urban neighborhoods became increasingly alienated from the formal labor economy (Useem 1998). According to

Fullilove (1995), the declining labor economy and Black dependence on the illegal drug economy created a perfect storm for the spread of HIV/AIDS. In addition, the policies against drugs also contributed to the spread of HIV/AIDS, as the laws criminalized the possession of drug paraphilia such as needles used for intravenous drug use and disinvested resources for substance abuse programs and treatment (Dalton 1991).

In summary, social movement scholarship provides insights about the factors that led African Americans to developed both protest and survival tradition to respond to state and economic exclusion and repression. However, the focus on survival is often viewed as accommodating, as it is often compared to to the visible protest traditions that characterize the Civil Rights Movement. However, utilizing the Civil Rights Movement as the main model of Black protest traditions obscures views of a Black survival politics that was advanced by groups that did not fully benefit from the Civil Rights movement. Activism related to welfare provides some insights into Black survival as political, particularly from the perspectives of the urban poor.

In the early twenty-first century, African Americans living in poor urban communities are among the groups left behind and have not benefited as much from the political and economic gains of the Civil Rights Movement. They are also among the group of African Americans whose survival is threatened by the HIV/AIDS epidemic. Yet they also forged a struggle for their rights to survive. In the following section I provide an overview of intersectionality, an analytical framework that has been used to explore the marginalization of other groups of African Americans, particularly Black women and more recently Black gay men.

2.2 Intersectionality: Black Protest, Marginality and Survival

Intersectionality is an analytical framework that draws attention to both the hierarchical and interlocking manifestations of multiple systems of oppression--race, class, gender and other systems inequality (Cole 2008; Collin 2000; Crenshaw 1991). Scholarship and activism informed by an intersectional perspective considers the numerous ways in which multiple systems of oppression operate simultaneously to shape people's lives (Combahee River Collective [1977] 2000; Collins 2000; King 1988). Based on studies of issues related to domestic and sexual violence (Crenshaw 1991), reproductive health (Davis 1994; Roberts 1997), and HIV/AIDS (Hammonds 1995; Stockdill 2003; Watkins-Haynes 2008), scholars have expanded understanding of how marginalized groups—particularly Black women are alienated from the benefit of larger social movements in both Black and White social movements.

2.2.1 Political Intersectionality: False Universalism

The concept of political intersectionality draws attention to the benefits and limitations of broad based social movements (Cho, Crenshaw and McCall 2013; Crenshaw 1991). With respect to the benefits of collective action, Collins (1998) argues that shared experiences of marginalization under the systems of race and gender oppression helped to foster the mobilization for resources to challenge the standard laws, policies, practices and procedures that have been employed by the state to maintain White male privilege. Yet the experiences of African American women have often been ignored, dismissed and made invisible in these larger movements around race and gender inequalities. While early predominantly White feminist organizations contested the unequal power and privileges afforded to men in the

home, labor market, schools, and other institutions they tended to collectively organize under the seemingly unified umbrella of gender inequality (Dill and Zambrana 2009; Hull, Bell-Scott and Smith 1982). The emphasis on gender-only politics ignored, suppressed, and devalued the unique experiences, concerns and interests of African American and other women of color (Collins 2000; Crenshaw 1991; Guy-Sheftall 2009).

Similar patterns are observed in the organized activism of predominantly White gay and lesbian organizations. Studies indicate that although queer activists in the United States unmask and contest the systemic ways in which Judeo-Christian doctrine and patriarchy reinforced and maintained sexual inequality and heteronormativity, such activism often failed to advance a political and social agenda of Black gay men and Black lesbians (Cohen 1996; Johnson and Henderson 2005). This has also been observed in Black freedom struggles such as the Civil Rights and Black Power Movements (Springer 2005).

2.2.2 Constructing Deviance: Black Motherhood and Sexuality

Feminists utilizing intersectionality as an analytical framework have explored the unique role and positions of African American women in society. For example, feminist research suggests that nationalist structures are both racialized and gendered as women are expected to serve specific functions (Collins 2006; Davis 1994). One function focuses on women's role as mothers, particularly in fulfilling their reproductive capacity to ensure the continuity of society. Another function is to maintain the cultural traditions of society, the community, or group and transferring that knowledge on to the next generation. In their role of mothers and preservers of

culture, women have historically been viewed as a privileged group deserving of protection and preservation (Collins 2006). Yet studies indicate that African American women have historically been regarded as deviant or bad mothers (Collins 2005; Roberts 1997).

Intersectionality examines how ruling elites work to create stereotypes of Black sexuality. Scholars using an intersectional perspective have explored how Western science and religion, as well as political institutions and the media, work to construct Black women's bodies as sexually and socially deviant (Collins 2000; Harris-Perry 2011). For example, Collins (2005:104) explains that the construction of Black women's sexual identities as the hypersexual *jezebel,* the asexual *mammy* figure, and the dishonest, lazy, and hypersexual *welfare queen* maintain stereotypical images of Black women used to justify "slavery, Jim Crow Segregation, and the racial ghettoization." Roberts (1997) explores how Black women who are dependent on drugs are similarly stigmatized and criminalized through labels such as "crack mothers." Donovan (2001) discusses the implications of such criminalized labels in the context of HIV/AIDS. Donovan asserts that the criminalized construction of an Intravenous Drug User (IDU)—particularly of those in poor urban cities—has been used to justify the adoption of restrictive criminal rather than public health approaches to prevent the transmission of HIV/AIDS.

2.2.3 Black Survival: Domestic Violence and HIV/AIDS

Intersectional scholars have also contributed to understandings of Black survival. For example, studies employing an intersectional framework have explored the impact of violence on the lives and well-being of African American women

(Brown 2012; Crenshaw 1991). A classic example of this is analysis of domestic or intimate partner violence, a major cause of death for women (Crenshaw 1991). While currently regarded as a social problem, domestic violence was largely considered a private matter occurring in some isolated families rather than a public issue having broad-scale implications (Brown 2012; Crenshaw 1991; Gillum 2008). Prior to the Second Wave Women's Movement, there were no laws created to protect victims of domestic violence and no programs or services that provided women with safe refuge from their offenders (Crenshaw 1991). Thus women's mobilization against domestic violence as well as rape led to the development the reform policies and programs. However, some argue that these state interventions tended to favor White women and addressed their needs (Brown 2012; Gillum 2009). This universal model failed to account for the ways in which race and economic inequalities serves as barriers to African American women's ability to take advantage of domestic violence services.

As mentioned in the literature on social movements, African Americans have historically utilized survival traditions to develop strategies to help their members avoid death. Yet as the case of domestic violence suggests, African American organizations have been less willing to deploy resources to save the lives of their members, especially women and girls (Crenshaw 1991). Instead, standard models for survival focus on racial inequality and violence perpetuated by White ruling elites against Black men, even though women and LGBT people within Black communities encounter this same violence. Some have examined the ways in which domestic and structural violence shapes African American women's risk for HIV/AIDS (Farmer 2010; Watkin-Haynes 2008; Winood and DiClemente 2010)

2.3 Religious Authority Structures: The Black Church

Sociologists have long explored the influence of religions in shaping the institutional and cultural practices of organizations (Ammerman 2005; Durkheim 1915). Over the years, sociologists have examined issues related to racism (Edwards, Christerson and Emerson 2013; Gilkes 2010), the ordination of women (Adams 2007; Chaves 1999; Gilkes 2003), abortion (Dillon 2014), marriage and family (Gallaher and Smith 2003; Edgell 2006), sexuality (Alder 2012; Burdette, Ellison and Hill 2005), and HIV/AIDS (Barnes 2013; Leong 2006; Harris 2010). These analyses provide critical insights into Black protest and survival traditions from the perspective of the Black church.

2.3.1 Black Church Protest Traditions

A primary contribution of sociology of religion is analysis of the role of the Black church in the development of Black protest or oppositional traditions. In analyses of Black church traditions, scholars explore the ways in which some churches deploy cultural, human and material resources to contest racial inequality in African American communities (Barnes 2004; Lincoln and Mamiya 1990; Pattillo-McCoy 1998). The activism of Black churches includes voter registration, the election of politicians that promise to represent Black interests, as well as mobilization related to fair housing, employment and education (Owens 2007; Tucker-Worgs 2011). Others examine the role of Black churches in the Civil Rights Movement (Harris 2012; Morris 1984). For example, the SCLC served as the centralized arm of church mobilization (Morris 1984). Still others note the connection of church activism to the Black Power Movement and the development of a radical

Black liberation theology (Cone 1999; Harris 2012). Overall, this literature examines how the activism of the Black church, targets the state with an eye toward eliminating economic and racial inequality.

The second contribution of sociology of religion is its analysis of African American resistance to second-class status in predominantly White churches. One of the earliest examples of this activist tradition includes the formation of oppositional religious structures and cultures (Lincoln and Mamiya 1990). For example, in *The Negro Church*, Du Bois (2003) notes that the Black church was both informally and formally established as Black resistance to the discriminatory practices and repressive religious ideologies in White churches and the larger White society. Despite this legacy of activism, some groups continue to occupy second-class status within the church. This has been particularly true for African American women.

Most religious organizations, including the Black church, maintain gender inequality where a minority of men within religious organizations and control women who make up the majority of church members (Adam 2007; Chaves 1999). They embrace a patriarchal system of social relations where "power is allocated to men over women and children. Patriarchal social relations are characterized not only by an unequal share of power that privileges men over women but also by ideologies that justify these practices as either inevitable and/or natural" (Floyd-Thomas et al. 2007:108). Biblical scriptures have been used to justify the subservient role of women and reinforce gender hierarchy (Tucker-Worgs 2011; Williams 1989). However, not all churches maintain the same traditions around gender. Some churches are more gender inclusive, allowing women to hold leadership positions as pastors. Others

have noted Black women's roles as church mothers and the ways they use their positions in terms of power and influence (Lincoln and Mamiya 1990; Gilkes 2003). Yet there some women experience even greater marginalization—these include African American lesbian women (Coleman 2008; Copeland 2010).

Like African American heterosexual and lesbian women, African American gay men have held second-class status in the Black church. A few studies reveal the development of oppositional religious consciousness in Black LGBT churches (Leong 2005; 2006; McQueeney 2009). Moreover, Leong (2005; 2006) found that such churches also adopted more progressive practices toward people living with HIV/AIDS. In the following sections, I provide an overview of the religious repression of Black sexuality, as this set of ideas is important to understand African American response to HIV/AIDS.

2.3.2 The Black Church and the Reification of Sexual Deviance

In most religious traditions, sexual desires of the body are typically viewed as corruption to the spirit. However, since African American bodies have historically been associated with sexual deviance, a key function of the Black church has been to enforce conformity to dominant sexual norms through the use of psychological coercion (Douglas 2010; Frazier 2003; West 1999). Moreover, scholars note that aspects of Judeo-Christian myths about sex and immorality were deployed by White authority structures to justify the enslavement and exploitation of African Americans (Frederickson 2002; Douglas 2010). One of the most prominent sacred myths tied to Black sexual deviance is that of Ham. Other scholars have explored religiously informed inventions of women's bodies and sexuality (Harris-Perry 2011;

Williams1989). For example, in the Judeo-Christian tradition, the myth of the Virgin Mary serves as model for sexual chastity, purity and submissiveness, and is often associated with White women (Harris-Perry 2011). Whereas the mythical story of the Jezebel represents the sexual temptress and has been deployed to oppress Black women (Douglas 2010; Harris-Perry 2011).

In addition, aspects of Judeo-Christian traditions have deemed homosexuality as immoral. One of the most prominent sacred myths deployed in the Christian tradition to support the claim of homosexual sin is the Sodomite (Burdette, Ellison, and Hill 2005). The term sodomy has generally been used to refer to non-procreative sexual activities that violate a sexual standard. Though sodomy generally includes oral sex and human sexual intercourse with animals or other non-humans, most religious references focus on anal sex. Overall, through its priestly function, religious authority structures have promoted the belief that in order to develop a closer relationship with their deity one needs to conform to a particular sexual code (West 1999). This involved conforming to strict religious code of conduct, particularly regulation of sexual lives. This has great implications for people at risk for HIV/AIDS since the main assumption was that people were at risk because they were sexually promiscuous.

2.3.3 Social Service Traditions and HIV/AIDS

A third contribution of analysis of religious authority structures is their social service function. More than 90% of churches provide some form of social service programs, particularly to the poor (Chaves and Tsitsos 2001).[5] These services include providing food, clothing housing, education, as well as health services. However,

Black churches tend to offer more programs to the poor than their White church counterparts (Chaves and Higgins 1992; Cavendish 2002). Some argue that this is because Black churches tend to be located in poor urban communities with greater economic and social needs (Barber 2015; Barnes 2004; Frazier 1974, 2003). While Black churches are more likely than White churches to provide social services that are necessary for survival, some Black churches are more socially engaged than others. For example, larger Black churches tend to offer more social service programs (Barber 2015; Barnes 2011; 2013). Historically activist African American denominations such as the African Methodist Episcopal (AME) and Baptist churches affiliated with the Progressive National Baptist Convention (PNBC) tend to provide more social services than those rooted in the Church of God in Christ denominations (Billingsley 1999; Lincoln and Mamiya 1990).

Studies indicate that some African American churches have mobilized to address the HIV/AIDS epidemic (Barnes 2013; Fulton 2011; Harris 2010). The responses ranges from the deployment of morally repressive framing of HIV/AIDS, to ones that offer more progressive (Barnes 2013; Leong 2006). According to Fulton (2011), Black churches that tend to respond to the epidemic generally have a history of doing community outreach and are more externally engaged in their communities. Leong (2006) notes that such as those based sexually inclusive have worked to address religious homophobia and HIV/AIDS.

2.4 Conclusion

In this chapter I provided an overview of the three sets of literature that guide this study—social movements, intersectionality, and sociology of religion--and their

contributions to the legacy of African American organizational patterns in response to social problems and social inequalities in the United States. Though overlapping in many ways, each offers unique insights into African American protest and survival traditions. For example, all three sets of literature note the significance of Black organizations in the United States, given the historical and continued racial inequality which contributes to the devaluation of African American lives. These literatures also include studies that note the limitations of Black organizations. With a focus on race and class inequality, social movement scholars note that Black protest traditions have typically privileged the needs and interests of the Black middle-class. Scholars employing an intersectionality framework note similar patterns of unequal organized mobilization by highlighting the mutually constituting dynamics of race, class, and gender inequality. In other words, the analytical framework of intersectionality has been used to draw attention to the ways in which the needs and interests of African American women have been suppressed or ignored by more powerful Black, as well as White, social movement organizations. Sociologists of religion note the legacy of Black church repression from the perspective of gender inequality and heteronormativity.

Analyses of the patterns of organizational mobilization provide insights to the dynamics of Black survival traditions related to HIV/AIDS. For example, Black survival traditions are typically conceptualized as accepting prevailing power structures. Much like their analysis of protest, social movements scholars typically explored Black survival strategies through the lens of race and class inequality. Yet a few studies document the legacy of Black political activism from the perspective of

the Black urban poor based on their analysis of the Welfare Rights movement. While not as transformational as the Civil Rights Movement, the struggle for welfare rights involved the empowerment of poor African Americans to gain access to public resources basic subsistence. The patterns of unequal mobilization on behalf of the poor African Americans have grave implications for HIV/AIDS since the disease disproportionately impacts poor urban Black communities. However, movements such as those advances for welfare indicate that poor African Americans are not without agency and that mobilization for HIV/AIDS may be present among poor African Americans.

Given the focus on race, class, and gender inequality, intersectional scholars offer important insights into Black survival strategies and Black organizational mobilization for HIV/AIDS. As discussed above, African American women have not only been marginalized in the larger society and powerful Black and White movement organizations, they have also been regarded as socially and sexually deviant. Analyses of organized responses to issues such domestic violence draw attention to the historical patterns in which the lives and interests of African American women have been devalued and underrepresented—given unequal race, class, and gender power dynamics. Since African American women are disproportionately impacted by HIV/AIDS, the history of inequality has had devastating implications for Black women and girls. This study offers the opportunity to explore the extent to which Black survival traditions reinforce or contest race, class and gender inequality not only for African American women but also African

American gay men, one of the groups most at risk for HIV/AIDS and viewed as sexually and morally deviant.

As noted above, the Black church has been central to patterns of Black organized activism and survival in African American communities. As one of the most independent and longest standing institution in African American communities, the Black church has utilized its authority for liberation but it has also mobilized resources for gender and sexual repression. Given the Black church's reinforcement of sexism and homophobia its ability to advance an oppositional Black survival tradition has been limited. Yet as mentioned above, the Black church is not homogeneous. Some churches may be more oppositional in their response to HIV/AIDS than others. However, secular organizations may prove to be more oppositional in their response to HIV/AIDS. In the next chapter, I provide an overview of the methodology that guides this study and the justification for including Black faith-based and secular organizations that have responded to HIV/AIDS.

Chapter 3: Methodology

This chapter provides an overview of the research design used in this study. The primary research question that guided this study is: *How do Black AIDS organizations respond to the multiple experiences, needs, and interests of groups impacted by AIDS in Black communities?* Given the centrality of religion in Black community and life, this study also sought to answer the following sub-question: *To what extent does religion, specifically Black religious traditions, directly or indirectly impact the actions of Black AIDS organizations?* Three data sources were used to answer these research questions—semi-structured interviews, document analysis, and participant observation.

This chapter begins with an overview of the methodological approach used to answer these research questions. It then proceeds to discuss the research design. This is then followed by a description of the sampling strategy used to select specific organizations along with the rationale for the selection of the study site. The next section gives a detailed description of the procedures used to collect and analyze the data. I also discuss my role as a researcher, especially the challenges I faced in doing research on this sensitive subject. The chapter concludes with organizational profiles of New Hope Baptist and Greater Faith Ministries, the two faith-based organizations in this study; and Community Alliance and Brothers United, the two secular organizations. These organizational profiles provide background information for the two results chapters that follow.

3.1 Qualitative Methodology

Social scientists use qualitative research methods to examine the factors that shape organized responses to social problems. For example, in her study of the organized responses of African Americans to address racial health disparities in diseases such as HIV/AIDS, Harris (2010) employed in-depth interviews, participant observation, and document analysis. Others have utilized qualitative methods to examine health issues related to breast cancer and heart disease (Klawiter 2008; Shims 2014). Qualitative research techniques are useful to examine complex social issues or experiences that cannot be answered in quantitative terms (Creswell 2007; Merriam 2009). Moreover, qualitative methodology lends itself particularly well to empirical inquiry that seeks to understand the social factors that inform the ideas, beliefs, and practices of a particular group, organization, nation, or society (Patton 2002). As mentioned in chapters 1 and 2, the HIV/AIDS epidemic threatens the survival of African Americans. However, many organizations that have worked to historically pursue community interests initially viewed HIV/AIDS as being outside the purview of community interest and concerns. This study was purposefully designed to examine African American organizations that have responded to the needs and interests of African Americans living with or at risk HIV/AIDS, a response that reflects the survival politics of African American communities.

3.2 Research Design: Case Study Approach

This study utilized a case study research design. According to Yin (2009) a case study research design is one of the preferred strategies used by social scientists to answer "how" or "why" questions. It is also used when an investigator is interested

in examining a contemporary social phenomenon in the context in which that phenomenon occurs. This study sought to answer how African American organizations respond to the needs and interests of their constituents that face an important social issues, in this case, HIV/AIDS. Case studies also show how groups organize to confront issues. For this study, African American have historically organized around issues race and class. African American women have also fought for the inclusion of issues related to gender inequality as part of how African Americans should conceptualize social problems and organize to confront them.

As discussed in chapter 1, African Americans have taken political action in response to health-related social problems by forming religious and secular community organizations as part of a Black survival politics. HIV/AIDS is not only a relatively new disease that African Americans face but it an issue that presents a set of similar as well as different challenges—one of which includes the need to fight for the rights of homosexual men. As a result, HIV/AIDS proses a new challenge as for using a case study approach to explore the survival politics African American organizations.

3.2.1 Case Selection Strategy

This study utilized a *purposeful sampling* strategy to distinguish Black organizations of interest from those excluded from consideration. According to Merriam (1998:61), purposeful sampling is "based on the assumption that the investigator wants to discover, understand, and gain insights, and therefore must select a sample from which the most can be learned." Based on the research questions

and theoretical frameworks guiding this research, I created a list of criteria to select the most "information-rich"[6] organizations.

3.2.2 Criterion #1

Two types of Black organizations were selected for this study: (1) Black religious organizations, specifically Black churches, and (2) secular organizations within African American communities with an explicit HIV/AIDS focus. These two types of organizations were chosen for several reasons. First, this study examines Black religious organizations, specifically Black churches, because they have been considered the central institutions in Black community and life (Barnes 2005; Lincoln and Mamiya 1990). Historically, Black churches have mobilized political, material, and psychosocial resources for organized action (Barnes 2005; Morris 1984). Black churches have also been sites of oppression or marginalization (Barnes 2006; Tucker-Worgs 2011; Tucker-Worgs and Worgs 2014). With respect to matters of health, studies indicate that African American involvement in the church promotes life satisfaction, optimism, and mechanisms to cope with stress as a response to racial health disparities in the United States (Chatters et al. 2015; Ellison and Henderson 2011). Black churches have also played an instrumental role in Black health based movements/activism (Quinn and Thomas 2001; Smith 1995). Despite their slow and often conservative religious worldviews about sex and sexuality, Black churches are still regarded as important sites to address the contemporary social crises such as AIDS (Barnes 2013; Harris 2010). This study examined AIDS organizations established by existing Black churches. These organizations are often regarded as AIDS or Health Ministries.

This study also included secular or community-based organizations. Throughout this dissertation, I use the term "community-based" organizations, often interchangeably with secular organization, in large part because the term community based is typically used to refer to secular organizations that work in the field HIV/AIDS. While few would disagree that Black churches remain central to Black communities and life, not all scholars are confident that Black religious organizations can fully address the needs of all people living with and affected by AIDS. For example, Harris (2012) and Glaude (2010) argue that many Black churches fail to speak against issues affecting the most socially, politically, and economically marginalized members of Black communities and have thus lost their prophetic and progressive function in society. Though these scholars do not identify an alternative organization type for Black progressive action, several scholars have discussed the potential of non-religious organizations to foster Black leadership, consciousness and action (Johnson and Stanford 2002; Cohen 1996; Tucker-Worgs and Worgs 2014). Calhoun-Brown (2002:23) notes that in the post-civil rights era, the leadership positions, once mainly occupied by ministers, are increasingly filled by individuals who have acquired "professional training, administrative skills, and political sophistication" outside the church. Moreover, groups historically barred from gaining full access to leadership positions and membership (in this case Black women and Black LGBT) within the church have often turned to more secularized spaces to develop oppositional consciousness and action that simultaneously challenged racism, sexism, classism, and/or homophobia (Cohen 1996; Collins 2000, 2005). Examples of these organized spaces included universities, kitchen tables, women's organizations,

and secularized urban spaces such as the night club (Davis 1998; Collins 2000; West 1999).

Based on these studies, I postulated the following: Black community-based organizations would be more responsive to the HIV/AIDS-related needs and interests of African Americans than their religious counterparts. In other words, prior to beginning the research, I assumed that the community-based organizations would be more engaged than churches in terms of: (1) their participation in HIV political activism and health policy, (2) their discussions about sex and sexuality, and (3) their overall role in addressing HIV/AIDS health disparities. Moreover, Black churches would be more conservative (i.e. maintain a paternalistic heteronormative sexual standards) than their secular counterparts as they respond to the needs and interests of African Americans at risk for and living with HIV/AIDS. As such I also assumed that Black churches would be more likely to withhold some resources, services and support to groups of African Americans who have traditionally occupied lower moral status and power in the church and/or community.

3.2.3 Criterion #2

The second criterion for this study required that each type of organization be founded or led by groups historically marginalized within established African American institutions, in this case Black women and Black gay men. The selection of organizations founded by these groups was guided by theory and empirical evidence which indicate that the interests and concerns of Black women and Black gay men have historically being ignored within African American and mainstream organizations that have been associated with social movements and Black activism.

To illustrate, Black churches and even powerful civil rights organizations such as the NAACP have historically been led and controlled by Black men (Cohen 1996, 1999; Collins 2000; Crenshaw 1991). Moreover, these organizations have themselves historically experienced marginalization in White control health organizations (Brier 2009; Morgen 2002). Given this political and interpretive context, Black women and Black gay men who experience double or triple marginalization within both mainstream and African American organizations should be more likely to respond social problems in ways that fill the gap left behind by more mainstream political or service-based organizations (Springer 2005). Since both Black gay men and Black women are most at risk for HIV/AIDS, analysis of the organizations or AIDS programs led by each group is useful to understand the different ways these two groups address the epidemic in secular and religious realms.

An analysis of Black community-based and faith-based organizations founded by Black women and gay men reflect what Patton (2002) regards as critical cases. According to Patton (2002:236), the statement "if it doesn't happen there, it won't happen anywhere" points to a critical case. In other words, if the goals and strategies of Black AIDS organizations founded or led by Black women and gay men do not, at some level, directly or indirectly provide more inclusive responses to people living with HIV/AIDS, such action will most likely not happen in any other AIDS organizations. Examining critical cases is also significant when resources are limited (Patton 2002).

In summary, a total of four (4) Black organizations with substantial programming concerning HIV/AIDS were selected for this study—two community-

based organizations and two Black churches. These categories were further subdivided by the race, gender and sexual identification of each organization's founders or leader. To illustrate, I examined one Black church and one community-based organization with an HIV/AIDS program that is founded and/or led by African American women. In addition, I analyzed one Black church and one community-based organization with an HIV/AIDS program founded and/led by Black gay men. In the following sections, I provide an overview of the study site and case selection.

3.2.4 Study Site

For this study, I examined community-based and faith-based AIDS organizations in Washington, D.C. This location was chosen because Washington, D.C. has one of the highest rates of HIV/AIDS of all major cities in the United States. Relative to other major cities hit hard by the epidemic such as New York and San Francisco, Washington D.C. is quite small. Washington, D.C. has a population size of a little over 650,000 residents. In 2012 approximately 2.5% or 16,072 of the city's residents were living with HIV/AIDS (D.C. Department of Health 2013). This 2.5% is more than twice the rate of what the World Health Organization (WHO) defines as a severe epidemic. Moreover, African Americans are disproportionately impacted by the epidemic in Washington D.C. According to the Washington, D.C. Department of Health, African Americans were 4 times more likely to be diagnosed with HIV than their White counterparts in 2013.

The District of Columbia is also an important site of study because African Americans represent approximately 50% of the total population (U.S. Census 2015). Once regarded as "Chocolate City" because of its large population of Black residents,

the District of Columbia is experiencing declines in the number of number of Blacks who reside in the city given the processes of gentrification. Despite this, many neighborhoods remain disproportionately Black. This is illustrated in demographic maps of the city.

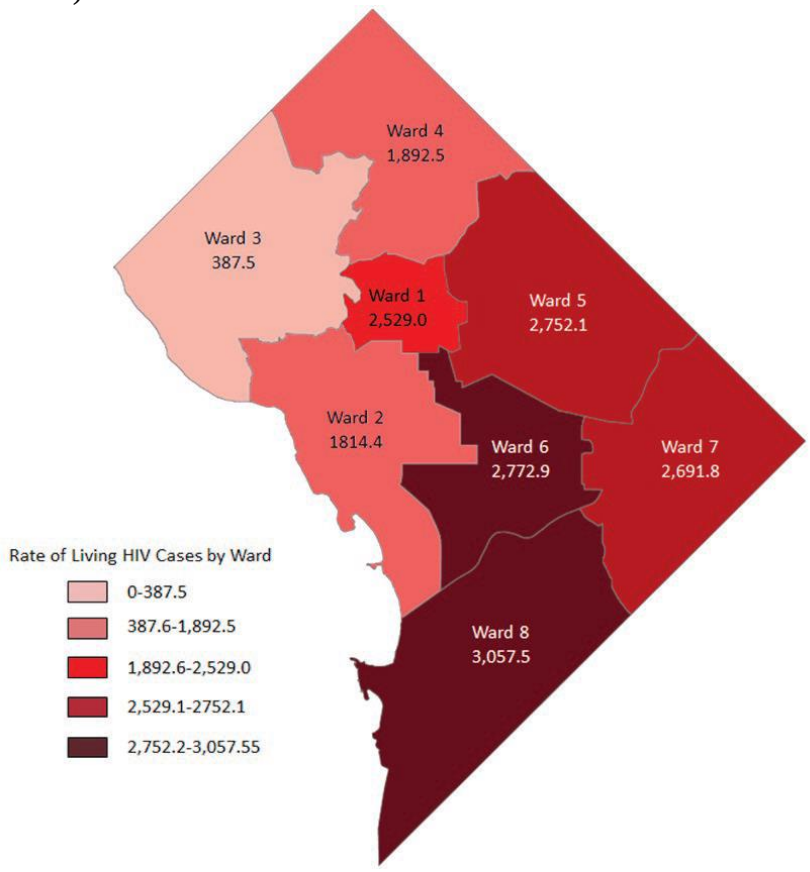
Washington D.C. is divided into 8 wards. In 2010 most non-Hispanic Blacks resided in Wards 7 and 8 while most non-Hispanic Whites lived in Wards 2 and 3 (see Table 3.1.1). Moreover, Wards 7 and 8 along with 2 and 3 reflect a continued representation of racial apartheid in the United States. This inequality is also reflected in economic terms. According to the Urban Institute (2012), Wards 7 and 8 are not only disproportionately Black but these two regions of the city have a higher concentration of poverty as well as the communities with the highest number of low-income female-headed households with children. Wards 7 and 8 are among the wards with the highest number of people living with HIV in the city (see Figure 3.1.1).

Table 3.1.1: Racial Composition of Washington, D.C. by Ward for 2010

Wards	Population Size	% White non-Hispanic	% Black non-Hispanic
1	74,462	40%	33%
2	76,883	70%	9.8%
3	78,887	78%	5.6%
4	75,773	20%	59%
5	74,308	15%	77%
6	76,000	47%	43%
7	71,748	1.5%	95%
8	73,662	3.2%	94%

Source: The Urban Institute (2015) http://www.neighborhoodinfodc.org/wards/wards.htm

Figure 3.1.1: HIV Cases Diagnosed in Washington, D.C. by Ward in 2012 (Race per 1000 persons)



Source: D.C. Department of Health. 2013. *Annual Epidemiology & Surveillance Report*

A focus on Washington, D.C. is also important because the epidemic disproportionately impacts Black men who have sex with men (MSM) and Black women. For example, 24% MSM compared to 14% of White MSM are living with HIV in 2010 (D.C. Department of Health 2013). In that same year, 16% of Black heterosexual women compared to 0.7% of White women were living with HIV in 2010 (D.C. Department of Health 2013). These numbers reflect patterns of health disparity at the intersection of race, gender and sexuality.

Though Black residents of Washington, D.C. continue to experience health disparities in terms of HIV status, the city has become relatively progressive in terms

of LGBT rights. In addition to being known as Chocolate City (see above), Washington, D.C. is also known as one of the most welcoming cities to LGBT people in the United States. For example, Breen (2014) ranks Washington, D.C. as the number one 2014 Gay friendly cities in the United States. This rating was based on the high number of elected gay officials (18), more than 40 popular gay bars and restaurants, its arts and culture, as well as being among the first to legalize same-sex marriage. Black gay organizations have also been influential in Washington, D.C.'s LGBT history in terms of culture and politics (Cohen 1999). Yet sociologists have understudied the influence of the Black LGBT organizations in the region.

Washington, D.C. was also selected because of its sociopolitical position and influence. Given the significant role that policy makers and advocates play in shaping the national and global responses to HIV/AIDS, it is important to consider the role that HIV/AIDS organizations representing Black Washingtonians play in addressing public health and policies related to HIV/AIDS. Three of the four organizations in this study are located in Ward 8, the community with the highest HIV/AIDS rates.

3.2.5 Selecting Organizations

The Black community-based and faith-based organizations were selected from two lists: (1) the Black AIDS Institute[7] and (2) the D.C. Department of Health's HIV/AIDS, Hepatitis, STD, and TB Administration (HASHTA). These two lists include organizations that have HIV/AIDS related programs and services that are provided by Black churches and community-based organizations. The use of multiple lists was necessary as there are no exhaustive lists of Black community-based and

faith-based AIDS organizations in Washington, D.C. The Black AIDS Institute, the largest national think tank to exclusively focus on the AIDS epidemic in Black communities, created a list of AIDS organizations in Washington, D.C. in 2009. This list included a total of 14 AIDS organizations addressing the impact of HIV/AIDS in Black communities in Washington, D.C. Only one of the 14 organizations was explicitly identified as faith-based. Because the other 13 organizations seemed to have no religious affiliation, I categorized them as secular or community-organizations. Two of these organizations matched the criterion for the community-organizations.

Because the Black AIDS Institute listing includes only one faith-based organization, I consulted another list—the Washington D.C. Department of Health's HIV/AIDS, Hepatitis STD, and TB Administration (HAHSTA). HAHSTA maintains a list of faith leaders who address HIV/AIDS. The board includes 11 representatives from different faith-based organizations in Washington, D.C. All the organizations represented on the board address the issue of HIV/AIDS in some capacity. Six of the 11 organizations had representatives from Black churches. Two organizations included Black women as the main leader of the church AIDS program. One of these two churches included on the HAHSTA list was also listed on the Black AIDS Institute's list. Since this church occurred on both lists I selected it as one of the cases. Though none of the churches on the HAHSTA list explicitly stated that it targeted Black gay men, one church had a website saying it was explicitly open and welcoming to Black gay men. As such, this church was selected for observation and study. Upon interviewing the pastors, I discovered that several identified as gay/same

gender loving. The term same gender loving is credited to Cleo Manago to describe the sexual orientation of African Americans with same-sex attraction and behavior (Lassiter 2014). Same gender loving was used as an alternative to terms such as gay and lesbian which has been considered by some African American as to be White identified terms.

Overall a total of four organizations were selected. The first set of organizations includes two churches or faith-based organizations where Black women and Black gay men play key leadership roles in the church's AIDS programs. In this dissertation I refer to the two churches as New Hope Baptist[2], where Rev. Julia Tar serves as the AIDS director, and Greater Faith Ministries where Bishop Kwame Jones is the pastor and founder of the AIDS program (see Table 4.2). The second set includes two secular or community-based organizations in which Black women and Black gay men play key leadership roles. I refer to these two organizations as Community Alliance, where Sandra Nelson serves as leader and founder, and Brothers United where Raymond Sage acts as the executive director (see Table 3.2.1). I provide a description of each case below (see organizational profiles).

[2] The names of the organizations and respondents in this study are pseudonyms.

Table 3.1.2: Pseudonyms of Churches and Community Based-Organizations in this Study

Orgs.	Org. Type	AIDS Leader	Year AIDS Program Established
New Hope Baptist Church	Church	Rev. Julia Tar (AIDS Program Director)	1989
Greater Faith Ministries	Church	Bishop Kwame Jones	1993
Community Alliance	Community Based Organization (CBO)	Sandra Nelson	1993
Brothers United	CBO	Raymond Sage	1985

3.2.6 Recruiting Organizations for the Study

Before entering the field, Esterberg (2002) recommends that investigators gain access to the research site—particularly for field research. Since this study was designed to include participant observation, I relied upon a mutual contact to introduce me to the gatekeeper of the organization. For secular organizations, the gatekeeper was the organization's director or leader. For faith-based organizations, the gatekeeper was the pastor and/or the program director. I provided a written informed consent form that described the purpose of the study and the research procedures discussing the steps necessary to carry out the study. The consent form also explained why the organization was chosen as a research site. The form provided an overview of the steps that would be taken to guarantee the confidentiality of the organization as well as the research participants. (See Appendix A for the copy of the consent form).

3.3 Data Collection: Methods and Data Sources

According to Merriam (1998), case study research involves the quest to obtain "both breadth and depth" of information. In order to achieve breadth and depth of understanding about secular and faith-based AIDS organizations, this study employed three data collection techniques— (1) analysis of organizational documents, (2) observation of specific public events organized by each organization, and (3) semi-structured interviews with key representatives from each organization. These three methods allowed the exploration of a broader range of issues from different perspectives. Moreover, multiple methods permitted the "development of converging lines of inquiry, a process of triangulation and corroboration" (Yin 2009:4). The following sections provide a more detailed explanation of the procedures of each method and the issues that I encountered garnering data from the field.

3.3.1 Documents

This study began by collecting, organizing, and analyzing documents of each organization. In qualitative research, the term *document* is used to describe sources of data that include "written, visual, digital, and physical material relevant to the study at hand" (Merriam 2009:139). This study examined the written and visual documents posted on each organization's websites and distributed by representatives of the organizations at public events. These documents included, but were not limited to, letters, newsletters, reports, posters, press releases, advertisements, government records, and news links. I mined the documents to obtain understanding of the goals, strategies, tactics, and missions of each organization. I specifically focused on the extent to which these documents noted their engagement in political activism,

whether it entailed protest, letters to political representatives or discussion of AIDS related policies. I also focused on discussions related to health care access such as treatment programs for HIV/AIDS and the matters related to HIV prevention. Attention was paid to the level of engagement, whether the focus of political action was at a local, national or global level or a combination of each. I noted the target of grievance or programs (institution or particular demographic).

Most documents were reviewed during the study period of February 2012 to April 2013. However, I also reviewed several documents that were instrumental in the early works of the organizations. These included pamphlets from the mid-1980s and early-1990s when the leaders of these organizations were beginning to mobilize for the inclusion and representation of Black women and Black gay men in HIV public health education campaigns in Washington D.C. Such documents proved to be fundamental to understanding the organized responses to health education and medical needs of different groups of African Americans from an intersectional perspective.

3.3.2 Participant Observation

Participant observation allows the investigator to directly witness and experience the activities of interest in their natural setting (Esterberg 2002). During participant observation, Merriam (2009) suggests that researchers pay attention to factors such as physical setting, the participants, the interactions, and conversations. In addition, Merriam recommends that researchers observe or reflect on their own behavior and role in the research site. I used the following rubric when taking field notes.

The physical setting: I define physical setting as the environment or structure in which organizational activities or work takes place. Merriam (2009) explains that the design of a space can provide great insights about the kinds of behaviors deemed appropriate for that particular space. Thus, during the observation phase of this study, I paid attention to the design of the physical buildings in which each organization is housed. How are the rooms or offices designed? Do they serve a particular purpose that is specific for specific groups such as serving Black women or Black men? In other words, how might the space be racialized, gendered, sexualized, or shaped by class as well other issues specific to HIV/AIDS?

These questions reflect the critical assumption that physical spaces are not neutral. Rather, the design of the space can have important implications pertaining to issues related to race, class, gender, and sexuality. For example, studies show that African Americans have historically been marginalized from medical organizations relative to their White peers, due not only to a history of medical abuse or lack of medical insurance, but also because they lack access to physical spaces of clinics and hospitals (Byrd and Clayton 2002; Gamble 1997; 2010). In addition to the physical design of each organization's setting, I focused on the objects, images, and pictures displayed in each AIDS organization. What, if any, kinds of images are displayed of Black women and gay men in the organization? Are there condoms or messages about condoms and other forms of prevention technologies? How are these items displayed?

The participants: I described the people involved in organizational activities. I also recorded the roles that people play. Questions to consider regarding participants included: Is there a particular group that organized this event? Who was invited or allowed to be there? Who is not in attendance that would be expected? What are the race, class, and gender characteristics of the participants?

Activities and Interactions: In this section of my field notes I provided a description of the activity.

As a participant observer, I attended four to seven events at each of the four organizations from February 2012 to April 2013. For example, I attended four events at the New Hope Baptist Church, the church in which Black women play key leadership roles as it relates to HIV/AIDS. These events included two HIV-specific programs and two Sunday morning church services. One of the HIV-specific events included a Mother's Day AIDS event organized by the leaders of New Hope Baptist's AIDS program. The event occurred in the basement of the church where HIV screening was administered. HIV Testing was also available during the event in a mobile health unit in the church's parking lot. Condoms and brochures were available for people to take. Representatives from the D.C. Department of Health provided statistics about HIV trends as it relates to African American women living in the District. Such observations allowed me to witness first-hand the work that the church does in terms of providing access to health information and services to the community and church. I was also able to do the same for the other organizations. Overall, I conducted participant observation at a total of 20 events.

3.3.3 Interviews

I conducted a total of 28 semi-structured interviews. Twenty of the 28 were conducted with official representatives of the four organizations in this study, such as the director, pastor, and community outreach workers (staff and/or volunteers) from each organization. Each representative provided a different perspective on his or her organization's approach to AIDS. For example, the organization's director and pastor hold leadership positions and provided a perspective that emphasized how decisions are made pertaining to the goals, strategies and actions of the organization. They also provided background on the history of the organization, which was important to understand the organization's early and current work. In addition to the pastors and directors, I interviewed the outreach workers (staff/volunteers) (See Appendix A for Interview Questions). These individuals were selected because they may have access to information that the director does not have, for example, the everyday tasks of working with communities and clients living with and impacted by HIV/AIDS (See Appendix B for Interview Questions).

During the course of data collection, I discovered that the organizations relied heavily upon other organizations within their networks. Much of the data collection took place in 2012, the summer that Washington, D.C. hosted the first international AIDS conference. The conference served as an opportunity for organizations in the District to build coalitions and work together to bring visibility to the grievances that the leaders of the organizations had with the D.C. Department of Health as it relates to HIV/AIDS. The community-based organizations in this study were particularly engaged in organizing HIV policy meetings, education forums, and grassroots

mobilization leading up the conference. This work required that they joined with allies from other organizations. The inclusion of allies was based on the observed strategies used by the organization's leaders to acquire resources and/or influence HIV/AIDS policies and practices. Thus, in addition to the 20 core interviews with members of the four targeted organizations, this study included eight additional respondents who served as allies to these organizations.[8]

Before beginning each interview, respondents were asked to read and complete a consent form. This consent form described the purpose of the study. The form also explained the steps taken to guarantee the confidentiality of the research participant, and inform the respondent that he or she has the option to opt out of the study at any time during the process. Each interview was conducted in person and lasted for approximately one to two hours. Each interview took place in a location convenient for the respondents, for example in the director's or pastor's office, the organization's conference room, a coffee shop, or a restaurant. The interviews were digitally recorded and transcribed in order to capture the discussion verbatim as well as to allow the investigator to be fully engaged in the interview process (Merriam 2009). All interviews were transcribed and identifying information was omitted from the data. The electronic files were stored on a password-protected computer. Hard copies of the transcripts were stored in a locked file cabinet.

3.4 Coding and Data Analysis

Qualitative data collection can be a complex and difficult undertaking. Merrian (2009) describes the process of data analysis as an iterative process in which the investigator goes back and forth from reviewing, describing and interpreting

segments of the data in relation to different concepts or ideals of interests. One of the most underdeveloped aspects of qualitative research is the analysis of data collected in the field. Since there are few fixed formulas or codebook recipes, much of the analysis "depends on an investigator's own style of rigorous thinking, along with the sufficient presentation of evidence and careful consideration of alternative interpretations" (Yin 2009:110). Thus, one of the first steps or stages of the data analysis process was to construct a codebook. The initial construction of the codes was guided by the sensitizing concepts that emergence from theoretical frameworks. According to Bulmer (1969:456), sensitizing concepts provide the researcher with a "general sense of reference" and "directions along which to look." The sensitizing concepts of this study are derived from understandings of institutional authority (practices, policies and procedures that organizations fight to maintain, reform, or abolish) and cultural authority (the ideas, values, and norms that guide people's behavior and understanding of the social world, and behavior/action towards self and other identified groups). For example, a sensitizing concept for this study is "safe spaces" or "collective action." Social movements include organizations that are able to exercise collective power by working in collaboration with other organization or network of organizations to advance the interests of their constituents. In this study, the codes were identified by a code label, such as safe space, and text from the interviews, documents, or field notes that reflect that code such as safe space. The first codebook was constructed prior to collecting data from the field. Once the data was collected I selected information that reflected the initial codes.

3.4.1 Step 1: Placing Data into Categories (Deductive and Inductive Coding)

Two approaches are typically used to create codes—deductive and inductive analysis. This study used what Patton (2002) refers to as a "hybrid approach," defined as the use of both deductive and inductive data analyses. Thus, the second step of the coding and analysis phase included a deductive analytic technique, where I applied the codes from the codebook discussed above to the transcripts with the intent of identifying aspects of the data that answer the research question. I used the Atlas.ti software to help identify patterns in the data as well as to identity texts that fit the existing codes that were created from the research question and theoretical frameworks. Since it was impossible to anticipate all the data that would be meaningful to the purpose of this study, I employed the inductive analytic technique. As such, several codes were constructed after the data had been collected. These codes reflected new categories, patterns, and themes that were identified from the analysis of the transcriptions and field notes gathered from organizational documents, interviews, and participation observation. Furthermore, the new codes were different from the original codes or reflected a new subcategory from an existing code. I used Atlas.ti to organize the data in both the inductive and deductive phases of analysis.

3.4.2 Step 2: Data Interpretation Phase I

The third step included interpretation of the data. I used information gathered from the categories, themes, and patterns that emerged from data and related them back to broader concepts and concerns that inform this study (Blumer 1969; Patton 2002). In chapters four and five, I explain the research findings in relation to the

primary research questions and theoretical frameworks in order to elucidate why the findings are important.

3.4.3 Step 3: With-Case & Cross-Case Analysis

Since this study examined more than one Black AIDS organization, data analysis included: (1) *within-case analysis* and (2) *cross-case analysis*. According to Merriam (2009), within case analysis involves the exploration of each case as a complete case in and of itself. The cross-case analysis seeks to explore generalization across cases. During the cross-case analysis phase of the research, I looked for codes that occur cross multiple organizations and clustered them in tables to determine how they related to the sensitizing concepts of the theoretical frameworks used in the study.

3.5 Research Reflection: Challenges and Researcher Role

Throughout the research process, I encountered some expected and unexpected challenges while obtaining the data needed for analysis. In the following sections I provide an overview of these challenges. This is followed by a reflection on my experience as a researcher in the field. In the reflection of my role, I discuss how my social position as an outsider and insider in the community might have influenced my level of access into these organizations.

3.5.1 Research Challenges

I experienced two main difficulties during the research process. The first included acquiring access to my first choice for one of the community-based organizations in the study. Prior to entering the field, I made contact with leaders and

representatives in four organizations that met the criteria of the study. While I gained access to three of the four organizations, the leader of one secular organization was less willing to be a part of the study. This community-based organization was a woman-led African American AIDS organization that was very active in the community, in terms of advancing the interests of poor women of color. Although I provided a description of my study and a member of the staff advocated on my behalf to gain access to the study, the executive director decided not to permit access. She gave the reason that that the staff was overburdened with work and that they had already been working with other universities on several research projects.

Since I was denied access to this organization with Black female leadership, I was forced to choose another organization. I selected another community-based organization that was devoted to AIDS, which I referred to as Community Alliance. Given my work in the area of HIV/AIDS since 2005, I both knew and had worked with the executive director. When I called to ask if I could include the organization in my study, the executive director welcomed me with open arms.

The second challenge lay in gaining access to different members of the organizations that agreed to participate in the study. While I was able to gain access some employees of both community-based organizations, other workers within those same organizations were non-responsive. For example, the case workers at Brothers United, the Black gay men led community-based organization, did not return my calls and emails after numerous tries. In addition, while I was able to interview one leader of the fields outreach manager of the women-led community-based organization—he

would not return my call for follow-up. Both of these challenges might have been shaped by my insider/outsider status, which I will discuss in the following section.

3.5.2 Role of Researcher: Outsider Within

Interviews were important in this study, but participant observation also yielded valuable information. I attended approximately 6 public events where representatives of the organizations were involved. For example, for both faith-based organizations I attended programs where they provided HIV/AIDS testing services to the public. They also handed out fliers for people and condoms were also distributed at these events. These events were fairly infrequent. For the community-based organizations, I attended events where they were involved in helping to develop policy for HIV/AIDS in the city.

I was able to attend and participate in some activities that the community-based organizations were engaged particularly during the 2012 International AIDS Conference held in Washington D.C. The 2012 International AIDS Conference was a historic event and program for HIV/AIDS in the U.S. The leaders of the conference decided to boycott coming to the U.S. because of its immigration policies which banned people living with HIV/AIDS from receiving visas to enter the country. At the conference representatives from all four organizations were in attendance. The faith-based organizations helped to organize a gospel group that performed in the Global Village, a part of the conference that was open to the entire public for free. The community-based organizations were much more engaged with the conference: they used it as an opportunity to help inform HIV/AIDS policy locally and nationally. For example, two years before the conference both community-based organizations

helped to establish a diverse coalition of individuals and organizations to craft a city-wide HIV/AIDS strategy that was similar to the National HIV/AIDS Strategy. They created a document that included the demands made for groups such as African American women, African American gay and bisexual men, people with a history of substance abuse, and transgender individuals.

In one particular event, I felt like both an outsider and insider. My prior participation and volunteer work in various Washington D.C. public health and AIDS organizations granted me access to a community forum led by Brothers United, the Black gay male led organization in this study. However, my gender and sexuality nearly restricted my access to the forum. To illustrate, despite having worked with the executive director of Brothers United in a local AIDS coalition, I felt comfortable asking if I could sit in on one of the AIDS forum organized by Brothers United for Black gay men across the Black Diaspora. When I asked the executive director if I could attend, he initially hesitated. He explained that the forum was mainly for Black gay men and not women. However, he agreed to allow me to sit in and observe the forum but asked that I not participate. Had I not being granted access I would not have known how similar and different the interests of Black gay men in the United States were relative to Black men who lived in or were from Canada, the UK, as well as African and Caribbean countries. I had the opportunity to see some tensions unfold in between age groups and listened as some men discussed issues around religion and political engagement. I also attended several meetings of a coalition that Brothers United helped to establish. I noticed that meetings were done person but individuals

could call into the meetings. The inclusion of the telephone allowed others in the coalition who had to work or could not travel to the meeting to participate.

3.6 Organizational Profiles:

The following sections include a description of each organization in this study. First, I provide an overview of the two Black faith-based or religious organizations. To give a sense of the AIDS organizational mobilization within these two Black churches, I begin with an overall description of the churches then discuss their specific AIDS initiatives. After describing the churches and their AIDS organizations, I provide a profile of the two community-based organizations. The names of each organization are pseudonyms.

3.6.1 New Hope Baptist

History: New Hope Baptist was established in the late 1960s. As a member of the National Progressive National Baptist Convention (PNBC), New Hope Baptist is a part of a historically progressive African American Baptist denomination. The PNBC emerged in response to the failure of the National Baptist Convention, an older African American denomination, to advance and support the struggles of the civil rights movement in the 1950s and 1960s. Thus, New Hope Baptist was not established in response to HIV/AIDS but rather it developed an HIV/AIDS initiative or ministry that dealt specifically with addressing the epidemic in the church and surrounding community.

Demographics: New Hope Baptist is a large Black church located in a poor and Black neighborhood. The church has a membership size of approximately 2000

members. Like many Black churches, women represent the majority of the membership, comprising 60-65% of the congregation. According to the senior pastor, there was a concerted effort to have the demographics of the church include people from different economic backgrounds. He noted that nearly half the members are middle-class and the other half are working class or poor.

The majority of the members reside outside the neighborhood. Most live in the suburban communities in Maryland. However, the church is located in one of the most economically depressed and racially segregated areas of the city, in Ward 8. In its effort to address the economic, social, educational, and political well-being of the community, New Hope Baptist has created more than 50 mechanisms through its internal and outreach ministries to help feed, clothe, and care for the sick, as well as to provide job training and programs on entrepreneurship and home ownership.

AIDS Ministries: New Hope Baptist has two AIDS programs. The first was established in 1989 to support, educate, and serve the members of the church who were HIV positive. In 1999, the church expanded its HIV/AIDS outreach to those in the community through the establishment of a non-profit faith-based organization. This AIDS non-profit utilized government funds to provide HIV/AIDS prevention services and support community access and adherence to antiretroviral treatment for people living with HIV/AIDS. The church's AIDS Ministries provide support to combat HIV-related stigma. Women play an instrumental role in the leadership and function of the church's AIDS Ministries.

Theology and Activism: New Hope Baptist is more than a participating member of the PNBC; its theology and history of activism reflects its commitment to

social justice. To illustrate, the theology of New Hope Baptist is based on in Black liberation—the belief that God is on the side of the Black people who live under the oppressive racial regime (Cone 1999). This theology is depicted in the symbols and images presented throughout the church. For example, the mural behind the church's pulpit depicts a race and gender reconstruction of the famous 15th century Leonardo d Vinci mural, known as the *Last Supper*, which depicts Jesus Christ with his 12 disciples. Instead of the blond haired, blue eyed, White Christ with his male disciples, New Hope Baptist repaints this image to depict the image of a Black Christ, with dread locks, dark skin, and full lips, dressed in kente cloth with 13 Black disciples.[3] The disciples of this Black Christ include both male and females who are all historical figures that have fought for the rights and freedom of Black people in the United States. The Black disciples include activists from the abolitionist movement such as Frederick Douglas and Harriet Tubman. Included in the reconstructed mural are activists during the period of reconstruction such as W.E.B Du Bois, Booker T. Washington, Marcus Garvey, and Mary McCloud Bethune. Finally, there were images of the civil rights activists in the United States and Africa that included Martin Luther King Jr., Rosa Parks, Dorothy Heights, Malcolm X, Elijah Muhammed, Louis Farrakhan and Nelson Mandela.

In addition to maintaining a symbolic a religious tradition rooted in African Americans' collective fight for equality, New Hope Baptist also participates in activism. For example, in the late 1980s, New Hope Baptist organized a protest that led to the boycotting of a local business for its mistreatment of Black customers. The

[3] New Hope Baptist's mural initially had 12 disciples but an additional disciple was added years later, making the total 13.

church was also at the forefront of the Million Man March and the Million More Movement. During 2012, New Hope Baptist served as a site for the community mobilization and discussion over the mass incarceration of Black men, women, children, and families in prison.

Leadership: New Hope Baptist was founded and led by African American men. The senior pastor, Rev. John Williams, is known as the current patriarch and leader of the church. Though the senior pastor plays an instrumental role in sanctioning the agenda of the church, he is also known for his support of gender inclusion. For example, he was among the first group of pastors to ordain women in Baptist churches in Washington, D.C. In the late 1970s, he was expelled from the local Baptist denomination for ordaining women. Rev. John Williams currently co-pastors New Hope Baptist with his wife, Rev. Pamela Williams. Their daughter also serves as associate pastor of the church and often shares the ministerial role with her father.

In addition to being more gender inclusive than many Black Baptist churches, New Hope Baptist has also made efforts to speak out against church and familial Black rejection of LGBT people. To illustrate, in the late 1990s, the church held a community forum to encourage the parents of LGBT people to love and accept their children. This act was well received by the Black LGBT community as a progression to the church's affirmation of this marginalized segment of the community. However, several years after this forum, the senior pastor who led the forum used the pulpit as a platform to speak out against homosexuality. After much backlash from the LGBT

community, the pastor apologized but the damage had already been done, some members in the LGBT community were deeply hurt and felt betrayed.

3.6.2 Greater Faith Ministries

History: Greater Faith Ministries is a LBGT inclusive non-denominational Black church established in 1993 in Washington, D.C. Greater Faith Ministries emerged out of the Unity Fellowship Church Movement--a network of churches that arose in the 1982 that sought to provide an open and affirming religious experience for members of the Black LGBT community. The first church to be established in the Unity Fellowship Movement network of churches was in Los Angeles, California. However, LGBT inclusive churches existed long before the Unity Fellowship Movement began in the 1980s. One of the earliest representations of such churches includes the predominantly White Metropolitan Community Churches (MCC) founded in the late 1960s (Kane 2013). Thus, like their White counterparts, the Unity Fellowship Church Movement emerged in the 1980s to provide a sexually inclusive religious environment for their members. As mentioned in Chapter 2, Black churches have historically served as a safe and affirming place for African Americans particularly under the system of racial inequality. Yet many churches failed to fully recognize and include members of the church who fall outside of the heteronormative sexual standard (Miller 2007).

Members at Greater Faith Ministries are given the opportunity to attend church without having to hide their sexuality or to be told that their sexual orientation is a sin. Moreover, Greater Faith Ministries and other churches that emerged under the Unity Fellowship Church movement have performed same-sex marriage for their

members. According to the Pastor of Greater Faith Ministries, the church performed same-sex marriage long before the government legally sanctioned these unions. Today Greater Faith Ministries is no longer a part of the Unity Fellowship Movement. However, it is still closely tied to Black Churches that sexually inclusive.

While Greater Faith Ministries performs worship services on Sundays, its services take place in a house rather than a tradition church building. The first floor of the house is converted into a sanctuary with church pews and a pulpit. Compared to New Hope Baptist there is relatively few religious symbols. For example, there is no images of Christ. According to the senior pastor of Greater Faith Ministries there was an intentional decision not to have images of Christ as a way to refute the prevailing Christian beliefs that reinforce the notion of masculine images of their deity or God. In fact, it was not unusual to hear members of the church refer to their deity as "Mother Father God." The sexuality of their deity is viewed as not having a particular gender. This practice is part of the effort of the leaders to be more gender inclusive. Despite this inclusion the majority of the leaders are male.

Demographics: Greater Faith Ministries is a relatively small church. It has a membership size of approximately of 45 to 60 members. However, according to the senior pastor, Greater Faith Ministries was much larger, comprising of approximately 500 members in the early 2000s. The reduction in size was due to tension in the church related to its theological focus, leadership training, and misuse of funds. The gender composition of the church is almost equal for men than women, consisting of approximately 55% women and 45% men.

Greater Faith Ministries is located in Ward 8, the same neighborhood as New Hope Baptist. However, one of the key difference between New Hope Baptist and Greater Faith Ministries is the number of outreach programs that it provides to the community. While New Hope Baptist has approximately 50 programs and ministries open to the community, Greater Faith Ministries only has a food program and its HIV/AIDS or health ministry. Thought its food bank, Greater Faith Ministries offers non-perishable food to those that the hungry and the poor. One of the main reason for its limited outreach ministries relative to New Hope Baptist is the differences in the size of the congregation. With a membership size that ranges from 45 to 60, Greater Faith Baptist has limited resources to provide programs that are typically found in Black megachurches like New Hope Baptist. Despite this difference, the pastors of the church explain that they have has primarily relied on the support and resources of other churches and charitable organizations to provide members of the church and community with material support to address their basic needs such as food, clothing, and shelter.

AIDS Ministries: The AIDS program at Greater Faith Ministries has existed since the formation of the church in the 1990s. The primary services provided by the church included social support for people living with HIV/AIDS—particularly Black gay men. The church has acted as an intermediary for members both within the church and the surrounding community to access HIV-related health services. The senior pastor has played an instrumental role in the formation of Black AIDS organizations such as Brothers United (see below). Both the senior pastor and assistant pastor have worked to expand the capacity of Black churches in

Washington, D.C. to respond to the epidemic in African American communities. In 2010, the church developed a non-profit arm of the church to acquire government funding to expand its AIDS programs to provide additional HIV/AIDS related services. The main services include HIV/AIDS education, HIV/AIDS prevention promotion, HIV testing, mental health support, and access to treatment and care.

3.6.3 Community Alliance

History: Community Alliance was established in 1993 as a national HIV/AIDS advocacy organization. The initial goal of the organization was to represent the public health interests of women living with HIV/AIDS in the United States—particularly poor African American women. In many respects, Community Alliance is in large part shaped the reproductive rights movement. According to the founder and executive director, Community Alliance emerged as a result of the failure of a predominantly White reproductive rights organization to provide the necessary resources to address the HIV/AIDS epidemic among African American women who were often poor and dealt with substance abuse issues.

Although not a part of the reproductive rights movement, Community Alliance continues in the tradition by provide health related services to African Americans in a building that once housed an abortion clinic. In a tour of the building, the executive direct showed the damages to the building which she explained were the result of pro-life protesters. While Community Alliance does not provide clinical reproductive health services, it focuses on providing African American women and the larger Black community in which it resides access to safe-sex education and tools such as condoms.

There are aspects of Community Alliance that has changed since its founding in 1993. For example, while Community Alliance began as a national HIV/AIDS advocacy organization, Community Alliance focused on HIV/AIDS health policies focus on women's public health rights the work of the organization shifted largely to HIV education and testing service delivery. A key part of this shift was due to the lack for funding to do HIV/AIDS policy and advocacy work. Despite this shift in focus, Community Alliance maintains some political advocacy. The advocacy and service has expanded to include African American heterosexual men.

Demographics:[9] Community Alliance is a community-based AIDS organization that serves the residents in the most impacted regions of Washington D.C., such as Wards 7 and 8. The residents in these neighborhoods are predominantly African Americans who experience high unemployment and underemployment. They are also more likely than the residents of other wards in Washington D.C. to experience high incarceration rates and have female-headed households. The majority of the people Community Alliance serve struggle with issues of substance abuse in a neighborhood with few drug treatment programs.

AIDS Programs: Community Alliance offers a range of HIV-related programs and services to improve access to HIV prevention, antiretroviral treatment, and drug treatment services. In terms of prevention, the programs include small group interventions that teach condom negotiation, and community outreach programs such as the distribution of condoms in the streets and local businesses. Other public health interventions offered through the organization include the assistance of medical navigation peer health workers who support people living with HIV/AIDS to access

and adhere to treatment. Community Alliance also works to improve the capacity of Black community organizations such as Black churches, barbershops, and beauty salons to educate community members about prevention as well as improve access to treatment.

Ideology and Activism: The main ideology of Community Alliance is health promotion and health equity. The ideology of the organization is in part shaped by the gender and racial inequality and the legacy of women's reproductive health, which has historically worked to improve women's control of their reproductive and sexual health in a male dominated health industry. Community Alliance worked to alter the predominantly White, male, and gay focused HIV health policies and medical practices to benefit women living with, and at risk for, HIV/AIDS. Activism included the building a coalition of women-serving organizations and women living with HIV/AIDS to pressure public health officials and government to develop HIV prevention information tailored to African American women, as well as women's access to HIV treatment.

Leadership: Community Alliance was founded and led by Sandra Nelson, an African American woman who, prior to her work in HIV/AIDS, was involved in the women's reproductive health and gay and lesbian health movements. Sandra used her experiences of losing close friends to HIV/AIDS, as well as the knowledge and skills she learned from these health movements, to advocate for the interests of African American women and heterosexual men. She has helped to develop HIV prevention programs targeted to African American women, and has been instrumental working to ensure that funding is available to train new generations of African American AIDS

leaders and community health workers. The staff at Community Alliance is primarily from the neighborhoods most impacted by HIV/AIDS.

3.6.4 Brothers United

History: Brothers United is a community-based organization formally established in the 1985 by and for Black gay men living with and at risk for HIV/AIDS. Brothers United currently stands as an independent organization, however it began as part of a larger organization—a Black dance club—which has a deep history in African American gay and lesbian rights. The dance club was established in 1975 in response to the racial discrimination that African Americans faced in the dance clubs in Washington D.C. The club not only served as a place for African American LGBT people to socialize and have fun but it was a site for politicians to campaign for office and it also held a ball for a 1979 conference for Black gays and lesbians. Brothers United was created as an HIV/AIDS initiative of the founders of the club to response to the deaths and illness of members of the club who were predominantly gay men. After the dance club closed in the early 1990s, Brothers United continued to provide support for African American gay and bisexual men living with and at risk for HIV/AIDS. Although Brothers United has historically focused on Black gay and bisexual men, during different periods of its existence, the organization offered support to African American women and transgendered individuals living with and at risk for HIV/AIDS.

Demographics:[10] During the time of the study Brothers United served approximately 143 African American gay and bisexual men. Many of these men are living with HIV/AIDS. However, the organization also service African American gay

and bisexual men who are HIV negative. According to the executive director, many of the men who turn to Brothers United are poor or have experienced some instability with employment. Some did not have health insurance.

Ideology and Activism: As a community-based public health organization, the main ideology of Brothers United is HIV health promotion and equity. The main goal of the organization has been to improve the physical, mental and spiritual well-being of African American gay and bisexual men. With this goal in mind, Brothers United offers a number of HIV-related services to improve community access to culturally sensitive HIV prevention programs and care. This has required that the organization leaders join with and develop national and local coalitions to ensure that the unique needs and interests of African American gay and bisexual men are addressed in a predominantly White gay male controlled and dominated health industry. Moreover, given the issues related to homophobia in many Black churches, Brothers United has offered a space for men to discuss issues related to the church. Its leaders have also worked to establish open and affirming religious environments.

Leadership: Brothers United was founded by a Black pastor—Bishop Kwame Jones, who is also the founder of Greater Faith Ministries (see above). Jones left Brothers United in the 1990s to form Greater Faith Ministries. Today Brothers United is led by Raymond Sage, who prior to assuming leadership, was a member and volunteer at Brothers United. Sage also worked as college professor and as expertise in communications. Both Jones and Sage are HIV positive and gay.

AIDS Programs: Brothers United offers several HIV/AIDS prevention programs to its constituents. For example, Black gay men and youth are taught how to

negotiate condom use with their partners and navigate power dynamics in intimate relationships. The organization also provides in house mental health services and space for men to provide support to each other. To improve access to HIV treatment and care, Brothers United serves as an HIV testing site and offers support to help men gain access to HIV treatment.

These organizational profiles provide a framework for understanding how the organizations in this study reflect specific historical, political, ideological and social contexts. The histories of the Black churches for example are worth noting given that their ideologies/theologies are rooted in the Black liberation movement, which has been regarded as maintaining Black activist traditions. The community-based organizations are also themselves rooted in their own traditions of activism. Community Alliance's involvement with the reproductive health movement provides some insights about its activism for gender equality. The region and place that the organizations are located also shape their responses to HIV/AIDS, since three of the four organizations are located in Ward 8, which is not only disproportionately impacted by HIV/AIDS but is also among the region that has experienced great economic decline.

3.7 Conclusion

In this chapter I provided an overview of the methodology used to conduct this dissertation. I focused on the research design, the strategy used for case selections, data and the tools used to analyze the data and well as provide a reflection of the challenges I encountered in the study along with a profile of each of the cases. The next chapters examine key findings from this case study of organizational

mobilization. As stated above, the primary research question that guided this study is: *How do Black AIDS organizations respond to the multiple experiences, needs, and interests of groups impacted by AIDS in Black communities?* Given the centrality of religion in Black community and life, this study also sought to answer the following sub-question: *To what extent does religion, specifically Black religious traditions, directly or indirectly impact the actions of Black AIDS organizations?*

In the next chapter, I analyze the organized mobilizing strategies of each organization as they aim to represent the political interests of their constituents within the contemporary public health environment. Political representation is particularly important since those most affected by HIV/AIDS are treated as second-class citizens. This political representation focuses on ensuring that constituents have access to the most basic human needs for survival. This involves dual strategies of securing government resources often via engaging in strategies of coalition building with others in their political networks. Because both churches have progressive traditions, their strategies resemble one another as well as the responses of their community-based organization counterparts. Collectively, the struggles for political representation by these four organizations are part of an effort to advance a Black survival politics of HIV/AIDS.

Chapter 4: Black Survival Politics of HIV/AIDS: African American Organized Mobilization for Political Representation

This chapter analyzes the mobilization efforts of the organizations in this study to represent the needs and interests their constituents. I focus on the activism that is related to political representation, which I argue is essential to Black survival politics of HIV/AIDS. Two main strategies are employed by the organizations. The first includes coalition building and deployment of organizational networks. The second strategy focuses on gaining access to public health resources from the government.

Social movements are comprised of networks of organizations or coalitions that mobilize to combine resources for a particular aim (see page 34). Given the history of political marginalization, African American organizations have mobilized resources to represent the political interests of their constituents. One strategy of African American organizations is to target government agencies to represent the rights of people who occupy second-class citizenship status in the nation. In the United States, African American women, African American gay/bisexual, men and African American substance abusers are among the groups most at risk for HIV/AIDS. They are also treated as second-class citizens, not simply due to their race, but also because of intersecting identities of race, gender, and sexuality (Cohen 1999). This chapter brings attention to the ways in which the community-based organizations and the Black churches in this study utilize their networks to advocate for the political and health interests of these marginalized constituents.

A key part of the HIV/AIDS activism includes mobilization through coalitions or networks to gain and preserve community access to HIV/AIDS resources for prevention, treatment, mental health, and other services for basic survival. For each organization, I examine the uses of coalitions are essential to procure financial resources from the government to implement specific HIV/AIDS initiatives. In doing so, they highlight the right to life of their marginalized constituencies. The activities of the churches in particular illustrate how varying aspects of Black religious traditions can be deployed, maintained, and altered in defense of this right to life.

This chapter is organized into four sections, with one section devoted to each organization in this study. First I analyze the community-based organizations as models of AIDS activism. I begin with Brothers United, historically the first of the organizations in this study to address HIV/AIDS. Brothers United represents the needs and interests of Black gay men living with and at risk for HIV/AIDS. Thus, much of its activism or coalition building has occurred at the intersection of race, class, and sexuality. The second organization is Community Alliance, mainly focusing on African American women and African American heterosexual men, is also organized around the politics of community rather than a sole focus on identity. Together, these two community-based or secular organizations share a common goal advancing the interests of a particular constituency group by deploying the power of coalitions. However, one key difference between the organizations is the extent to which the leaders of the organizations see themselves as having the authority to influence HIV/AIDS policy. The leader of Community Alliance suggests that women and heterosexual men have less power in government policy related to HIV/AIDS.

Third, I examine New Hope Baptist Church, which fits the model of the traditional progressive Black Baptist Church. New Hope Baptist is rooted in the Black religious traditional rooted in the mobilization for civil rights and has also defied prevailing religious norms by ordaining African American women at a time when most Baptist Churches denied women the right to the pulpit. In its response to HIV/AIDS, New Hope Baptist has maintained this religious tradition by politically represented the health interests of substance abusers and women. The final organization Greater Faith Ministries, in among a new group of Black churches organized around LGBT religious inclusion and rights and HIV/AIDS. While these two church have different religious histories, they share connection to a larger faith-based coalition and have sought out funding to deliver programs for HIV/AIDS in the church. One key difference between is that New Hope Baptist Church has greater resources and the issues tied to their key constituents, substance abusers, have more support than that of Black LGBT in the church.

4.1 Brothers United: Saving the Lives of Black Gay Men

Brothers United historically organized at the intersection of race, class and sexual inequality to save the lives of Black gay men who experienced triple marginalization—neglect by the state, Black organizations, and White gay organizations. To illustrate, in 1985, the year that Brothers United was founded, the Reagan administration called for cuts in AIDS funding from $96 million to $85.5 million data, despite the fact that the epidemic was on the rise (Shilts 1987). Since there were no medications available at the time, many people who were diagnosed with HIV/AIDS died within a few months. In reflecting on the 1980s, Bishop Kwame

Jones, the founder of Brothers United, recalls, “It was really a different time. A person would find out that they had HIV this month and 6 months [later] it was AIDS and in a year they were dead. We were struggling to find answers.” Not only were gay men trying to find the cause of the disease and to prevent the death of themselves and their loved ones, they were forced to do so at a time when powerful Black organizations failed provide the resources to save their lives. According to Raymond Sage, the executive director of Brothers United, the Black community turned their backs on Black gay men. He explains, “[F]or the first 10 or 15 years of the disease they [the Black community] ignored it [HIV/AIDS] because it was either a, you know, a White gay problem or an IDU problem or a Black gay problem. But it wasn’t until it started affecting their women and children that suddenly it became [a problem]. But you’re 15 years behind the curve now.” Unlike women and children who were generally considered more innocent members of the community, Sage indicates that Black gay men faced community stigmatization and neglect.

Brothers United also emerged in response to marginalization in White gay AIDS organizations. As Jones recalls, “All of the [AIDS] programs in the beginning seemed to have been geared to White gay men and so all the information was coming from White gay men. So we needed to put something together that was […] addressing our community.” Unlike many White gay men living with AIDS, the issues that African Americans faced were rooted in economic and racial inequality. Sage explains, “you’re dealing with a population that does not have as much resources, that may not have health insurance, that may not have access to services. And you’re dealing with a population that is distrustful of the medical establishment,

you know because of it being abused." Relative to their White counterparts, African Americans have been more distrustful of the health care system, given the history of medical abuses such as the Tuskegee Syphilis Experiment funded by the U.S. Public Health Service (Washington 2006). Thus, while powerful, predominantly White AIDS activist organizations such as ACT-UP fought the FDA and other public health organizations to fast track the access of developmental drugs to people diagnosed with HIV/AIDS, African Americans were less trusting of this medical process. Early activism focused on bringing attention the needs of African Americans, particularly to mitigate this medical distrust. However, more recent activism utilizes three strategies. Firsts, a key component of the Black survival politics of Brother United include connecting their constituents to a larger network of HIV/AIDS government and social service organizations. Second, in cases where the government fails to respond to health and material needs, Brothers United works within a coalition of politically active organizations. Third, the activism of Brother United includes challenges to the prevailing belief of Black hypersexuality in HIV/AIDS.

4.1.1 Representing Poor Black Gay Men

Black survival politics for HIV/AIDS involves efforts to address economic inequalities in health. For much of the early and continued mobilization of Brothers United, efforts have been made to assist clients with the resources needed to afford medication for survival. The organization helps African American gay men who face economic challenges to access medical and material assistance through existing social safety net programs such as the Ryan White Program—a federal program specifically designed to assist poor people living with HIV/AIDS. Sage explains:

> [W]e do have Ryan White Services for people who don't have health insurance or money for needed services like food and rent and some stuff like that. We don't provide it, but we have agreement with agencies that do. And we have a full time case manager who his whole job is to help people with the services that they need [and] with the services that are available.

In Washington D.C. a network of HIV/AIDS service organizations utilize funding from the federal government's Ryan White program to ensure that people who poor and living with HIV/AIDS can gain access to medication. Yet the medical care may also be difficult even for people who have health insurance. As Donald notes:

> [Y]ou may want to take meds but you can't afford to go get your meds because you had no money to go across town to go get that. You don't have money to pay for the co-pay to get that as well. So you make the choice, do I get my meal, my peanut butter sandwich for the next few days or do I take this few hundred dollars to pay for medication but I still have to have something to eat.

When faced with the dilemma of choosing medical care over food, Donald explains that the need for basic subsistence tends to prevail over medical care. Moreover, there are groups that fall through the cracks of the health care system even when they have health insurance.

Although Brothers United is able to assist men to gain access to medical care and food, some basic needs such as housing go unfulfilled. According to Sage, more than 20% of their clients who are homeless. Donald explains that while the government has emphasized medicine and medical, the issue of housing is often not

prioritized. “For a lot of Blacks the first level [issue] is not HIV medication. We’re living in shelters, we living with people and you know certain things are just not on top priority […] So the question is how is the city gonna help them [African Americans] to figure out some of these problem.” Since 1992, the federal government has provided resources through the Housing Opportunity for People Living with HIV/AIDS (HOPWA). This federally funded program was established to help people living with HIV/AIDS to avoid homelessness during illness. Yet with more individuals living longer lives due to more effective medication, the slots for available housing is limited for people living with HIV/AIDS who lose their homes or have no permanent place of residence.

In order to deal with the issue of lack of housing for people living with HIV/AIDS, Brothers United works through a coalition of organizations to pressure the government to expand resources for housing. For example, in 2010 Brothers United co-founded a D.C. HIV/AIDS coalition which had the issue of housing as one of the main priority. Kathryn, the co-chair of this coalition and a long time HIV/AIDS housing activist describes the housing crisis for people living with HIV/AIDS in Washington D.C. as one that is tied to a larger issue of the general lack of publically funded housing.

> The HIV/AIDS waiting list for housing continues to grow [in D.C.]. And it’s anywhere between 900 and 1100 people [on the waiting list] depending on which day you call AIDS Housing Counseling Services [...]. And the other thing is in the perfect world what people would do is go into the established housing choice section 8 program or supportive program, the housing for

> disability 811, or the housing for the elderly in 202. [The problem is] they [too] don't have a lot of funding. So the housing situation is still really challenging.

With the dismantling of welfare programs since the 1980s, the government has disinvested resources for affordable housing in many cities like Washington D.C. For example, in 1993 the Department of Housing and Urban Development's Hope Project destroyed more than 20 public housing projects in the city which had devastating effects on African American communities in Washington D.C. (see Williams 2009). While new buildings and housing facilities have been erected in the city, these new residential units are often unaffordable even for middle-class African Americans. Donald explains:

> According to the law in the District of Columbia, every new condo, building, town house, whatever they're call, 15% of that is supposed to go to low income [residents]. But their price it so high that even though there may be 15% that is supposed to have low income, they still can't afford the price of $3000 a month. It still does not give you enough lead way to actually afford to live in that facility. It's a market issue. It's crazy, it really is.

The issue of HIV/AIDS is tied to the economic structure that maintains race and class inequalities. When the availability of affordable housing declines or remains inaccessible to people it also affects African Americans living with HIV/AIDS.

In order to appeal to the government to expand resources for HIV/AIDS housing, the coalition utilizes statistics and personal stories to convey the structural inequalities tied to housing. However, in comparison to statistics, Kathryn notes that

personal stories are often more powerful to convey the significance of expanding resources for housing.

> [Some people say] well this is what happens when I don't have housing. I go back to using [drugs]. I start trading sex for a roof over my head. I don't take my medications [because] I have no place to put them or I can't access them so or doctors won't give them to me because I don't have a place to live. So I start hearing those things and being able to tie that to the policy, tie that to the cuts at the state, local and national level.

The work of Brothers United is tied to a larger issue facing African Americans and others in poverty who have depended on the state for public assistance. Through its coalition, Brothers United work to pressure the D.C. government to expand access to housing for its clients. However, the stories and advocacy had done little to reducing the number of people on the waiting list for homes. The housing waiting list continued to have more than 900 to 1000 people living with HIV/AIDS who were in need of a place to live.

While the government has failed to provide the necessary resources to end the housing waiting list, Brothers United and others in its network have worked to ensure that federal resources are not completely eliminated for housing. For example, Richard, a volunteer at Brothers United, explains that he is an advocate for housing people living with HIV/AIDS.

> I went to a Ryan White Planning Council meeting the other night and they wanted to start getting clients to start to speak up about HOPWA [to say], oh we need this program. It helps me to improve my HIV. Without a house and

> roof over my head I won't take my medicine, that means I'mma die and that kind of stuff and having a roof over my head through your program I'm grateful and I need that.

Richard goes on to explain that he's an advocate for such programs because there is a need particularly in Black communities. "As a Black man […] I see the challenges that we still have to go through and I see that there is still a push to do civil rights and human rights and stuff like that and so I see that ability still exist. So I'm you know I'm one of those fighters." While Richard associates his activism with civil rights, the advocacy for food, medicine, and housing is in many ways more connected to Black struggles for welfare rights. Those impacted by HIV/AIDS have historically been regarded as undeserving of public resources needed for survival. Since housing is not a human right in the United States, organizations such as Brothers United must work to represent and serve their constituents who do not have the economic means to care for themselves. Yet economically disenfranchised African Americans have limited resources to galvanize a movement powerful enough to alter the larger economic structure. While Brothers United is mobilized as the local level to advance the economic interests of their constituents, its activism also includes coalition building more broadly at the intersection of race and sexual inequality.

4.1.2 Political Representation and Distributive Justice

Based on their sexuality, African American gay/bisexual men occupy second-class citizenship status similar to their White peers; however, they have far less political power and authority given their racial status. To foster political power and influence, Brothers United strategically joined with a network of African American

gay men and organizations to form a coalition powerful enough to target and influence government public health agencies. Raymond Sage explains:

> We belong to [name of national Black gay men policy coalition]. We are one of the founding organizations […] and I'm on the executive committee for that. So when we have meetings with the CDC or with SAMHSA or with Office on AIDS Research, a lot of times I would be one of the people, even at the White House. […]. We'll have meetings with them.

The formation of the national coalition is significant because it gives Black gay men access to key public health organizations such as the CDC where they can voice grievance and gain a seat at the table where important policy decisions are being made about HIV/AIDS.

Race and sexual inequalities shaped Brothers United participation in the establishment of the national policy coalition. In 2005, the national Black gay policy organization emerged in response to the release of biostatistics from the CDC that showed a 46% infection rate among Black gay men studied in five major cities throughout the United States. Paul, one of the founding members of this national policy organization, recalls:

> It [the national political coalition] started in 2005 after the [release of the] CDC […] 46% study, you might have seen this. […]. This is the behavioral surveillance and […] it was like 5 or 6 cities where they […] tested people and everyone who was tested, of the Black gay men who were tested, like 46% of them were HIV positive. It's a study, it doesn't mean that that's the

> real probability but […], everyone was just oh my God 46% of Black gay men!

Health issues become a matter of public concern when institutions like the CDC provide biostatistics that reveal a health crisis. Yet despite the availability of broad-scale biostatistics, the lives of Black gay and bisexual men did not become a national public health priority. According to Paul, "In the Black community and the gay community leadership, people were like oh my God this is just awful and nobody said anything about a plan, nobody. That's why we formed our group to demand a response out of the government. And so that's what we've been trying to do since 2005."

Through the national coalition, Brothers United could participate in a larger collective action where Black gay men could make citizenship claims to the state. Part of the early political agenda of the national coalition was to demand that government increase public health resources to organizations serving Black gay men. This activism includes struggles to fight the double marginalization that results from racism and homophobia. Sage asserts:

> [We're] dealing with the homophobia and racism of the local health departments. The fact that there are not enough agencies dealing with Black gay men, nor is there enough CDC money going toward agencies. When about 5 years ago when they did that first youth program, the youth funding, they put $8 million out on the street, they didn't fund any agencies in New York City which was always crazy […] but we told them this isn't going to work, you got to come up with some [more money]. So […] they found another $1

> million and funded another 3 or 4 agencies around the country. So it was like that kind of advocacy, you know.

In the face of marginalization in the government, in African American and White gay organizations, Brothers United was able to join with other organizations and individuals at a national level to make demands that the state provides public health resources for Black gay men.

In addition to mobilizing to demand government prioritization of Black gay men's lives, Brothers United's activism also includes the challenge to prevailing belief that African American gay men are hypersexual. Since the 1980s, the dominant paradigm of HIV/AIDS has been based on the premise that the high rates of HIV are due to high-risk behavior, such as having multiple sexual partners, failure to use condoms, and intravenous drug use. For example, during the early years of the epidemic, public health officials regarded gay men as being more promiscuous than their heterosexual counterparts, and thus considered them more susceptible to HIV (Brier 2009; Patton 1990; Treichler 1999). Today the same narrative has been recast through the lens of race where Black men who have sex with men (MSM) are singled out as being more sexually deviant than their White, Latino, and other ethnic counterparts. To contest these general belief Raymond Sage, identified studies from the CDC which he asserts disclaim this viewpoint. Sage asserts:

> The CDC found […] in 2005 in a study it did of 5 cities […] showing that an average of 46% of the Black men tested positive for HIV infection but […] they were engaging in less risky behavior. And Greg Millet who's a

> researcher for the CDC, uhm has, he's been doing uh meta-study analysis. And he's found it going back as far as '87.

The overall goal of Brothers United was to influence public discourse to challenge the prevailing view of Black gay male sexual deviance in HIV/AIDS, and present new images of Black MSM as sexually responsible. For example, representatives of Brothers United noted that a 2010 surveillance study of MSM in Washington D.C. found that Black gay men were using condoms more frequently than their White counterparts.

> The 2010 study of 500 gay men in the District of Columbia found that 32% of the Black gay men over 30 years old and 12% of the Black gay men under 30 years old were HIV-infected. In comparison, 8% of the White gay men over age 30 and *none* of the White gay men under age 30 were HIV-infected. Yet, the Black gay men reported using condoms 50% *more* and having fewer sex partners than White or Latino gay men. The same paradox was reported in a 2011 surveillance study of gay men in Chicago.

Through the use of scientific knowledge, Brothers United has worked to contest stereotypical views of the sexual deviance of Black gay men. Representatives of Brothers United emphasized research which suggested that higher rates of HIV/AIDS among Black MSM was not the result of sexual irresponsibility (i.e. the failure to consistently use condoms). Rather they pointed to studies that Black MSM were generally *more* sexually responsible than White their peers.

In summary, Brothers United has a long history of political mobilization that targets public health agencies, particularly in the government for their survival. This

targeted political activism includes dealing with the needs of poor Black gay men. In addition, this Black survival politics include the building of networks and coalitions among African American organizations representing Black gay men living with or at risk for HIV/AIDS. The activism of Brothers United includes demands on the government to make public health funding available for the African Americans constituents. It also includes effort to target the moralizing aspect of public health, which tends to view African Americans as more sexually deviant than Whites.

4.2 Community Alliance: Saving Black Women and their Community

In this section I focus on Community Alliance, the second community-based or secular organization in this study. Like Brothers United, Community Alliance emerged in response to love ones dying of HIV/AIDS. It has also mobilized coalitions at the intersection of race, gender and class inequality. However, there are two main difference between the organizations. First, while Brothers United focuses on Black gay men, Community Alliance focuses on African American women and African American heterosexual men. Second, Community Alliance not only mobilizes to address a particular identity group, it also mobilizes at the neighborhood level.

Community Alliance emerged in 1993 as death bed wish to represent the interests of African American women living with HIV/AIDS. In recalling the motivation for establishing Community Alliance, Sandra Nelson, the founder and executive director states, "[O]riginally […] there were not a lot of national organizations that did work particularly around women, uh women of color. And when I started doing HIV work in the late 80s, one of my best friends died. He

suggested that if I continued to do work around HIV/AIDS I should do work for people who looked like me." In some ways, Sandra and her best friend were similar as neither conformed to heteronormative standards of sexuality. She identified as bisexual and her friend was gay. However, with respect to their race, gender, and class background, Sandra and her friend were very different. Based on their differences, Sandra recalls her friend encouraging a focus on people like her who lacked financial and social privilege. Sandra recalls:

> Ah, he [her best friend] was White and he's probably the first rich person, wealthy person I would actually say […] I ever knew. And it was during that time, I almost knew [it was] the end for him […] and he said you know, "what if this was you." […] And he said, you know I would be your only friend that would be able to give you any sort of support. […] It wasn't that I didn't have friends […] but the level of cost associated with medication and with care and treatment at that point […] was high. And so he said you should work on issues related to people who look like you, not necessarily people who look like me. It was really kind of bad because it was this death bed thing. And so how do you say no […]. So that really […] remains the driver for what we do.

This death bed wish forced Sandra to think about her own potential survival and the survival of those who shared her similar socioeconomic status.

Community Alliance is located in Ward 8, a region in Washington D.C. with a high HIV/AIDS rate, high rates of unemployment and incarceration, and low educational attainment. Moreover, in these communities, some continue to regard HIV/AIDS as a death sentence. As Delroy, a staff of Community Alliance explains,

"a lot of people when they first find out, they think […] I'mma die next week." Thus part of the work of the organization is to address the fear of death. Denise, another staff at Community Alliance states, "I tell them, you know this is not a death sentence. You know you can live a really really long time, you can party, you can do whatever, as long as you take care of yourself." Given the history of the organization, part of the work of Community Alliance is to advance a Black survival politics that represent the interests of African American women and their communities.

4.2.1 Political Representation and Distributive Justice

Since its inception, Community Alliance has worked to politically advance the HIV/AIDS health interests of poor African American women—a group that occupy-second class citizenship status in the United States. Unlike middle class White women, poor African American women have less political power and resources to demand that the government prioritize their health and lives. Thus, in recalling another reason for establishing Community Alliance, Sandra spoke to the great difficulty she experienced convincing a predominantly White reproductive health organization in Washington D.C. to prioritize HIV/AIDS.

> [Before establishing Community Alliance], I worked at a national women's health organization and they had 3 to 5 women's health priorities and most of them were around vaginal health. And I'm thinking HIV had to be one of your priorities […]. They had gotten a partial grant for me to do some focus groups around the country and I did the focus groups and I came back and I was like, there is a clear need out there for leadership in women and HIV. And they were like, good great, it will be our 5th health priority but we really won't

> work to resource it or anything else because it's not who our membership [are] and their membership is who pays the bills.

According to Sandra, the members of this national women's health organization were predominantly White middle-class women, while the women disproportionately impacted by HIV/AIDS were "primarily women who were low-income, poor, of color, [and with a] history of drug use." Though this national women's health organization eventually included HIV/AIDS among their top priorities, Sandra asserts that they, along with many other reproductive health organizations, were initially hesitant to address the issue and slow to allocate resources to address a disease that primarily impacted African American women. In 1993, Sandra left the national reproductive health organization to form Community Alliance.

As part of its effort to inform HIV policies in ways that were more inclusive of African American women, Community Alliance organized an AIDS conference in 1994 in collaboration with the National Skills Building Conference. The conference was held in Atlanta, Georgia, the city where the CDC headquarter is located. Over 157 women and representatives from women serving institutions attended the conference. Sandra recalls:

> The summit was really to say, what are the issues? 'Cause this is so new. We better have a collective voice kind of thing. We looked at everything from why weren't there more money targeting women? So how can we help them with accessing money, accessing resources, [and] accessing information?

The AIDS conference was organized as part of a national effort to bring together a group of women and their allies to identify their concerns and develop strategies to

pressure the federal government to extend resources to this underserved and marginalized group. One of the issues identified as a priority was the need for HIV information and prevention specifically geared towards African Americans and other women of color as they were often excluded from HIV prevention marketing campaigns developed by the CDC. In the early 1990s, the members of Community Alliance formed two key policy committees, which included the Public Policy Issues Working Group and the Federal Response to AIDS Working Group. These two committees pressured the federal government and the CDC to extend institutional resources to provide HIV prevention materials that included African American women and other women of color. Today there is a lot of HIV information that includes African American women; however, such inclusion can be in part attributed to mobilization of organizations such as Community Alliance which was created to ensure the representation and visibility of Black women in HIV information and AIDS education campaigns. It also included mobilization related to women's inclusion in clinical trials.

Improving access to medical care and facilitating substance abuse treatment constituted two foundational issues for Community Alliance. While the issue of medical care has been given attention in public health, for women, substance abuse had been given far less attention. In 2010, Community Alliance helped to establish the same coalition that Brothers United also co-founded to demand that Vincent Gray, the then mayor of Washington D.C., more effectively respond to the health care needs of people who struggle with substance abuse and HIV/AIDS. Mary who is the

community organizer for the coalition, explains that the substance abuse programs in the United States have been historically designed to address the needs of men.

> [Drug Abuse programs] requires that you jump off the bridge you can't just do this in steps and so that's why it's really bad for females. A man could jump off the bridge a woman cannot do that because she has children or she's maybe the only one that takes care of her grandmother or whatever. So to have to get into these programs and stay for 30 days or 60 days and turn your whole life around.

The participation in substance abuse programs requires that women fully engage in a health care system that does not consider the ways in which their lives are shaped by gender norms and roles. As a result, some women, particularly those with children, may not be able access the health services they need. One of the early activism of Community Alliance was to advocate for substance abuse programs that was more family focused and allowed women the option to take their children with them the drug treatment therapy. The organization also advocated for child care support. Yet the focus on gender inequalities of substance abuse programs become more pressing when entire neighborhoods in Black communities are without substance abuse services.

Community Alliance serves African Americans living in regions of Washington D.C. with limited medical services, such as substance abuse. For example, Shelia, a staff at Community Alliance, explains:

> We're doing our mobilization project for Blacks in Wards 6, 7, and 8. We're looking at, through our gap analysis, what needs aren't available. For instance,

> most of the substance abuse programs aren't right in our community. We have to go into a different ward. A lot of the mental health, even though we have St. Elizabeth in Ward 8 isn't in our community for people living with HIV and AIDS. We have to go into another Wards besides 6, 7, and 8.

In an effort to deal with the lack of substance abuse programs in the neighborhoods it serves, Community Alliance was able to secure funding to provide transportation to other neighborhoods. Much like the busing strategies that were used after the civil rights movement to deal with education equality, transport residents in Wards 6, 7, and 8 to other neighborhoods that have health resources for substance abuse programs. The health transportation strategy is also used to connect people in the community to HIV/AIDS medical services.

Like Brothers United, Community Alliance responds to common economic barriers that prevent adherence to HIV/AIDS medication. For example, Community Alliance has developed an extensive list of partner organizations that provide economic and financial support services. These organizations include faith-based and other charitable organizations where people can obtain the basic necessities for survival such as food, clothing, and shelter. Damon explains that economic issues are often the primary concerns that the people in the community face, which often make adherence to HIV medication secondary to community members. He asserts:

> What we found is that, often times people in [the field of] HIV like to term anything other than HIV within itself as a secondary issue when actually in the individuals that we're servicing in their lives, those […] quote unquote secondary issues are really the primary issues in their life at that point. So

> what we've found is providing assistance with dealing with those secondary issues [such as the need for food, clothing and shelter] really makes it a lot easier for that individual to become engaged in care and remain engaged in care.

The needs of the community extend beyond integration into medical care. The response to basic human need such as food, shelter, and clothing is an important aspect of health. Without addressing this material need, Damon suggests that is it is often difficult for people to adhere to their medication.

While Damon focuses on the economic aspects of the needs of his clients, these needs are also shaped by race and gender. When providing HIV/AIDS medical treatment and care, Sandra explains that they come up against many structural inequalities. She notes:

> If I address HIV, I've got to address a myriad of other issues […] Because if I address your HIV status and I kind of have to address probably your history of underemployment, your educational attainment levels that is very low, probably got to address your housing issue, and probably gonna have to deal with the criminal justice system at some point, and that's a lot of shit.

As part of its response to the economic needs of the community, Community Alliance assists African American with accessing food from local charities as well as to provide employment opportunities for community members. Though Community Alliance has worked to represent the interest of African American women and their

communities, there are unequal race and gender power dynamics in the state that makes the work politically challenging and in many ways reinforces marginalization.

4.2.2 Marginalization of Black Women and Black Heterosexual Men

Much has changed for women since the 1990s. For example, women are now included within the disease paradigm. However, Sandra explains that women remain marginalized within the field of AIDS even two decades later.

> If you look around nationally, the national organizations that work on HIV issues are typically not run by women and particularly not run by women of color. I think that that's the big challenge. I think the level of equity on the national decision making playing field, I mean there is a reality about who makes the HIV/AIDS policy decisions for the advocacy community and rarely are those decisions being made by women, particularly women of color.

According to Sandra, the major decisions related to HIV/AIDS are "predominantly still by White gay men. I think that they are predominantly made by men who would be identified as gay or men who have sex with men." The limited representation of African American women in seats of power and influence with respect to HIV/AIDS becomes even more apparent to Sandra when she on rare occasions attends meetings such as those held at the White House Office of National AIDS Policy:

> I mean, it's rare that you walk into a room where honest and earnest decisions are being made and there's a woman particularly a woman of color there. I mean whenever I'm there, personally I feel lucky. I was in a conversation in a meeting recently with the new AIDS Czar [the director of the White House

> Office of National AIDS Policy (ONAP)] and I was really; 'cause when they called here and invited me to the meeting, I was like "are you sure you have the right person?"

Sandra explained that she was shocked to be invited to meet with the Office of National AIDS Policy because such meetings are typically only open to men.

Though African American women have limited political voice in terms of HIV/AIDS, their heterosexual male counterparts are viewed as having even less representation. Although women remain the key constituency group of Community Alliance, the organization expanded its constituency group to include African American heterosexual men, particularly those who are poor. Alexis speaks to the marginalization of African American heterosexual men in HIV/AIDS programs.

> I feel like the HIV field, there hasn't really been uhm any, there hasn't been a lot of attention or programing for heterosexual Black men, it's been like you know women, Black gay men, White gay men, youth, [and] transgender. Where are the heterosexual men in this conversation?"

According to Sandra, the marginalization of African American heterosexual men became apparent in the way that the local health department prioritized and distributed resources for HIV prevention:

> I think 5 organizations were funded in D.C. [in 2012], one for women, three for youth, one for African American men who have sex with men. Now what you miss in that paradigm there is nobody is kind of reaching out to African American heterosexual men who are who these women are typically gonna

> have sexual relationships with. So what are we doing, it's like where are our priorities

In the case of Community Alliance, African American heterosexual men become beneficiaries of the political action of women's organizations. This includes include the prevention of the sexual transmission of HIV/AIDS.

Unlike African American gay men and African American women, there has been less mobilization on the part of African American heterosexual men to mobilize to save their own lives from HIV/AIDS. The limited mobilization is tied to a general effort of the group to distance themselves from any association to being labeled homosexual. Damon, who identifies as African American heterosexual, explains:

> When you try to start a conversation with an African American man in the community about HIV, his very first response is going to be stand offish […] This is based on the messages around HIV which was for so many years coincided with messages of homosexuality or gay health […]. That [association with gay health] kind of puts people on guard to […] sort of to protect themselves from somebody thinking they're gay. So I think there is a level of homophobia in that people don't want to have the HIV conversation because they don't want to have to have the I'm not gay conversation.

The association of HIV/AIDS with gay men's health has served as a major barrier to community mobilization around the issue. While African American heterosexual men are at risk for HIV/AIDS, there has been less community organizing around that particular identity.

Community-based health organizations like Brothers United and Community Alliance have been mobilized to represent the interests of groups of African Americans whose lives, health and well-being has been devalued in the United States and their own communities. The organizations share similar origin stories in they were both formed in the period in which HIV/AIDS was still considered a death sentence and when there were little political and health infrastructure to address the needs of African Americans. As a consequence, Brothers United was forced to respond to the limitations of the single identity politics of predominantly White and Black organizations which failed to utilized their political platform and power to demand that the government prioritize the lives of Black gay men. Brothers United advanced the political interests of Black gay men by joining with a coalition or network organized at the intersection of race, class, gender and sexual inequality. Community Alliance similarly uses coalitions to present the interests of its constituents which includes African American women and African American heterosexual men—many of whom struggle with issues of substance abuse. While both organizations represent a particular constituent, Community Alliance's activism expanded beyond a particular constituency group to include the African American neighborhoods most impacted by HIV/AIDS. Through its mobilization efforts, Community Alliance draws attention to the lack of substance abuse programs and treatment.

4.3 New Hope Baptist Church: Saving Substance Abusers and Black Women

In this section I focus on New Hope Baptist's long history of activism that began in the 1960s. It is a member of the Progressive National Baptist Convention,

the Black Baptist denomination founded during the era of the civil rights movement to advance a religious voice for Black social justice. As part of this larger denomination, New Hope Baptist has maintained a religious tradition rooted in African Americans' collective fight for equality in the United States. For example, in the late 1980s, New Hope Baptist organized a protest that led to the boycott of a local business for its mistreatment of Black customers. The church was also at the forefront of the 1995 Million Man March—one of the largest social protests held in Washington D.C. following the civil rights movement. In addition, New Hope Baptist participated in electoral politics and the pastor of the church once campaigned to be mayor of Washington D.C.

When it comes to HIV/AIDS, the church maintains aspects of its political activist tradition. This activism includes two main strategies. First, New Hope Baptists provides direct services through its ability to secure government funding for its programs. Second, New Hope Baptist, through its connection with a larger faith-based coalition, works with others to advance the public health interests of their constituents. The key constituents are substance abusers and women. Two main issues are considered important for the use of church resources and support: include access to substance abuse treatment and HIV prevention programs for women and girls.

4.3.1 Representing People with HIV/AIDS and Issues of Addiction

Since the early 1970s, New Hope Baptist has been providing programs for African Americans who suffer with issues of substance abuse. Its substance abuse initiatives were important to the development of the church's HIV/AIDS program. In

recalling his reason for sanctioning the formation of the church's HIV/AIDS program in 1989, Rev. John Williams, the senior pastor of New Hope Baptist states:

> Well we had quite a few persons in the congregation who were HIV positive through our work particularly with the NA [Narcotics Anonymous] programs and other substance abuse programs, so from there we felt a need to obviously be involved and try to do something about the problem.

New Hope Baptist began its first substance abuse program in 1973, at the time the U.S. government began to disinvest federal funding in drug treatment programs. In 1973, the Nixon administration redirected resources from substance abuse treatment and begun to focus on initiatives that criminalization of drug use (see Donovan 2001). This change in federal government initiatives would develop into the War on Drugs Campaign which led to mass incarceration of African Americans in cities like Washington D.C.

In dealing with the issue of substance abuse and HIV/AIDS, New Hope Baptist utilizes two main strategies. The first includes securing government funding for people who are HIV positive and struggling with some form of addiction. For example, in 1999 New Hope Baptist drew upon the financial resources of the government to provide HIV/AIDS-related services to the church and the community. Rev. Williams explains, "[When] the whole epidemic began to grow and government began to put monies out to help, we put together proposals and took some of our properties […] and developed an AIDS program." The church was able to secure funding in large part because the level of expertise within its core membership. Rev. Julia Tar, who was the primary grant writer, had spent years working in other

community-based organizations to garner funding for HIV programs, particularly around substance abuse. Rev. Tar also has a degree in management and public relations and access to a network of people who worked for the D.C. government in their HIV/AIDS office. Thus in reflecting on the early mobilization to attend government resources, Rev. Tar recalls:

> The funding was more available to focus on our issues and doors opened based on relationships that I had established prior to coming to that position […]. So in 1998, a friend of my mine, as it was called HIV/AIDS Administration at the time District of Columbia Department of Health […], he brought me a RFP, request for proposals for funding and he said, apply. And I thought to myself. I had already been looking at that as a possibility, using government funds to support the work.

Between 1999 and 2012 New Hope Baptist has acquired over $3 million in funding to provide services to the community. Funding has been provided through the federal and local government such as the Office of Women's Health in the D.C. Department of Health. Other funding streams include established Black organizations such as the National Council of Negro Women, Howard University Center for Urban Progress, and HIV specific revenues like the Ryan White Part A and B funding.

Through these funding streams, New Hope Baptist could provide HIV/AIDS related services to clients, many of whom suffered with substance abuse issues. Rev. Julia Tar, explains: "As far as the population that we serve, I would say, over 60% of them has substance abuse issues." At New Hope Baptist, individuals suffering from issues related to substance abuse are provided mental health and drug treatment

services. Rev. Tar explains, "When we started providing services, the ideal was to […] have a professional here that could provide […] case management services, mental health services, [and] substance abuse counseling." These programs could be provided through funding from the D.C. Health Department, which has in the past allowed New Hope Baptist to hire a social worker and a psychologist who could provide one-on-one counseling for people living with HIV/AIDS and other issues like drug addiction. Moreover, since the majority of these individuals are poor or living below the poverty line, New Hope Baptists helps women and men to access public resources through the Ryan White program—the federal AIDS program that offers medical and economic support to people who are poor. This approach to HIV/AIDS is considered a part of the holistic HIV/AIDS intervention.

The second strategy used by New Hope Baptist to deal with issues related to substance abuse and HIV/AIDS is through its participation in a larger faith-based coalition and community organizations mobilized to represent the interests of people who are HIV positive, are formerly incarcerated, and dealing with substance abuse issues. For example, at an HIV/AIDS rally in the months following the 2012 International HIV/AIDS conference, Tammy, a member of the faith-based coalitions, stood in front of the Mayor's Office to speak on behalf of the faith community and the people they typically serve. Holding a "Effective Re-entry" poster in her hand, Tammy offered a testimony on behalf of the faith-based community working with people living with HIV/AIDS. "The faith community has a huge role in the epidemic regarding HIV. […] Most places of worship have people who are returning home from incarceration, people dealing with substance abuse, people who are dealing with

all the social issues." Mary, who helped to organized the rally, speaks to the challenges that many African American men and who are formerly incarcerated face as they seek treatment for HIV/AIDS.

> We have about 2500 men and women returning every year from the mandatory sentencing. […]. So we've got a huge population of men and women who are coming back to D.C. some of whom have been away for 20 years. Some only 10 years, but they don't know […] where to go for treatment. Some of the places are newer than others. Or if they knew a place, […] maybe they're gone now.

Unlike like other secular organizations, the Black church is one of the most stable institutions in African American communities. Some returning from prison after a mandatory minimum sentences for drugs and other crimes have turn to the church for information and heath support.

While churches such as New Hope Baptist helps people to gain access to medical services, the issues that clients face after returning from prison is something that is often not addressed by the government. By joining with a larger coalition of activist organized to pressure the D.C. government to improve HIV/AIDS care, Tammy draws attention to the limitation of the larger public health focus on biomedical interventions as the main tool to address the epidemic in Washington D.C. She says:

> While HAHSTA [HIV/AIDS, Hepatitis, STD and TB Administration, in Washington D.C.] has viral suppression as part of its goals; they are leaving out the very people they need to make contact with. How can you reduce

> someone's viral load if they're dealing with substance abuse and they have no housing, if they're dealing with some incarceration issues, court and all those different types of things [which] supersedes […] connecting in treatment, getting care, and staying into medical care? So the faith community wants to rally around and say we are a part of this and pushing and demanding that there is a comprehensive strategy that needs to address all people.

In reflecting on the role that the church can play in addressing the epidemic, Tammy states that the faith-based community has begun to make demands on their government to represent the interest of groups left behind by the government and its response to HIV/AIDS. The mobilization for effective re-entry is connected to ACT UP, the AIDS movement that begun in the 1980s and 1990s but that declined after its majority White middle class gay membership successfully got the federal government to provide resources to develop effective HIV/AIDS treatment to prevent HIV/AIDS related deaths and discrimination. The connection to ACT-UP was seen through the symbols used at the demonstration that said "ACT-UP to end HIV/AIDS." In addition, after Tammy made the demands on behalf of the faith community, one of the leaders of the demonstration utilized the mantra that had been prominent during the HIV/AIDS movement in the 1980s and 1990s. Through a megaphone the leader who had been a longtime activist and part of the ACT-UP movement, shouted in a call and response cultural practice similar to that used in many Black churches. She said, "When people with AIDS are under attack, what do we do?" The demonstrators responded "ACT-UP Fight Back!" Tammy drew attention to the larger public health policy which has emphasized treatment to reduce and control the level of HIV viral

load in the body. Treatment had been a part of the larger emphasis of the AIDS activist since the beginning of the HIV/AIDS movement in the United States. However, for Tammy, the government needed to deal with the larger structural issues that impact poor African Americans living with or at risk for HIV/AIDS such as the impact of the criminal justice system.

Overall, New Hope Baptist has since the 1970s deployed institutional resources to serve African American substance abusers--a group who have been viewed as socially deviance and unworthy of government resources to protect their health and well-being. With the discovery of the HIV/AIDS epidemic in the 1980s, New Hope Baptist has worked to become politically engaged in the process of representing the interests of members of the church and community who struggled with substance abuse. While much of the political action involves securing government resources for the expansion and development of substance abuse and mental health program, its activism also includes the participation in larger faith-based coalitions that draw attention to the ways repressive practices within the criminal justice system directly affects the health and well-being of people living with HIV/AIDS. In addition to addressing the political and health needs of substance abusers, New Hope Baptist has also mobilized to represent the interests of African American women.

4.3.2 Representing Black Women: HIV/AIDS Prevention

African American women represent the majority of the members of New Hope Baptist church. Women not only occupy positions as members, they also hold key leadership positions as pastors in a church and denomination that has historically

denied African American women access to the pulpit. To illustrate, the senior pastor of New Hope Baptist defied the sexist religious traditions of the Baptist denomination by ordaining its first woman pastor in the 1970s. For this act, the church as was ousted from the local Baptist denomination for which it belonged. New Hope Baptist would continue the tradition of representing the interests of African American women through its activism in the mobilization against gender inequality in HIV/AIDS policy.

Much of New Hope Baptist's activism for HIV/AIDS has included demands for political representation and integration of groups such as African American women. Rev. Tar, the director of New Hope Baptist's HIV/AIDS non-profit, explains that she was among a small group of women leaders in the 1990s who mobilized to fight for the political representation of African Americans in general, and Black women in particular. In many respects, New Hope Baptist was a part of the first wave of HIV/AIDS activism that demanded that women were granted full citizenship rights in the field of HIV/AIDS particularly as public health reports indicated a growing epidemic among African American women since the early 1990s. Rev. Tar recalls, "Statistics was showing at that point [the early1990s] that the HIV transmission among African American women was rising and within a 10 year period between '94 and 2004 women and […] heterosexuals went to being the majority of the new cases in the District of Columbia." Prior to the 1990s, HIV/AIDS was still considered a white gay and male disease.

Though women made up a growing share of the epidemic, they lacked the political power and platform to advance their own needs and interests. According to

Rev. Tar, during the early 1990s there were few women at the table where key decisions were being made as it related to HIV/AIDS. Most of the key decision makers and AIDS advocates in the local health department in Washington D.C. were primarily men, particularly White gay men. Thus in recalling her political activism in HIV/AIDS, Rev. Tar explains, "I was in a minority in that I was a woman and heterosexual at the table […]. So I mean, my presence was challenged in that African American women weren't thought to be an at risk population at the time." Given the underrepresentation of African American women in HIV/AIDS policy and programs, Rev. Tar recalls using her position to speak up for Black women's access to HIV information, support, and preventive services. She asserts, "As far as women were concerned, I had to lead in sense of this is how we're going to this outreach to women and be adamant about it. […]. We decided to go where women were, beauty salons and to church and anywhere else in between." In addition to pressuring the local health departments to expand its health policies to include African American women, Rev. Tar worked to ensure that such programs were implemented in local Black churches and Black hair salons.

One of the standard public health approaches to disease prevention is to develop a multimedia campaign to raise public awareness about a threat of a disease. With a background in public relations and organizations, Rev. Tar was well suited to take on the challenge of ensuring that African American media outlets, Black churches, and Black businesses were involved in this new HIV/AIDS awareness campaign. Rather than merely changing the faces and images of HIV information developed for and by White gay men, Rev. Tar used her knowledge and expertise as a pastor and her

education background in public relations to develop HIV health messages for the wider Black church and beauty salon. This activism was done in collaboration with African American pastors as well as Black hair stylists.

Another area of activism consisted of efforts to gain public health funding to carry out HIV/AIDS prevention for women and girls. While Rev. Tar collaborated with African American church leaders — mainly males in the first wave of collective action — she deployed the assistance of her teenage daughter, Nia, and other women in the church in the following wave of AIDS activism. In 2010, New Hope Baptist received funding to carry out an intergenerational HIV prevention intervention. The program was funded through Office of Women's Health. This intervention was part of Nia's senior high school class project. It was also done in collaboration with New Hope Baptist's self-help women's rite of passage program.

The funding from the Office of Women's Health (OWH) empowered women and girls in the church but is also fostered some gender disempowerment. With respect to the former, New Hope Baptist served as a mechanism for both teenage girls and their mother figures to learn to communicate about safe sex and other issues they faced in their daily lives. However, Nia explains that the church experienced political barriers when they tried to expand the program resources to include boys, a group both she believed also needed information and support. In reflecting on her initial vision for her HIV prevention high school senior project, Nia states:

> I didn't want it [the safe-sex programs] to be as structured as it turned out to be. [I] just want it to be like a rap session, more than a structured class [that was] open to males and females in the neighborhood. […] But with […] the

> straight talk grant was only for females. […] I didn't have a target population; I just knew that I wanted to work in Washington D.C. But they [OWH] said that you had to pick a minority group in the city.

Since the funding was provided through a woman's health agency, New Hope Baptist could only administer HIV/AIDS prevention interventions to African American women and girls. In discussing the nature of this political limitation, Rev. Tar asserts that her vision was to implement gender-centered programs that focused on the sexual health needs of women and girls, but then work to show the government and other public health organizations that there was a need for inclusion of boys and men in HIV prevention programs. However, before she could plan to justify the expansion of the HIV prevention program to include boys, the federal government made cuts to HIV prevention programs. Due to sequestration, New Hope Baptist lost what would have been a three-year grant to implement HIV prevention programs in the church and community.

In summary, New Hope Baptist has a long history of activism that begun in the 1960s. When the crisis of HIV/AIDS became apparent in the church through its substance abuse program, the pastor of the church sanctioned the development its HIV/AIDS initiative in 1989. Much like Brothers United, the action of the church includes efforts to attain funding for HIV/AIDS programs and services. In addition, much like the secular or community-based organizations, New Hope Baptist tied to coalitions have been important for the representation of substance abusers and women. However, there has been less political advocacy on the part of New Hope

Baptist to represent the interests of African American men—particularly African American gay men.

4.4 Greater Faith Ministries: Saving Black Gay Men and the Black Community

In this section, I focus on the activism of Greater Faith Ministries, the second church in this study. Much like New Hope Baptist, Greater Faith Ministries can be regarded as an activist Black church. However, unlike New Hope Baptist that has its activist roots civil rights, Greater Faith Ministries helped to create a new religious movement around African American LGBT rights. Greater Faith Ministries emerged out of the Unity Fellowship Movement—a network of Black religious leaders and churches that arose in the 1980s during the height of the AIDS epidemic. One of the earliest representations of such churches includes the predominantly White Metropolitan Community Churches (MCC) founded in the late 1960s (Kane 2013). Though White LGBT religious organizations such as MCC existed more than two decades before Greater Faith Ministries was formally established in 1993, the Unity Fellowship Church was founded in the 1980s. Greater Faith Ministries displays its connection to an African American religious tradition through the Afrocentric symbols and rituals represented in the church along with the dress and actions of the members.

Given the impact of HIV/AIDS among African Americans in general and African American LGBT in particular, Greater Faith Ministries has deployed its institutional resources to challenge the local health department to improve its response to HIV/AIDS prevention. Greater Faith Ministries adopts two main

strategies. The first includes securing HIV/AIDS funding from the government. The second includes shaping public health knowledge about Black sexuality.

4.4.1 Representing Black LGBT People and Community

Like New Hope Baptist Church, Greater Faith Ministries mobilizes resources to address the HIV/AIDS epidemic by applying for government funding. According to Bishop Jones, the senior pastor of Greater Faith Ministries, the church's work on HIV/AIDS is rooted in social justice. Thus the rationale for securing funding for HIV/AIDS was to expand the work they were already doing in the church and community. He states:

> The social justice piece is whatever you do onto the least you do unto me. So how can we have our brothers and sisters who are ill and not be the best that we can. Now we recently for the first time applied for a grant, to do HIV work. Before this all of our HIV work was simply a part of our health ministry and we worked out of pocket. And someone finally said listen, why don't you apply for this money. So we develop an AIDS ministry and apply for the money

In 2011, Greater Faith Ministries was the recipient of two different grants, each amounting to $10,000. These monies are directed to a different group—Black LGBT youth and the larger Black community.

The first grant which focused on LGBT youth is part of the larger initiative by the faith-based coalition for which Greater Faith Ministries. The coalition of mainly Black churches decided to allocate faith-based resources to LGBT inclusive churches such as Greater Faith Ministries. Dr. Dawn Carr, the manager of this faith-based grant

for which Greater Faith Ministries is a recipient, explains that the money was part of a larger initiative to do advocacy for LGBT youth. She states:

> The [faith-based grant] project is through the Advocates for Youth, through their anti-homophobia and transphobia project. So we do give them [churches] some training around […] what a safe space should look like. […]. The biggest thing is that you want to create an environment where they [LGBT] feel safe, where they feel like they can express themselves within their gender identity without fear of violence fear of verbal abuse. […] So like I said in my assessment of trying to do it within the churches, the churches should be able to do that and so these particular churches are doing projects that exemplify […] creating that space for youth.

In order to carry out the goals of this larger initiative, Greater Faith Ministries offers events to foster safe spaces. For example, they organize cultural events such as poetry competitions. These poetry events provide opportunities for youth to have fun at Greater Faith Ministries. However, they did not provide training for youth to advocate for themselves.

The second activism effort that Greater Faith Ministries participated in relates shaping the knowledge construction HIV risk for Black gay men and youth. Given the continued devastating impact of HIV/AIDS among African Americans, public health experts have looked for answers through quantitative and qualitative research. The knowledge produced from these studies is typically presented in journal articles and public health conferences. As a representative of Greater Faith Ministries, Jones explains that he has attended a number of AIDS conferences. These conferences have

historically served as venues to expand the church's network. It is also a site to learn about, improve, and contest scientific knowledge. With respect to the production of public health knowledge, Jones recalls contributing to conversations about HIV risk – particularly the elevated rates of HIV/AIDS among youth and seniors. Bishop Jones explains:

> One time I was at a conference and this woman was presenting. She was from the Health Department and they noticed that there was a rise in young adults and teens and seniors. But the middle had sort of leveled off. And she said, "we can't figure out the answer." She said, "Does anybody have the answer? I would love to know." And said that's not a rhetorical question, "I'd really love to know." So I hollered out, "payday!"

Rather than focusing religious rhetoric which tend to connect sex to immorality and sin, Jones drew attention to the economic factors that contribute to HIV risk, something that he explained eluded this public health expert. He goes on to say:

> So she came to me and said, "What did you mean by that?" I said on payday seniors cross that middle group and go down to the teens and have sex. Teens have sex with the seniors. It's called situational sex; if you get put out your house, if you don't have the latest clothes or whatever. It's not the middle group that got the money, it's the senior. So they skip over, or have sex over here on payday and go back into their community. […]. She was like, "oh my God. We didn't think of that." I said, because you're up on the Ivory Tower, come down in the street. Everybody, I said didn't you notice there was a

> group that was laughing, those were all addicts. Those were all addicts or people in recovery. They knew immediately what I was talking about.

The development of HIV knowledge and discourse on risk has historically focused on individual level behavior outside of the larger socioeconomic context. In this case, the pastor of Greater Faith Ministries was able to provide a public health expert with insights about the economic drivers that might lead youth to engage in unprotected sex with older individuals. The factors he identified were related to poverty, family rejection, or homelessness.

4.4.2 Representing the Larger Black Community

As mentioned above, Greater Faith Ministries politically represents the interests of its constituents through founding from government agencies. While the first funding source focuses on a specific population, its second funding source is geared towards the larger Black community and emphasizes community mobilization and education. As Rev. Martin, an assistance pastor at Greater Faith Ministries explains:

> [The grant we received is] is the Effie Barry Grant. It is kind of helping us to create [our community outreach program]. Bishop had the idea of creating small groups where one group goes out and train [about HIV/AIDS] in the community. And so it involves outreach where we're distributing condoms. We are having testing done every fourth Sunday. And so it's basically, to create groups at the church and to provide counseling services and group service.

The Effie Barry grant is part of the Washington D.C. government's, faith-based HIV/AIDS initiative. This grant is intended to help the church develop its AIDS ministry in a way it could have broader reach and impact in the community. The focus on community mobilization is considered particularly important since Greater Faith Ministries is located in Ward 8, the neighborhood with the highest HIV/AIDS epidemic rate in the city. Thus for this initiative, Rev. Jenkins explains that the goal is to be broad reaching:

> Our focus on this particular grant is for Ward 8 and subsequently Ward 7, and it is open to everyone. We are concerned about a lot of things as the District is. We are concerned about the amount of young people who are contracting the virus. We're concerned about the high numbers of seniors that are contracting the virus. We are really concerned about the high numbers of Black gay and bisexual men that are contracting the virus and also the number of women that are contracting. So as it relates to HIV work, it relates to everyone. The goal is to eliminate the epidemic so they're no more new infections.

The focus of this outreach initiative is to develop training for people who can become HIV/AIDS health educators for the larger Black community that reside in Wards 7 and 8—the two regions of the city most impacted by HIV/AIDS. These regions are also disproportionately Black.

Though the church provides a safe space to deal with issue of religious homophobia, Greater Faith Ministries also works in a faith-based coalition to mobilization Black churches to address the epidemic in their church and

communities. One of the focus of the coalition is to expand congregation access to health information by training the pastors and lay leaders of other Black churches. Though the work of Greater Faith Ministries involves acts of institutional mobilization for non-responsive Black churches, religious homophobia limits the extent to which openly gay religious leaders can influence their religious peers. To illustrate, Bishop Jones describes the religious discrimination he faced while working the coalition.

> When I was in a meeting one time and there were all pastors […] they kept referring to me as brother […]. So I raised my hand, I said excuse me […]. Are you referring to everybody else here as reverend and me as brother? Why? He said, "there are those of us that would not recognize you as an ordained minister given that you are a practicing homosexual." I said, first of all I'm not practicing, I got this down [laugh]. I'm long past practice. [laugh] I didn't come here looking for your approval. I said, this ministers meeting was about HIV work. I've done more HIV work than all of you put together. […] I've trained your ministry. I trained your ministry and I trained your ministry […]. So are we here to talk about HIV and how to save our people or are going to go into a theology pissing contest. He said, "well brother." I said, brother? I said this meeting is over.

Though Bishop Jones is an ordained pastor, his moral legitimacy and authority was questioned or contested in the meeting to mobilize churches to respond to HIV/AIDS. Jones' experience shows how difficult it might be for people who may have the skills,

knowledge and expertise to empower the black church and community around AIDS, yet might be stunted due to conservative moral ideology.

In summary, Greater Faith Ministries was created to provide a safe and affirming religious space for African American LGBT people. Like New Hope Baptist, Greater Faith Ministries has been able to politically represent its constituents by securing funding for HIV programs that are LGBT focused. However, there are great differences in the resources that Greater Faith Ministries has acquired relative to New Hope Baptist.

4.5 Conclusion

Throughout the history of the United States, African Americans have been politically, economically, and socially disenfranchised. Since African American disenfranchisement exists at the intersection of race, class, gender, and sexual inequalities, African American organized mobilization requires the development of intersectional activism traditions that prioritize all Black lives. As mentioned in chapter 2, the most powerful Black organizations have privileged the political and economic interests of the Black middle-class and heterosexual men. They have also maintained survival politics which reinforce economic, gender and sexual inequality. In response to the needs and interests of their constituents, the organizations in this study developed a survival politics of HIV/AIDS that is more oppositional than is typically discussed in the literature.

Of the four organizations in this study, Brothers United was the most politically mobilized to end the epidemic of HIV/AIDS in Africa American communities. In its representation of the political interests of African American gay

men, Brothers United deployed the resources of a larger network of organizations to build coalitions powerful enough make demands on the government to prioritize the material and health needs of Black gay men given the continued neglect of both powerful Black organizations and White gay organizations. Though less politically engaged than Brothers United, Community Alliance also advanced a Black survival politics at the intersection of race, class and gender. Despite its lower political engagement, Community Alliance altered aspect of its organization to expand its key constituency group to include heterosexual men. Moreover, Community Alliance's activism included the larger Black community—particularly poor Black urban communities which have fewer economic and health resource available to African American women and men who struggle with issue of substance abuse. Given the focus on multiple constituents and poor Black neighborhoods, Community Alliance has worked to represent a broader segment of the African American community affected by HIV/AIDS than its secular counterpart, Brothers United.

Historically, Black churches have played a central role in African American activism and the responses of the two churches in this study indicate that some Black churches may be able to maintain this oppositional tradition in response to HIV/AIDS. Though less politically engaged than both Brothers United and Community Alliance, both New Hope Baptist and Greater Faith Ministries are politically mobilized. For example, through its faith based coalitions, New Hope Baptists has fought for the government to expand HIV/AIDS health care resources and services for African substance abusers and African American women. The political advocacy for African American women was particularly surprising given

that the church has historically maintained conservative religious traditions in matters related gender and the sexual health of women and girls. When compared to New Hope Baptist, Greater Faith Ministries is even more oppositional in its political engagement as it relates heterosexism. Greater Faith Ministries not only represents the political interests of the Black LGBT community, it also actively works to secure government funding to expand its HIV/AIDS programs and services for the group that has had the least power and support in Black churches.

Chapter 5: Access to Life Saving Technologies for HIV/AIDS: Responses to Deviance Related to Rapid HIV Tests and Condoms

In the previous chapter, I examined organizational strategies to expand HIV/AIDS-related political representation of African Americans with multiple second-class citizenship status. I argued that political representation and funding are key components of Black survival politics of HIV/AIDS. Chapter 4 examined how the four organizations engaged a Black survival politics by *representing* their constituencies to external institutions—particularly the local and the federal government. In contrast, this chapter focuses on services that these organizations provide *to* their constituents by examining the efforts to improve community access to HIV-related health technologies or what is also regarded as biomedical technologies. By discussing how the organizations provide rapid HIV tests and condoms for their constituents, I examine strategies that aim to mobilize and empower their constituents. This chapter thus depicts another aspect of the Black survival politics of HIV/AIDS.

Given the history of medical apartheid and disinvestment in the U.S. health system, African Americans have often had limited access to quality health technologies and care services relative to their White counterparts (Smedley, Stith and Nelson 2003). The denial of health care services has included lack of access to health technologies. In this context, one key component of the Black survival politics of HIV/AIDS has been to improve access to and use of biomedical technologies. Rapid HIV tests are an example of a biomedical technology used to diagnose HIV. The test is also a pathway to help health providers improve access to the treatment

and care services needed to lead long and healthy lives with the disease. Because they prevent the sexual transmission of HIV, condoms are also an important tool for survival. Yet these biomedical tools are not value neutral.

Rapid HIV tests and condoms offer life preserving potential but they also reify social, sexual, and health deviance. Since its official discovery in 1981, HIV/AIDS has been associated with people with a history of substance abuse, gay men and prostitutes (Treichler 1999). These groups have been branded as social and sexual deviants. Some have also been stigmatized as medically deviant since they seemingly fail to conform to health norms and practices (Lupton 2003). The four organizations in this study address this issue by themselves by directly providing health care delivery services.

This chapter examines the strategies that these organizations use to respond to the stigma associated with HIV/AIDS by providing access to technologies to improve the social and physical health of their constituents. First, I provide an analysis of efforts related to rapid HIV tests. Although the Black churches serve as mechanisms for the delivery of rapid HIV tests, I found that relative to the community-based organizations faith-based organizations only occasionally provided this service, primarily because they had limited resources. As a result, in my discussion of rapid HIV tests, I exclusively focus on the community-based organizations since the rapid HIV test is one of the main health care services that they offer to their constituents. Second, despite the fact that community-based and faith-based organizations both offer health programs concerning condom use for HIV/AIDS prevention, I examine the two Black churches' approach towards the use of condoms. Historically condoms

have been viewed as secular health tool that is forbidden in many religious settings. However, both New Hope Baptist and Greater Faith Ministries work to alters aspect of their religious traditions related to condoms and sexual health.

5.1 Rapid HIV Test: Resisting Social, Sexual and Health Deviance

One of the hallmarks of modern medicine and public health is the development of biomedical technologies to improve health care services and to expand the longevity of life. Health screening technologies are particularly powerful because they allow medical providers to identify diseases in the body long before they become symptomatic (Klawiter 2009; Sontag 1989). The biomedical technology of rapid HIV tests is one among many such technologies because it tests for the presence of HIV antibodies in a seemingly healthy person. The first oral rapid HIV test was approved by the FDA in 2002 and was considered to be a major breakthrough in biomedical science, since earlier HIV testing technologies required patients waiting for 10 days to 2 weeks to know their diagnosis (Nearing 2009). In contrast to the first tests, which required a blood specimen and were restricted to facilities with professional clinical laboratories, rapid oral HIV tests detect the antibodies of HIV in the oral fluid specimens of patients and provide a preliminary diagnosis within 20 minutes. Moreover, these tests are small mobile technologies, which, as I will show below, allow community-based organizations to democratize one aspect of an unequal health care system. By providing access to HIV rapid tests, I also examine how community-based organizations continue a tradition of expanding health related services to African Americans who have been regarded as socially, sexually, and medically deviant.

5.1.1 Community Alliance: From Abortions to Rapid HIV Tests

Community Alliance is rooted in the reproductive health tradition, which has galvanized a movement to resist gender normalization in a society and medical system mainly controlled by men. Yet, given the early failure of the women's reproductive health movement to mobilize resources to save the lives of poor women of color living with HIV/AIDS, the leader of Community Alliance largely severed ties from this health movement.[11] Despite this experience, Community Alliance maintains aspects of its oppositional health tradition. For example, Community Alliance is currently located in a building that once housed a reproductive health clinic that offered abortions, a health service for women who are often regarded as socially deviant. Pointing to dents in the bars that protect the windows of her office, Sandra Nelson, the executive director of the organization, explains that these are the damages from pro-life activists. Sandra says, "See that window, that's from the bomb they threw in the building." When discussing the damage in the window, Sandra speaks with a level of nostalgia. "I feel like we've come full circle. […] When we were looking for a place to relocate [as the organization began to grow], I just knew it was the right place because I found one of our old brochures in one of the old cabinets." Although Community Alliance does not provide the full services and biomedical technologies of a reproductive health clinic, it does offer an important health care service through its free rapid HIV testing. Community Alliance employs three main strategies to address both social and health deviance associated with rapid HIV tests: (1) it provides training for individuals to become health care providers; (2) it provides HIV rapid testing through extensive community outreach; and (3) it

educated families and community members as a way of addressing the stigma associated with a positive HIV diagnosis.

The first strategy includes training lay individuals to administer rapid HIV tests—particularly African Americans with a history of substance abuse and incarceration. After receiving a grant from the Substance Abuse and Mental Health Service Administration (SAMHSA) in 2009, Community Alliance began a health-training program to develop medical skills and expertise among African Americans in Washington D.C. neighborhoods with the highest epidemic rates. As Carol, a staff member and graduate from the training program explains, "we ensure that everybody that participates in the [training] program has either a history of incarceration or history of substance abuse because that is a huge part of our target population." In the communities that Community Alliance serves, many residents contract HIV through substance use. Since drugs such as crack and heroin are criminalized in Washington D.C. and nationally, African Americans who use these illicit substances often become the target of harsh penalties of the criminal justice system and the federal War on Drugs Campaign (Alexander 2010).

African Americans who use and sell illicit drugs are not only at high risk for HIV/AIDS and incarceration but they are also viewed as socially deviant and unproductive members of society. However, Community Alliance sees them as having a particular expertise and/or knowledge that many traditional medical providers may not have. Delroy, a staff member and graduate of the HIV training program who has a felony record explains:

By being ex-offenders we're dealing with a lot of people who are in the street

> life. So you can come from a perspective of "I've been out here too." I know everything you been through. I done probably pretty much everything you did to a certain extent. I've never been a substance abuse user […] but I sold substances. […] I used to sell you stuff so I know what you're going through. It gives you a better insight of the mentality of a person and being good at tracking people like that because you know the signs.

Via its programs, Community Alliance empowers the group by training them how to use their existing skills to track people who may be unaware that they are HIV positive and administer the rapid HIV tests.

The HIV testing training program does more than empower African Americans with a history of incarceration and substance abuse to become health providers -- its work is a direct response to the larger racial and economic structures that exclude members of the community from the formal job economy. To illustrate, the main constituents of Community Alliance reside in neighborhoods with few employment opportunities. As Sandra explains: "Here at the East of the River in D.C., there are so few employment opportunities. And like I said, the folks that we hire, many people would not take a second chance on, but they are the greatest ambassadors of health." Given the limited employment, some are forced to turn to the drug economy to provide for their families. Damon, the head of field operations and testing explains, "I had an interesting life prior to working in HIV/AIDS. I had a criminal background let's say that. So I spent some time away. […] But honestly getting in the HIV [industry] was for all intents and purposes my first real job or career or employment. I was always doing what I did to make ends meet."

It is important to remember that the HIV/AIDS movement is rooted in a grassroots and professional activist tradition whereby those most impacted by HIV/AIDS become a part of the medical field as health experts (see Epstein 1996). Through Community Alliance, individuals like Damon become part of this history. However, the focus of the activism is not merely to work to address health disparities of HIV/AIDS but rather to also deal with some of the racial and economic inequalities that the staff of Community Alliance faces in their communities.

The second strategy of Community Alliance includes providing HIV rapid tests in multiple community settings. By doing so through community outreach, the organization challenges views that their constituents are medically deviant. Denise, an outreach worker at Community Alliance, explains the importance of HIV testing. "It's [HIV testing] the most important part of this organization, because if you don't get tested then you don't know." The HIV tests allow clients to become aware of their new health status in order to seek and receive care services to lead long and healthy lives. Since African Americans often are diagnosed with HIV/AIDS at the late stages of the disease, the focus on early detection is an important aspect of health mobilization to prevent deaths due to HIV/AIDS. Consequently, Community Alliance works to ensure that African Americans who are unengaged in the health care system have access to medical services in ways that focus on community health outreach than the traditional medical service which often requires that patients seek out health care services on their own. As Sandra explains "We don't wait for an individual to come in and say give me a test, we go [to them]." Thus one of strategies used by Community Alliance is to offer testing services in non-medical settings.

Given its small size and mobility, the rapid HIV test allows Community Alliance to administer the test anywhere in the community. Some of the testing sites include shopping centers, the local DMV, popular street corners where people hang out or the church. Damon explains that rather than being non-conforming to HIV testing services people often welcome the opportunity to receive these services. He states:

> What we find is that people are really receptive to it [the HIV street corner testing service]. […] [A] lot of people that we come across wouldn't get tested if it wasn't in that way. Because these aren't people who are generally going to go to a health fair, or wake up in the morning and say "yeah, I think I'm gonna go across town to the clinic and have an HIV test did today." So it's definitely a service that's very well received. It's been very successful organizationally for us, last year we tested over 10,000 people using this strategy.

This medical service is free to community members interested in learning their HIV/AIDS health status. In addition, Community Alliance offers small financial incentives to people who volunteer to become tested and engaged in HIV/AIDS related care. These incentives include $15 gift cards to grocery stores or the local CVS. These tactics provide positive reinforcements to encourage clients to become tested for HIV. Since the population they serve are in communities where many live below the poverty-line, these small incentives are important to help the organization increase the number of people who become aware of their HIV/AIDS status.

Finally, the third strategy employed by Community Alliance is to educate families and community members to be more informed about the meaning of a positive HIV diagnosis from testing. Via community education, Community Alliance helps addresses the stigma and alienation that people living with HIV may face by expanding the support network for those living with HIV/AIDS.

Medical sociologists have long argued that sickness is a form of social deviance because it often prevents people from carrying out their typical roles in their family, jobs and communities (Conrad 2006, Parsons 1951). The diagnosis of HIV/AIDS is regarded as particularly deviant. In addition to providing access to biomedical technologies such as rapid HIV tests, Community Alliance also deals with the experiences of social rejection that some of their clients face, particularly in their closest relationships such as their families. Delroy, one of the staffers that ensures clients are provided with the resources to seek and adhere to HIV treatment after diagnosis explains:

> [Some people believe that] if I touch you, I'mma get it. If I interact with you I'mma get it. Are my kids safe around you? I mean, just so many [other] different stigmas, you basically can […] miss out on a lot of opportunities, not just in the workplace but with your family. Cause your family can start acting another type of way towards you.

In order to respond to the stigma in the community, the staff is trained to educate people about the modes of transmission. Delroy explains that he had provided education to entire families of people who are HIV positive.

> I've talked to families, if the client asks me, I will go in the house and talk to

the whole family and let them know how to protect themselves against it [HIV]. And let them know that you can hug your mom. You can kiss your aunt, [if[she kisses you on the cheek you not gonna get HIV. If you drink out the same glass you not gonna get HIV; it's not transmitted through saliva.

Though Delroy provides education to family members, this is not the typical approach to education. Most education is done through short information sessions with the people who seek HIV testing services or when the organization does informational sessions at an HIV/AIDS event in the community.

5.1.2 Brothers United: Support and Pride for Black Gay Men

In this section I provide an analysis of the ways Brothers United, the second community-based organization in this study both provide rapid HIV testing services and deals with the stigmas associated with HIV/AIDS. As mentioned in the previous chapter, Black gay men living with HIV/AIDS established Brothers United in the mid-1980s. While the organization primarily serves gay men, there are only few symbols and images that represent the history of the organization related to sexuality. For example, there are no rainbow flags that are typically displayed in many organizations servicing gay men[4]. While there are no rainbow flags to symbolize gay pride, Brothers United distributes fliers with photographs of Black men. Some of these fliers include images of men in Afrocentric clothes. Moreover, Brothers United is grounded in a long tradition of collective resistance to heteronormativity. The organization grew out of an African American dance club created in 1975 to provide a place for African American LGBT people to transgress the heterosexual

[4] Historically, the rainbow flag symbolizes gay pride and a resistance to the deviant frame that is typically associated with homosexuality.

normalization in their families, church, and community to respond to the systemic racism in White gay organizations.[5]

In the following paragraphs, I examine the ways Brothers United carries on the tradition of transgressing sexual and health deviance with HIV testing and diagnosis. I analyze three main strategies employed by Brothers United to provide direct health care services to its constituency: (1) access to rapid HIV tests, (2) psychological counseling for men with an HIV/AIDS diagnosis, and (3) group based support for men with a positive and negative diagnosis.

Brothers United serves as a mechanism for African Americans to be screened for HIV. According to Raymond Sage, the executive director of Brothers United, "We do about 2000 HIV tests a year, mainly dealing with homosexuals because of the numbers." To ensure that community members are integrated in the health care system, Brothers United conducts routine rapid HIV tests both in and outside their main office. To recruit clients in their office for services, Brothers United use various media and social media outlets. They also administer rapid HIV tests at local events such as Black Pride, an annual Black LGBT festival in Washington D.C.

The leaders of other Black cultural events also actively partner with Brothers United to provide HIV testing services to their constituents. To illustrate, Chris, an outreach staff worker who is actively involved with the local Black theater and arts network, discusses one of the processes through which Brothers United provides HIV testing services in the large Black community.

[5] The club closed its doors in the early 1990s but Brothers United carries on the traditions in the new millennium by providing access to HIV testing technology and support services.

> Just the other day we had a meeting with the leaders of a local Black theater festival so that this organization [Brothers United] can serve as the primary community-based organization that will provide HIV/AIDS testing at a lot of the events and some of the events connected at the festival.

Brothers United provides HIV testing services in spaces outside of traditional medical settings, in the places where African Americans meet and socialize. This strategy is part of a larger effort to reduce health disparities in the Black gay community but to also respond to what is often considered in public health as African American's failure to conform to normal health practices.

The second strategy used by Brothers United is to provide professional mental health services to Black gay men diagnosed with HIV/AIDS. The primary mental health provider is Gina, an African American clinical social worker who was in part interested in working at Brothers United because she has a son who was gay. She explains, "Because my son is a gay man, which makes him a part of the high risk population, (…) I think that was initially the personal interest in wanting to do whatever I could to ensure that my son stayed negative." Within the broader HIV/AIDS epidemic African American women like Gina often use their identities as mothers to ensure the safety and protection of their children and families.

The mental health therapy at Brothers United primarily serves African American men who are gay, have an HIV positive diagnosis, and experience difficulties dealing with the stigma of their sexual orientation and their health status. Gina explains how some men deal with the experience of dual stigma. "Often what I've heard many clients say that it's [like] having to come out twice. They have to

come out to their families about being gay and now they have to come out about being HIV positive." Using her training in clinical social work, Gina helps clients understand the social process of the stigma related to their sexuality and health status and help them become empowered or re-empowered to embrace their sexual and health identity. She describes this therapy as a form of social death and grieving of self. Gina notes:

> It is a loss of a perception of one's identity […] one may see themselves as a healthy individual. If you are diagnosed with an illness then, you may still be healthy but nonetheless you have an illness […] and it's a loss of ones' identity.

The issue that African American gay men living with HIV/AIDS face is the general concern about how to cope with the stigma of being a person living with HIV/AIDS. Yet to achieve the position of an empowered individual Gina argues that they must first become at peace with the new identity.

The third strategy that Brothers United uses to deal with HIV/AIDS-related stigma is to provide a community setting for men who are HIV positive as well as for those who are negative. Brothers United provides emotional and mental health support to Black gay men living with or at risk of HIV/AIDS. However, Brothers United have a support group session Mondays through Thursdays for different groups of men. Sage explains:

> Mondays is a group for men regardless of [HIV] status. That tends to be younger. Tuesday is a group that focuses on men over 40. That is regardless of

> status. And then Wednesday is HIV positive men. Thursday is Narcotics Anonymous and that's not our group but we let them use our space.

Though the organization has three main support groups, this division is a reflection of tension within the organization resulting from HIV/AIDS-related stigma and age differences. To illustrate, Brothers United initially begun as a support group that served Black gay and bisexual men diagnosed with HIV/AIDS. However, in the early 1990s, members of the Black gay and bisexual community pressured Brothers United to extend resources and support HIV negative men. Both the organization's board of directors and the executive director worked to change the mission and goals of Brothers United to include HIV negative men. Some members within the support group, particularly long time members were against the inclusion of HIV negative men. Sage recalls:

> [They said], "We said we don't want them in here. We don't want them volunteering" […]. Well at the time we had already made the decision that we were going to transition [...]. People who had been with us 5 years or more were the most adamant against us serving negative men. The people who were with us 3 years or less didn't have a problem with it […]. So then the final compromise was we'll get a separate building. We had another building for those who were positive so this house […] will always be for HIV positive men, while the other building would be for positive and negative.

One main reason for the opposition reflected the issue of HIV/AIDS-related stigma. The inclusion of negative men threatened to take away the safety and community that the organization had provided to many positive men. However, these intra-group

differences within the Black gay community were ignored by Sage and the board of directors. A similar fraction occurred between the older and younger groups of men. To deal with community tensions, the organization's leaders created separate support groups based on HIV status and age.

Though divided, each support group provides a space for men to be seen and heard. As Chris, an outreach worker as Brothers United, explains:

> From what I understand of this organization in terms of what they started out as, which was a support group for Black gay men and giving people that kind of platform is priceless because people have the opportunity to be able to sit in a room and share, […] to have people be visible and speak their truth without shame, apology or whatever. I think that's powerful because at least then they're able to see, "I don't have anything to be ashamed of. I'm no different than any other person that is subjected to […] raped or had substance abuse problems or whatever. Whatever it is that you're facing, you can get through it.

Within this safe space, men are given a supportive outlet to break their silence about various violence and trauma they experienced in their lives. Richard, a volunteer and client of Brothers United, asserts that since the 1980s, the support groups provide a space for Black gay men to discuss and deal with tensions and differences that exist around race.

> Well they're 3 support groups during the week […], all centered around African American men. What I like about the groups is that they support me and my community as one. So I don't have to look at my situation as being

> different from my community. Because in the Black community we have issues with standing out and being who we are as people, whether you gay, lesbian, straight or whatever. We have an issue with being who we truly want to be in our lives. […] [I like it] because you have a chance to dialogue with others in the community. You'll find out that we hold prejudices against one another, whether we gay, whether we straight, whether we smoke drugs, whether we poor, whether we rich, whether we middle class, you know we have our own fight within our community and I think that by going to these groups […] they give you an opportunity to voice your understanding and your opinion about certain things and then you can kind of collaborate with other people in your community in terms of where we are and how do we grow through this.

Richard notes that tensions that exist within the community occur at the intersections of race, class, gender and sexuality. However, by coming together as Black gay men, the group has an opportunity to deal with such divisions and work together. They have the option of working together with other Black men to deal with internal community issues as well as seek support from alienation or abuse that they experience in their own families and communities.

In summary, Community Alliance and Brothers United, are part of long tradition of activism that challenge oppressive forces of "normal"—whether by gender, race, class, sexuality and/or health status. Through the use of the rapid HIV tests, these organizations provide health related services in non-traditional medical settings and in so doing expand access to medical services to groups of African

Americans that are disproportionately at risk for HIV/AIDS. The rapid HIV test or any form of HIV test are instrumental in creating a new category of people whose health status changes from one that is "healthy," in this case free of HIV/AIDS, to one that is sick, in this case HIV positive.

Although one might not be physically ill at the time of diagnosis, the very label of being diagnosed with HIV/AIDS carries with it a particular stigma that is associated with social and/or sexual deviance. Thus a key work of Brothers United and Community Alliance is to develop strategies, programs and initiatives to help their clients deal with the stigma of HIV/AIDS. This stigma is interconnected with other forms of stigmas and inequalities related to race, class, gender and sexual orientation. As a consequence, both organizations must not only deal with the health crisis that they seek to end but also address the different manifestations of inequality for the communities that they serve. In the following section, I provide an analysis of the ways in with the two Black churches in this study work to address HIV/AIDS through the safe sex technologies such as condoms.

5.2 The Black Church and Condoms: The Sexual Empowerment of Constituents

In the case of HIV/AIDS, community access to condoms is important for health and survival. However, because condoms have typically associated with sexual deviance rather than health, religious organizations have traditionally been opposed to them. These faith-based organizations engage in a Black survival politics by *representing* their constituencies to external institutions. This section focuses on an important service that these Black churches provide *to* their constituents by via their approach to condoms.

In the following section, I examine the ways in which the two Black churches in this study deal with the issue of safe sex and condoms. I begin the analysis with New Hope Baptist Church, specifically, the challenges it faced in altering aspects of it religious ideas and practices that reified sexual deviance associated with condoms. The approach to condoms by Greater Faith Ministries Church.

5.2.1 Saving Lives Before Souls: New Hope Baptist

New Hope Baptist is a member of the Progressive National Baptist Convention, an African American denomination that has its roots in the struggle for civil rights. Although, New Hope Baptist has worked to carry on this tradition for racial justice, for years it maintained the religious status quo of advocating sexual abstinence. Church members, particularly youth, were encouraged to refrain from sexual intercourse until heterosexual marriage. Thus, in describing his initial position on safe sex, Rev. John Williams, the senior pastor of New Hope Baptist, recalls his opposition to public health practices that promoted condoms. He explains, "Early on when the whole issue of putting condoms in the schools came up, I guess that must have been in the late 80s or early 90s, I was vehemently opposed because I felt that it would promote promiscuity." Condoms were a symbol of moral corruption as it could lead school-age children to reject ideals of sexual chastity. As a result, Rev. Williams was more concerned about preventing sexual deviance than viewing condoms as a tool for public health in the late 1980s and early 1990s.

Although New Hope Baptist would take a progressive step by establishing an HIV/AIDS Ministry in the late 1980s, Rev. Williams continued to maintain a conservative stance on condoms. However, he agreed to participate in a local mass

HIV/AIDS awareness campaign and after a compelling meeting with a congregant, described below, he changed and began to consider condoms not as a symbol of sexual deviance. To illustrate, Rev. Julia Tar, the director of New Hope Baptist's HIV/AIDS Ministry, collaborated with a group of Black churches to respond to the epidemic in African American communities. Rev. Tar explains that she utilized the communication technologies such as the radio, newspaper, magazines, public health pamphlets and billboards, as well as the church bulletins to communicate that there was an epidemic crisis of HIV/AIDS in African American communities. Given New Hope Baptist's involvement with HIV since 1985, Rev. Tar sought the assistance of her pastor to help mobilize other Black churches to educate their congregations and community about how to prevent HIV/AIDS. She recalls:

> In 1995 […] I started working for a D.C. mass media campaign. And since the religious community was one of our target populations […] I shared with my pastor what the goals and objectives were and I asked him [Rev. Williams] to participate as an advisor […] and in my initial conversation with him, he said he had been concerned about condom distribution—and so this was back in '95.

The senior pastor of New Hope Baptist agreed to participate in this local mass campaign to raise awareness about HIV/AIDS in the community. Although this safe-sex technology was considered a violation of moral order, it was a HIV positive congregant who was pivotal in changing the position of Rev. Williams and the church's safe sex tradition. He explains:

> I'll tell you what happened, one of the experiences that I had in that very seat that you're sitting. In the NA [Narcotics Anonymous] program, this guy was HIV positive and he had [a] relationship with this young lady and she didn't know it and she became HIV positive. And she came in here with tears in her eyes and she pulled a pistol out of the pocketbook […]. She had already planned how she was going to kill him that night and she had arranged everything. He was going to come over her place and all that and [I] talked her out of that […]. So when that happened that was part of the impetus for that particular move […] for the condoms.

The moral outcry of the church members represents different aspects of gender power relations in New Hope Baptist Church. First a woman's threat to take her partner's life forced Rev. Williams to alter the church's position on HIV prevention. Second, although New Hope Baptist later adopted condoms as part of its religious practice, this change would not have been possible without the approval of the senior pastor. At New Hope Baptist, Rev. Williams serves as the main gatekeeper for the inclusion of HIV prevention tools. Third, Rev. Williams' story was one that allowed him to make institutional change that would not violate patriarchal or heteronormative social standards. New Hope Baptist's adoption of condoms as a means of HIV/AIDS prevention occurred within the confines of heterosexual sex. The victim of HIV/AIDS was a woman, rather than a man who contracted HIV through sexual intercourse with another man.

New Hope Baptist eventually changed its practices around condoms by privileging physical health over morality. According to Rev. Tar, the church was able

to alter its practices when Rev. Williams "realized that in order to save a soul you got to save a life first." Since sexual desires have historically been associated with the flesh and viewed as a corruption to the soul, religious leaders have viewed it as their moral duty to regulate and to prevent sexual sin. The privileging of lives over souls allowed the church to carry out secular, or what some would regard as immoral, practices around HIV/AIDS prevention and safe-sex interventions.

New Hope Baptist adopted two different approaches to prevent the sexual transmission of HIV/AIDS. The first includes condom distribution. To illustrate, the leaders of the church make condoms easily accessible in the sanctuary. Condoms of different colors, sizes, and flavors can be found in the main entrance of the church on any given Sunday. Male and female condoms, as well as packets of lubricants, are also made available in the building where the community outreach AIDS organization is housed.

The second change includes the development of HIV prevention intervention in different arms of the church—particularly those led by African American women. One such organization includes New Hope Baptist's rites of passage program that was created in 1984 to prepare adolescent and teenage girls in the church and community for adulthood. This program is part of the effort of older women in the church and community to transfer knowledge about womanhood to younger generations. According to Nicole, a member of New Hope Baptist and the mother of two teenage girls who have participated in the womanhood training program, "It [the womanhood program] teaches them about their African American history, about

spirituality, about everything. Everything that they wouldn't, I mean even if they got it in school, they got it more there."

Mama D, an 80 year old retired nurse and former director of New Hope's AIDS program, serves as the director of the rites of passage program. She explains that in womanhood training girls are taught domestic skills such as cooking, and financial skills, such as balancing a checkbook and personal budgeting. They are taught how to apply for and secure a job as well as to own their own business. These skills and education are seen as crucial to becoming "a strong Black woman." The image of the strong Black woman is a contemporary construction of a widely accepted model of womanhood for which Black women can ascribe to for self-assurance and encouragement that they can get beyond all obstacles in life (Collins 2000; Harris-Perry 2011). Mama D describes a strong Black woman as "a woman who takes care of herself, a woman who can think for herself. Basically that's what it is because if you can think for yourself, you make better choices."

With approval from Rev. Williams about safe-sex, the leaders of the rites of passage program offer comprehensive HIV/AIDS prevention education and services. One of the topics discussed in the program is condom negotiation—a strategy used to empower Black girls to engage in safe-sex practices. As Mama D notes, "I talk to them and usually I talk to them in relations to their relationships with the guys and then I would tell them, I say okay. Now you going out with this guy and it's the first time you've been out with him and he approaches you to have sex, what you gonna do?" She states that most of the girls will say that they would not have sex. Churches have served as a regulatory space where women and girls are taught to maintain a

gender and sexual norm of the "good girl" or the virgin. While the virgin may be the ideal for which the church leaders aspire, New Hope Baptist takes a pragmatic approach to sex. Rather than leaving the conversation at abstinence, Mama D explains that she tries to convince girls to think about and plan for circumstances in which they may decide to have sex. She recalls saying:

> Alright, the second, third, or fourth time [you go out on a date and] you have sex. And everybody at that time is laughing, and I say what you going to do? […] She said, "well." And I said, "well is he getting it?" There has got to be the process here. You're gonna have sex over here and here you are, what's the process? What are we doing? So I finally end up telling her. Did you ask him did he have sex before? Did you ask does he have a condom? Did you tell him you not having sex without a condom? Did you tell him, "oh don't worry about it, you don't have a condom, I got one?"

Nia, a 19-year-old member of the church and the daughter of Rev. Tar, explains that she worked with her mother and other women in the church to teach her peers the appropriate ways to use a condom. Using cues from popular culture to serve as reminders, Nia notes:

> We talked about proper condom use, they have an acronym, Open, Pinch, Role and Hold (OPRAH) and so we displayed on the teaching tool how to properly do, because a lot of them did not know or if they were active they relied on their partner, a lot times the partner did not know. So we displayed that. And then we had a couple of discussions about how do you talk to your partner about introducing that into your relationship.

African American women and girls are taught to be assertive in the sexual relationships and to be prepared in the event that they should have sex in the gendered spaces at New Hope Baptist Church. As stated above, the program is geared towards women and girls, and boys are not taught the same lessons at New Hope.

Though there is a similar rites of passage program for Black boys at New Hope Baptist Church, Rev. Tar asserts that sexual health is not a part of their program or curriculum. The male leaders in the church who serve as mentors for the boys create the curriculum for manhood training. However, there is no specific HIV/AIDS prevention program that is directed towards boys and men. As part of the goal of preventing HIV, Rev. Tar notes that she has worked to extend information and services to support other ministries at the church, such as the rites of passage programs for boys and girls. However, she recalls having limited success convincing the male program directors to incorporate comprehensive safe sex education as part of their curriculum or program. This is not unusual since the issue of sexual and reproductive health has historically been targeted to women and girls. Moreover, HIV risk among African American men is typically framed from the perspective of homosexuality.

5.2.2 "Not Another Funeral": Greater Faith Ministries

In many respects, Greater Faith Ministries can be regarded as a non-traditional Black church as it was created both to contest the religious world view that African American LGBT people were sexually deviant, and in response to the failure of the Black church to respond to HIV/AIDS. Bishop Kwame Jones, the senior pastor and founder of Greater Faith Ministries, explains, "The motivation of starting the church,

in 1993 is when I started, [was because] there were not a lot of [LGBT inclusive and] affirming churches at the time. I was actually heavily involved in doing HIV work. And '93 there were not a lot of especially Black churches doing HIV work." In many respects, Greater Faith Ministries was forced into existence to because of the general lack of response by many Black churches to HIV/AIDS. In addition, Deacon Jack Lewis, who identifies as gay and HIV positive, explains that the pastor provides members with religious tools that encourage self-acceptance for those who identify as gay and HIV positive. He asserts, "The pastor of our church, he teaches us about how to accept who you are, accept where you are, HIV, that's where you are, gay, that's where you are. And he opens the door, and says we will embrace you, because a lot of churches don't embrace us." Lewis goes on to say that the church also draws upon the authority of the Bible to contest religious homophobia and HIV stigma:

> People be like homosexuality is a sin. That's in your eyes. Everybody has a different version; everybody interprets the Bible different. But the Bible, I see it the way Bishop taught us, that "For God so love the world that he gave his only begotten son, that whosoever." So I must be a "whosoever." Whosoever believes; and I believe in him. […] I'm a whosoever. So you all want to argue about who I sleep with, who I slept with, you want to argue about my HIV status, you all take it over with God. But God says whosoever, so that means he opens the door and the word. I did a study on the Bible, and the Bible speaks of whosoever way over 240 times.

As the church that has historically worked to contest the religious world views that many churches hold about people who are gay and HIV positive, Greater Faith

Ministries has extended its services to include HIV prevention through the promotion of safe sex technologies like condoms.

African American gay men, a population that was rejected and left behind by their churches and community, constitute key members of Greater Faith Ministries. Since HIV/AIDS threatens the lives of many of its members, one of the goals of Greater Faith Ministries is to save the lives of its constituents by serving as a mechanism for the distribution of safe-sex technologies like condoms.

Unlike New Hope Baptist church, Greater Faith Ministries has always emphasized safe sex. For example, in reflecting on the church's religious worldview about safe sex, Rev. Caleb Jenkins, an assistant pastor of Greater Faith Ministries notes, "We provide, and have always for years been providing, at least the encouragement for people to be safer when they're having sexual experiences and to make it less taboo, where we can talk about it from the church […] and in the church." In order to preserve the lives of their constituents, Greater Faith Ministries takes three approaches to safe-sex: (1) It includes condom distribution in the sanctuary of the church; (2) It educates its parishioners about the importance of using condoms; and finally (3) it offers alternative spiritual interpretation of sex and sexuality that challenges religious heteronormative beliefs about sex.

Similar to New Hope Baptist, male and female condoms are distributed in the church. Condoms are typically placed in a bowl on the table near the front doors of the sanctuary. The bowl of condoms sits next to items typically distributed in the church such as the church programs, church fans, and a box of candy. In addition to condoms are flavored lubrications for use during sexual intercourse. However, one of

the main differences between Greater Faith and New Hope Baptist is the level of engagement of the senior pastor in the delivery of this service and the general openness to making condoms available in church. The senior leaders of the church personally distribute condoms to parishioners after some of the Sunday morning services. As Bishop Kwame Jones asserts, "I'll stand at the door and pass out condoms, male condoms, female condoms. We talk about it, hand out literature. I told them no shame here, no. I have some ministers that think that's a little too radical. Then don't do it. Not for my church. We don't want that kind of guilt or shame." By personally distributing condoms, the church works to remove the shame and stigma associated with sex that is often promoted in churches.

While Greater Faith Ministries openly advocates the use of condoms and serves as a site for their distribution, there are some gender limitations. At Greater Faith Ministries, male condoms are always available to parishioners to take each time they attend a church service, program, or event. However, female condoms are only made available when the religious leaders, who are all male, decide to personally distribute condoms on those occasional Sunday mornings, which in many ways reifies religious patriarchy even a church that is inclusive of LGBT people. To illustrate, the majority of the congregation, approximately 55-60%, is comprised of women. Thus, women are among the church's priority groups, given the high infection rates among Black women. Yet female condoms are typically stored in a box beneath a table away from public access, away from the men and women who may use them. As a result, the contraceptives specifically designed for women are only available at the whim of the male pastors. Such limited access to female-designed contraceptives has gender

implications, as they were created to empower women to take control of their sexual health without dependence on men.

The issue of limited access to female condoms is reflective of a larger problem in society where male condoms are more accessible as well as less expensive than female condoms. First, there has been an overall limited medical and scientific investment in the development of female-controlled contraceptives such as microbicides. Despite the limited availability of female condoms, Greater Faith Ministries challenges the larger religious status quo to expand the moral boundaries of the church related to sex and sexual health.

Condom distribution constitutes one of two approaches to prevent the sexual transmission of HIV/AIDS that Greater Faith Ministries has adopted. The second approach is to educate the parishioners, particularly teenagers, about the importance of using condoms. However, unlike New Hope Baptist, which provides comprehensive HIV/AIDS prevention initiatives for women and girls, Greater Faith Ministries' prevention initiative is mainly comprises of condom distribution, distribution of literature about how to use condoms, and discussions from the point of view of the authority of religious leaders about the significance of safe sex. With respect to the latter, Rev. Kevin Martin, an assistant pastor at Greater Faith Ministries, states, "The mandate of the church is to help people. And so to not, for us not to sit in judgment. So […] for us in terms of HIV, it's educating, it's creating safe spaces […]. We talk about safe sex, kind of, we share our stories. We talk about how we became positive." Rev. Martin has been an HIV prevention educator since the 1990s after discovering that he was HIV positive in 1989 while in college. He recalls

volunteering to be an HIV/AIDS peer educator and sharing his experience with other college students and young adults. Now in his early 40s, Martin continues to educate youth and adults about HIV however instead of speaking in schools, he uses the pulpit as a platform to talk about HIV/AIDS with the authority of a pastor who is personally living with HIV/AIDS. Moreover, Martin identifies as openly gay. Thus, while Greater Faith Ministries does not offer the same practical skills to help their constituents to use and negotiate condom use, it offers a space the larger congregation of women and men, some of whom identify as gay.

Via its focus on education, Greater Faith Ministries provides sexual health education in ways that opposes religious reification of sexual deviance. This includes discussion about sex and sexuality in non-heteronormative ways. For example, Bishop Jones explains:

> We don't understand sexuality. We [often] think of it as sort of this Black and White thing. [Some believe that] the only time you're supposed to have sex is for procreation. I said really, well then anybody that's not capably of having children shouldn't be having sex. We've made sex this dirty thing except when God made us he said not only is it good, it's very good. That means everything that he created including our sexuality […] is good.

At Greater Faith Ministries, the issue of sexuality, particularly homosexuality, is viewed as morally good and divinely created. Since many Black organizations, such as the mainstream Black church, as well as some families, ostracize homosexuality and view it as a sin, Greater Faith Ministries works to affirm African American youth

and adults who live in a world where their lives are not valued and they are more vulnerable to engaging in unprotected sex.

5.3 Conclusion

It is well documented that African Americans have failed to benefit from the most advanced health care technologies and services in the United States health care system. Given a history of medical marginalization, African Americans have been forced to develop their own health infrastructure. This could be observed with the Black Hospital Movement since the time of Reconstruction (see Chapter 1). While there are no official laws that maintain medical apartheid, organizations such as Community Alliance and Brothers United have continued the tradition of providing health care services to African American that are aliened from the formal health care system. Yet the mobilization for health is different from that of the past. The health care services that Community Alliance and Brothers United provide advances a Black Survival Politics at the intersection of race, gender, and sexual inequality. Given its foundation in the Reproductive Rights Movement, Community Alliance draws upon and expands health care traditions of the women's health movement to empower lay individuals to become their own health providers. In this case, Community Alliance trains and hires African American women and men with a history of substance abuse and incarceration to become rapid HIV testers in poor African American neighborhoods in Washington D.C. that are also disproportionately impacted by HIV/AIDS.

Although less broad-scale than Community Alliance, Brothers United also provides rapid HIV testing through its network of community organizations to ensure

that African American gay men have access to medical services. Unlike Community Alliance, which mainly focuses HIV testing, Brothers United offers an array of mental health and support services. Brothers United also offers safe spaces for African American gay men to deal with the stigma and alienation they may experience related to race, sexuality, and HIV stigma.

African American religious organizations have served as a mechanism for the delivery of health care services. However, HIV/AIDS has been a particularly challenging issue for the church to address given the association with sex and sexuality. In order to maintain a tradition of health care, both New Hope Baptist and Greater Faith Ministries were forced to reassess the utility of a religious tradition. Overall, the two Black churches in this study contradict prevailing views on condoms and sex education within their religious traditions . Opposition to this religious authority involved different motivating factors. For New Hope Baptist, which represents the more traditional model of religious organizations, its change involved a form of institutional disruption that took place in the privacy of the senior pastor's office. The single act of a conversation with woman living with HIV/AIDS not only informed changes through condom distribution, but also facilitated the inclusion of HIV/AIDS prevention programs specifically designed for African American women and girls. When compared to New Hope Baptist, the change for Greater Faith Ministries was less drastic. This is in part due to the fact that the senior pastor of the church had already established a secular organization that provided comprehensive HIV/AIDS prevention programs, particularly to African American gay and bisexual men. The pastor of Greater Faith Baptist is also HIV positive and had personally lost

his partner and close friends to the epidemic.

Chapter 6: The Right to Life: Implications for Black Survival Politics and HIV/AIDS

The main contribution of this study is to expand the definition of what counts as politics. Black survival strategies have historically been viewed in relation to Black protest politics. When compared Black protest politics, Black survival strategies are typically conceptualized in two main ways. First, Black survival strategies are often described as a submission to, rather than the struggle against, repressive political, economic, and social power. Second, Black survival strategies are usually regarded as maintaining or conforming to prevailing views of Black sexual and social deviance. Yet, in the wake of broad-scale collective action such as the Black Lives Matter Movement, it is important to reconsider the ways in which African Americans have politically mobilized to ensure their survival. In this study, I focus on Black organizational mobilization to fight for the right to life for groups of African Americans at risk for and living with HIV/AIDS. These groups include African American women, African Americans with a history of substance abuse, and African American gay men—groups whose lives have often been considered less deserving of large scale protest and community resources.

The Black survival politics of HIV/AIDS is not as large scale or visible as the protest politics for Civil Rights or the more recent Black Lives Matter Movements, but there are organizations that have historically mobilized to represent the political and life interests of the groups of African Americans most at risk for HIV/AIDS. In the first section of this chapter, I provide an overview of three main findings of how African American organizational mobilization of HIV/AIDS can contribute to

understandings of Black survival politics as protest. The second section includes a discussion of two main implications related to the lessons that can be learned from traditional Black protest politics for those organized to advance a Black survival politics of HIV/AIDS.

6.1: Black Survival Politics of HIV/AIDS

The results from this study suggest that African American organizational mobilization to address HIV/AIDS offers three main insights concerning Black survival politics. First, Black survival politics concerning HIV/AIDS include coalition building at the intersection of multiple systems of inequality, at the level of identity and community. Second, Black survival politics include altering aspects of religious norms and practices related to sex and sexuality. Third, Black survival politics relies on the resources of the government to provide HIV/AIDS related programs and initiatives that are, in large part, based on the gains made from collective action.

As mentioned in chapter 2, social movement and intersectional scholars have long noted the significance of coalitions particularly for groups with limited political and/or economic power. Historically, African Americans have established organizations and mobilized broad-scale coalitions to fight against racial inequality. Yet the issue of HIV/AIDS is more complicated as it requires mobilization at the intersection of race, class, gender, and sexual oppression. In this study, coalition building is a key strategy used by the secular community-based organization, Brothers United, to pressure the federal government and local health departments to prioritize the lives of Black gay men living with or at risk for HIV/AIDS. Thus rather

than focusing only on racial inequality, as has been the tradition of activism in many Black organizations, through its coalition, Brothers United draws upon and expands Black politics at the intersection of race, class, and sexual inequality. In other words, Brothers United was able to develop a politics that allowed Black gay men to fight for their right to life without having to suppress or hide their sexual identity. Intersectional coalition building is particularly significant since powerful Black organization have emphasized the struggle for racial inequality while maintaining heteronormativity. In addition, while more powerful gay organizations have been mobilized against homophobia and deployed resources to fight against the systemic heteronormative inequalities in the HIV/AIDS movement, they tended to ignore or suppress the racial and class struggles of Black gay men. Brothers United also used its coalition to forge a political struggle for the poor Black gay men who would otherwise been denied access to HIV/AIDS medical treatment and the basic necessities for survival. Overall, organizations such as Brothers United provide evidence of a Black politics that is often obscured or ignored by scholarship that focuses on the most powerful organizations in African American communities.

Community Alliance has similarly mobilized at the intersection of race, class, and gender; however Community Alliance draws attention to the needs and interests of African American women and the larger Black community. As a group, women have struggled to gain power and control in the political, economic, and medical institutions. This mobilization has led to the formation and continuity of one of the most influential health based movement in the United States and globally—the reproductive rights movement. Yet like Black women's organized activism of the

past, Community Alliance emerged out of racial discrimination in the predominantly White reproductive health movement which failed to expand political power and resources for African American women, many of whom are poor and struggle with issues of substance abuse. Since African American women's organizations have also forged a politics that has been inclusive of the needs of Black men, Community Alliance maintains this tradition in its political mobilization on behalf of African American heterosexual men diagnosed with HIV/AIDS. While Black organizations have historically privileged the interests of African American heterosexual men relative to that of African American women, the association of HIV/AIDS with homosexuality has limited Black heterosexual men's engagement in HIV/AIDS activism.

A focus on identity politics can, however, obscure the presence of inequalities that exist in poor Black neighborhoods. Community Alliance not only mobilized around the identity politics of race, class, and gender; it provides insights about the significance of addressing inequalities that arise from the disinvestment of public resources and limited opportunities in the Black urban ghettoes. Historically, African Americans have lived in racially segregated communities. However, as mentioned in chapter 2, following the civil rights movement, these segregated communities experienced greater marginalization, or what Wacquant (2008) regards as advanced marginality. Since HIV/AIDS has had a devastating effect in poor urban Black communities, Community Alliance advances a Black survival politics concerning HIV/AIDS by training, employing, and mobilizing groups of African American women and men to become community health care workers. These men and women

are not only disproportionately impacted by HIV/AIDS, but also reside in neighborhoods with limited health care services. Moreover, the neighborhoods that Community Alliance serves tend to have few labor market opportunities outside the informal drug economy. This makes residents not only vulnerable to HIV/AIDS, but also susceptible to repressive laws and policies that criminalize drugs use and sales.

Black survival politics concerning HIV/AIDS is also informed by the mobilization of the African American churches in this study. Historically, Black churches have been regarded as one of the most enduring and powerful organizations in African American communities. In the cases of HIV/AIDS, studies indicate that the institutional power of the church has been deployed in ways that were more repressive than liberating, given that the HIV/AIDS has been associated with sexual sin and social deviance (Cohen 1999; Harris 2010). However, the churches in this study were more progressive in their response to HIV/AIDS than typically noted in the literature. Much like Brothers United, coalitions are an important component to the work of New Hope Baptist Church, which, through a larger network of faith-based organizations, is able to deploy the voices of African American churches and other religious organizations. A primary issue of the coalition of churches is to make demands on the government to be inclusive of the experiences of the formerly incarcerated and those who struggle with issues of substance abuse.

The Black churches in this study adopted a more progressive response to sex and/or sexuality than initially expected. Both churches encouraged youth and adults to engage in safe-sex practices to prevent the sexual transmission of HIV/AIDS. They have also served as sites for the distribution of condoms—which has historically been

associated with promiscuity and sexual deviance. In the case of Greater Faith Ministries, effort is made to mobilize internal and external resources to ensure that Black LGBT youth have access to religious environments that are sexually inclusive or religiously affirming of sexualities that stand outside the heteronormative standards. Despite the level of sex and/or sexual progressiveness, each church maintains a patriarchal power structure, where the male leadership determines the direction and focus of HIV/AIDS initiatives and programs. Overall, the action of these churches suggests that some Black churches may be able to alter aspects of their religious ideology and practices to grant members of the church and community the right to life in the context of HIV/AIDS.

Concerns about African American sexuality are not only confined to the church. The secular community-based organization, Brothers United, has worked to contest prevailing beliefs in public health that African American gay men are sexually deviant. Through its larger networks, Brothers United distributed information with scientific evidence that portray Black gay men as being more sexually responsible than their White counterparts.

While the organizations in this study provide some insights regarding mobilization to pressure the government to prioritize the lives and well-being of their constituents, the focus of the organizations has been to ensure that public health gains from activism are available to their constituents. In other words, even after coalition building and collective action, the organizations in this study must assist groups and neighborhoods that are still alienated from the resources and technologies of traditional health care facilities such as hospitals and substance abuse programs.

Through government funding, both the community-based organizations and the churches implement programs that assist their constituents to cope with the stigma of being diagnosed with HIV/AIDS and being Black and gay, as is observed in Brothers United. Through government funding, New Hope Baptist can administer safe-sex HIV/AIDS prevention programs for African American women and girls in the church and community. Overall, people at risk for or living with HIV/AIDS can then become integrated into organizations with programs that help them to avoid death from HIV/AIDS.

6.2 Traditional Black Politics: Lessons for HIV/AIDS

Organizations and individuals concerned with responding to the epidemic crisis of HIV/AIDS in African American communities can learn from the traditional political activism utilized by African Americans. First, effective response to HIV/AIDS requires legal reform in the criminal justice system. Second, responses to HIV/AIDS must also include the mobilization against residential segregation and gentrification.

African Americans substance abusers and the formerly incarcerated are among the key constituents of organizations such as Community Alliance and New Hope Baptist Church. While African Americans returning from prisons or jails may have access to treatment for HIV/AIDS, the focus on medical intervention leaves unaddressed the racial and economic discriminations that often arise when employers refuse to hire people with a felony record. As part of the mobilization to fight to save the lives of African Americans living with HIV/AIDS, people working in the field of

HIV/AIDS can join or build coalitions to change laws and policies that legally support discrimination against African Americans.

Second, people working in the field of HIV/AIDS can learn from traditional African American mobilizing to address issues related to residential segregation and gentrification. The lack of housing for people living with HIV/AIDS in Washington D.C. should be tied to larger structural inequalities such as the destruction of public housing in African American communities. Since expensive condominiums and apartments tend to replace public housing, both poor and middle class African Americans have been displaced from their communities and are also vulnerable to homelessness. People working in the field of HIV/AIDS can, at the minimum, join and build coalitions with African American housing activists currently working to preserve the availability of public housing urban Black communities.

6.3 Future Work

This study has examined the contributions of four organizations and their efforts to combat the HIV/AIDS epidemic. In examining their work, this dissertation has introduced the concept of Black survival politics as an extension to the theoretical frameworks of social movements, intersectionality, and sociology of religion. A natural extension to this dissertation would be to increase the number of organizations surveyed. One source of interest is the several dozen organizations that comprise the coalitions built as part of the strategy employed by the organizations discussed in this dissertation.

Another dimension of future work is to survey organizations in other geographic locations. Of particular interest are organizations situated in communities

in conservative regions of the United States, such as the Bible belt. The effectiveness of strategies and techniques in this environment may vary greatly from regions such as Washington D.C. given the large difference in the political and religious climate.

As HIV/AIDS continues to devastate the communities with the least power and authority in society, this and future studies attempt to provide understanding of how communities can mobilize resources to stem and reverse race, class, gender, and sexual inequalities. Even for those not directly a part of the most affected communities, these insights ultimately can contribute to protecting the total sum of society from this epidemic and other diseases.

Appendices

Appendix A: Interview Schedule for Directors/Pastor

- How did you become involved with this organization?
- Could you describe the role that you play in this organization?
- What is a typical day/week like at this organization? Could you describe it?

<u>Background of AIDS Organization</u>

- What are the current goals/missions of this organization?
- How did the organization come to adopt the goals/missions? Could you describe the process?
    - Who was involved in the decision making process?
        - Constituents?
        - Board of directors?
        - Funders?
        - Government policies?
- What are some of the things the organization does to achieve its goals?
- Could you describe your target population? Who are they? Why were they chosen?
- What are the most pressing needs of the people you serve?
- How does this organization meet these needs?
- What are some of the challenges this organization face in addressing these needs?
- In your opinion what is the most important work this organization does? Why?

<u>Collaboration with other Organizations:</u>

- In what ways, if any, does this organization work with other organizations? Why?
    - Does the organization work with churches?
    - What role did you play in this relationship?

- Could you describe the general experience working with other organizations?

Factors shaping Action in Black communities:

- What factors have made addressing AIDS in Black communities more or less difficult?
  - Aspects of the different communities?
  - The Black church?
  - Relationships with other groups, alliances-supportive, antagonistic?
  - government policies, repression,
  - Funding sources?

- What are the most significant changes you have observed in the organization since you started working at this organization?
  - Change in constituents?
  - Size?
  - Programs offered?
  - Goal/mission

- What in your opinion contributed these changes?

Miscellaneous:

- Is there anything you'd like to add?
  - Questions or perspectives that are missing from the interview?

  - Suggestions for my research?

Respondent's Demographic Information:

I am going to ask you a series of questions about race, class, gender etc. Please let me know if you find any of these questions to be too sensitive or personal and we can skip them.

- How would you define or describe you:
  - racial or ethnic background
  - gender,
  - age
  - social class (level of education),
  - sexual orientation

Appendix B: Interview Schedule for Outreach Workers/Volunteers

- How did you become involved with this organization?
    - When did you become involved?

- Could you describe the work that you do in this organization?
    - What role do you play?
    - Have your changed roles?

- Could you describe your target population? Who are they?

- What are the most pressing needs of the people you work with?

- How does this organization meet their needs?

- What are some of the challenges this organization face in addressing these needs?

- In your opinion what is the most important work this organization does? Why?

<u>Community Mobilization & Outreach:</u>

- How does this organization work with the surrounding Black community?
    - What kinds of programs or services are provided?

- Describe your experience working in D.C. Black communities?

- What are some of the things you think are important for mobilization in Black communities?
    - Alliances, coalition work
    - Dealing with homophobia, sexism etc.

- What do you think the organization could do better to combat AIDS in Black communities?

<u>Respondent's Demographic Information:</u>

I am going to ask you a series of questions about race, class, gender etc. Please let me know if you find any of these questions to be too sensitive or personal and we can skip them.

- How would you define or describe you:
    a. -racial or ethnic background

b. –gender, age group, social class (level of education, occupation), sexual orientation

Bibliography

Adams, Jimi. 2007. “Stained Glass Makes the Ceiling Visible: Organizational Opposition to Women in Congregational Leadership.” *Gender & Society* 21:80-105.

Alder, Gary. 2012. “An Opening in the Congregational Closet? Boundary-Bridging Culture and Membership Privileges for Gays and Lesbians in Christian Religious Congregations.” *Society for the Study of Social Problems* 59:177-206.

Alexander, Michelle. 2010. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York: The New Press.

Ammerman, Nancy Tatom. 2005. *Pillars of Faith: American Congregations and their Partners*. Berkeley, CA: University of California Press.

Avery, Byllye Y. 1994. “Breathing Life into Ourselves: The Evolution of the National Black Women's Health Project.” Pp. 4-10 in *The Black Women's Health Book: Speaking for Ourselves*, edited by E. C. White. Seattle, Washington: Seal Press.

Barber, Kendra. 2015. “Whither Shall We Go? The Past and Present of Black Churches and the Public Sphere.” *Religions* 6:245-265.

Barnes, Sandra L. 2004. “Priestly and Prophetic Influences on Black Church Social Services.” *Social Problems* 51:202-221.

—. 2005. “Black Church Culture and Community Action.” *Social Forces* 84:967-994.

—. 2006. “Whosoever Will Let Her Come: Social Activism and Gender Inclusivity in the Black Church.” *Journal of the Scientific Study of Religion* 45:371-387.

—.2011. “Black Church Sponsorship of Economic Programs: A Test of Survival and Liberation Strategies.” *Review of Religious Research* 53(1):23-40.

—. 2013. *Live Long and Prosper: How Black Megachurches Address HIV/AIDS and Poverty in the Age of Prosperity Theology*. New York: Fordham University Press.

Battle, Juan J. and Natalie D.A. Bennett. 2005. "Closet are for Clothes: Tearing Down Boundaries to Freedom for Black American Sexual Minorities." Pp. 51-82 in *Free at Last?: Black America in the Twenty-First Century*, edited by J. Battle, M. Bennett, and A. J. Lemelle. New Brunswick, NJ: Transaction Publishers.

Billingsley, Andrew. 1999. *Mighty Like a River: The Black Church and Social Reform*. Oxford: Oxford University Press.

Bowie, J. V, A.M. Wells, H.S. Juon, K.D. Sydnor, and E.M. Rodriguez. 2008. “How Old are African American Women When they Receive their First Mammogram? Results from A Church-Based Study.” *J Community Health*, 33(4):183-191.

Breen, Matthew. 2014. “2014’s Gayest Cities in America.” *The Advocate*. Retrieved December 2014. (http://www.advocate.com/travel/2014/01/06/2014s-gayest-cities-america).

Brier, Jennifer. 2009. “Marketing Safe Sex: The Politics of Sexuality, Race, and Class in San Francisco, 1983-1991.” Pp. 45-77 in *Infectious Ideas: U.S. Political*

Responses to the AIDS Crisis. Chapel Hill, NC: The University of North Carolina Press.
Brown, Geneva. 2012. "Ain't I a Victim? The Intersectionality of Race, Class, and Gender in Domestic Violence and the Courtroom." *Cardozo Journal of Law & Gender* 19:147-183.
Bucher, Richard O., Rodney G. Hood, and Wilbert C. Jordan. 2005. "Optimizing Treatment for African Americans and Latinos with HIV/AIDS." *J Nati Med Assoc.* 97:1093-1100.
Blumer, Herbert. 1969. *Symbolic Interactionism: Perspective and Method*. Berkeley: University of California Press.
Burdette, Army M., Christopher G. Ellison, and Terrence D. Hill. 2005. "Conservative Protestantism and Tolerance toward Homosexuals: An Examination of Potential Mechanisms." *Sociological Inquiry* 75:177-196.
Burr, Chandler. 1999. "The AIDS Exception: Privacy vs. Public Health." Pp. 211-224 in *New Ethics for the Public's Health*, edited by D. E. Beauchamp and B. Steinbock. Oxford: Oxford University Press.
Byrd, W. Michael and Linda A. Clayton. 2002. *An American Health Dilemma: Race, Medicine, and Health Care in the United States 1900-2000*, vol. II. New York: Routledge.
Calhoun-Brown, Allison. 2002. ""Will the Circle be Unbroken?": The Political Involvement of Black Churches Since the 1960s." Pp. 14-27 in *Black Political Organizations*, edited by O. A. Johnson III and K. L. Stanford. New Brunswick, NJ: Rutgers University Press.
Campbell, Carole A. 1999. *Women, Families and HIV/AIDS: A Sociological Perspective*. Cambridge: Cambridge University Press,
Cavendish, James. 2002. "Church-based Community Activism: A Comparison of Black and White Catholic Congregations." *Journal for the Scientific Study of Religion* 39:64-77.
CDC. 2013. "Pediatric HIV Surveillance." Atlanta, GA. Retrieved December 10, 2013. http://www.cdc.gov/HIV/library/slidesets/index.html.
CDC. 2016a. "HIV Among African Americans." Atlanta, GA. Retrieved March 01, 2016. http://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html.
____. 2016b. "HIV Among African American Gay and Bisexual Men." Atlanta, GA. Retrieved March 01, 2016. http://www.cdc.gov/hiv/group/msm/bmsm.html.
____.2016c. "Pediatric HIV Surveillance." Atlanta, GA. Retrieved March 02, 2016. http://www.cdc.gov/HIV/library/slidesets/index.html.
Chatters, LM, RJ Taylor, AT Woodward, and EJ Nicklett. 2015. "Social Support from Church and Family Members and Depressive Symptoms among Older African Americans." *Am J Geriatr Psychiatry.* 23:559-567.
Chaves, Mark. 1999. *Ordaining Women: Culture and Conflict in Religious Organizations*. Cambridge: Harvard University Press.
Chaves, Mark and Lynn Higgins. 1992. "Comparing the Community Involvement of Black and White Congregations." *Journal for the Scientific Study of Religion* 31:425-440.

Cho, Sumi, Kimberle Williams Crenshaw, and Leslie McCall. 2013. “Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis.” *Signs* 38:785-810.
Clements, Ben. 2013. “Religion and the Sources of Public Opposition to Abortion in Britain: The Role of ‘Belonging’, ‘Behaving’ and ‘Believing’.” *Sociology* 48:369-386.
Cohen, Cathy J. 1996. “Contested Membership: Black Gay Identities and the Politics of AIDS.” Pp. 362-294 in *Queer Theory/Sociology*, edited by S. Seidman. Cambridge: Blackwell Publishers.
—. 1999. *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. Chicago: University of Chicago Press.
Cohen, Peter F. 1998. *Love and Anger: Essays on AIDS, Activism, and Politics*. New York: Harrington Park Press.
Cole, Elizabeth R. 2008. “Coalitions as a Model for Intersectionality: From Practice to Theory.” *Sex Roles* 59:443-453.
Collective, Combahee River. [1977] 2000. “The Combahee River Collective Statement.” Pp. 264-274 in *Home Girls: A Black Feminist Anthology*, edited by B. Smith. New Brunswick, NJ: Rutgers University Press.
Collins, Patricia Hill. 1998. *Fighting Words: Black Women & the Search for Justice*. Minneapolis, MN: University of Minnesota Press.
—. 2000. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York: Routledge.
—. 2005. *Black Sexual Politics: African Americans, Gender, and the New Racism*. New York: Routledge.
—. 2006. *From Black Power to Hip Hop: Racism, Nationalism, and Feminism*. Philadelphia, PA: Temple University Press.
Coleman, Monica. 2008. *Making a Way Out of No Way: A Womanist Theology*. Minneapolis, MN: Fortress Press.
Copeland, M. Shawn. 2010. *Enfleshing Freedom: Body, Race and Being*. Minneapolis: Fortress Press.
Cone, James H. 1999. *Risk of Faith: The Emergence of a Black Theology of Liberation, 1968-1998*. Boston: Beacon Press.
Conrad, Peter. 2006. *Identifying Hyperactive Children: The Medicalization of Deviant Behavior*. Burlington, VT: Ashgate Publishing Limited.
Crenshaw, Kimberle. 1991. “Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color.” *Stanford Law Review* 43:1241-1299.
—. 2015. “Why Intersectionality Can’t Wait.” Washington, DC: The Washington Post. Retrieved November 1, 2015. (https://www.washingtonpost.com/news/in-theory/wp/2015/09/24/why-intersectionality-cant-wait/).
Cress, Daniel M., and David A. Snow. 1998. “Mobilizing at the Margins: Organizing by the Homeless.” Pp. 73-98 in *Social Movements and American Political Institutions*, edited by A.N. Costain and A.S. McFarland. Lanham, MD: Rowman & Littlefield Publishers, Inc.

Creswell, John W. 2007. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. London: Sage Publications Inc.
Cutler, David M and Grant Miller. 2005. “The Role of Public Health Improvements in Health Advances: The Twentieth-Century United States.” *Demography* 42:1-22.
Dalton, Harlon L. 1991. “AIDS in Blackface.” Pp. 122-143 in *The AIDS Reader: Social Political Ethical Issues*, edited by N. F. McKenzie. New York: Meridian Book.
Davis, Angela. 1983. “Racism, Birth Control and Reproductive Rights.” Pp. 202-221 in *Women, Race, and Class*. New York: Vintage Books.
Davis, Angela Y. 1994. “Sick and Tired of Being Sick and Tired: The Politics of Black Women's Health." Pp. 18-26 in *The Black Women's Health Book*, edited by E. C. White. Seattle: Seal Press.
—. 1998. “Preaching the Blues: Spirituality and Self-Consciousness.” Pp. 120-137 in *Blues Legacies and Black Feminism: Gertrude Ma Rainey, Bessie Smith, and Billie Holiday*. New York: Random House Inc.
Dew, Kevin. 2012. *The Cult and Science of Public Health: A Sociological Investigation*. New York: Berghahn Books.
D.C. Department of Health. 2013. *Annual Epidemiology & Surveillance Report: Surveillance Data Through December 2013*. Washington, D.C. Retrieved June 11, 2013. (http://doh.dc.gov/node/1134032)
Dill, Bonnie Thornton. 2009. “Intersections, Identities, and Inequalities in Higher Education.” Pp. 229-252 in *Emerging Intersections: Race, Class, and Gender in Theory, Policy, and Practice*, edited by B. T. Dill and R. E. Zambrana. New Brunswick: Rutgers University Press.
Dillon, Michele. 2014. “Asynchrony in Attitude Toward Abortion and Gay Rights: The Challenge to Values Alignment.” *Journal for the Scientific Study of Religion* 53:1-16.
Donovan, Mark C. 2001. *Taking Aim: Target Population and the War on AIDS and Drugs*. Washington DC: Georgetown University Press.
Douglas, Kelly Brown. 1999. *Sexuality and the Black Church: A Womanist Perspective*. Maryknoll, NY: Orbis Books.
Douglas, Kelly Brown. 2010. “Black and Blues: God-Talk/Body-Talk for the Black Church.” Pp. 44-66 in *Sexuality and the Sacred: Sources for Theological Reflection, Second Edition*, edited by M. M. Ellison and K. B. Douglas. Louisville, Kentucky: Westminster John Knox Press.
Downs, Jim. 2012. *Sick from Freedom: African-American Illness and Suffering During the Civil War and Reconstruction.* New York: Oxford University Press.
Du Bois, W.E.B. 1906. *The Health and Physique of the Negro American 1906*. Atlanta: GA: Atlanta University Press.
—. 1899 [2007]. *The Philadelphia Negro: A Social Study*. New York Oxford University Press.
—. 1903 [2003]. *The Negro Church*, Edited by P. Zuckerman, S. L. Barnes, and D. Cady. Walnut Creek, CA: AltaMira Press.

Durkheim, Emile. 1915. *The Elementary Forms of the Religious Life*. New York: The Free Press.
Edelman, Marc. 2001. "Social Movements: Changing Paradigms and Forms of Politics." *Annual Review of Anthropology* 30: 285–317.
Edgell, Penny. 2006. *Religion and Family in a Changing Society*. Princeton, NJ: Princeton University Press.
Edwards, Korie L, Brad Christerson, and Michael O Emerson. 2013. "Race, Religious Organizations, and Integration." *Annual Review of Sociology* 39:211-228.
Ellison, Christopher G. and Andrea K. Henderson. 2011. "Religion and Mental Health: Through the Lens of the Stress Process." Pp. 11-44 in *Toward a Sociological Theory of Religion and Health*, edited by A. Blasi. Danvers, MA: Brill.
Epstein, Steven. 1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Berkeley: University of California Press.
Esterberg, Kristin G. 2002. *Qualitative Methods in Social Research*. Boston: McGraw-Hill.
Evatt, B.L. 2006. "The Tragic History of AIDS in the Hemophilia Population, 1982-1984." *Journal of Thrombosis and Haemostasis* 4:2295-2301.
Farmer, Paul. 2005. "Health, Healing, and Social Justice: Insights from Liberation Theology." Pp. 139-159 in *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California.
—. 2010. "Women, Poverty, and AIDS (1996)." Pp. 298-327 in *Partner to the Poor: A Paul Farmer Reader*, edited by H. Saussy. Berkeley: University of California Press.
Farrell, Anne-Maree. 2012. *The Politics of Blood: Ethic, Innovation and the Regulation of Risk*. Cambridge: Cambridge University Press.
FDA. 2015. "FDA Updates Blood Donor Deferral Policy to Reflect the Most Current Scientific Evidence and Continue to Ensure the Safety of the U.S. Blood Supply." Silver Spring, MD: U.S. Food and Drug Administration. Retrieved February 2016. (http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm478031.htm).
Floyd-Thomas, Stacey, Juan Floyd-Thomas, Carol B. Duncan, Stephen G. Ray Jr., and Nancy Lynne Westfield. 2007. *Black Church Studies: An Introduction*. Nashville, TN: Abingdon Press.
Fraser, Nancy and Linda Gordon. 1994. "A Genealogy of Dependency: Tracing a Keyword of the U.S. Welfare State." *Signs* 19:309-336.
Frazier, Franklin E. 1974. *The Negro Church in America/The Black Church Since Frazier*, Edited by C. E. Lincoln. New York: Schocken Books Inc.
—. 2003. "The Negro Church and Assimilation." Pp. 62-73 in *African American Religious Thought: An Anthology*, edited by C. West and E. S. Glaude. Louisville, Kentucky: Westminster John Knox Press.
Fredrickson, George M. 2002. *Racism: A Short History*. Princeton: Princeton University Press.

Fullilove, Robert E., III. 1995. “Community Disintegration and Public Health: A Case Study of New York City.” National Academy Sciences/Institute of Medicine, Washington D.C.
—. 2006. “African Americans, Health Disparities and HIV/AIDS: Recommendations for Confronting the Epidemic in Black America.” National Minority AIDS Council, Washington, D.C.
Galishoff, S. 1985. “Germs Know No Color Line: Black Health and Public Policy in Atlanta, 1900-1918.” *J Hist Med Allied Sci* 40:22-41.
Gallagher, Sally K. 2003. *Evangelical Identity and Gendered Family Life*. New Brunswick, NJ: Rutgers University Press.
Gamble, Vanessa Northington. 1997. “Roots of the Black Hospital Reform Movement.” Pp. 369-391 in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, edited by J. W. Leavitt and R. L. Numbers. Madison: The University of Wisconsin Press.
—. 2010. “‘There Wasn’t a Lot of Comforts in Those Days:” African Americans, Public Health, and the 1918 Influenza Epidemic.” *Public Health Reports* 3:115-122.
Gilbert, Dorie J. 2003. “Focus on Solutions: Black Churches Respond to HIV/AIDS: Interview with Pernessa C. Seele, Founder and CEO of The Balm in Gilead.” Pp. 139-152 in *African American Women Living with AIDS: Critical Responses for the New Millennium*, edited by D. J. Gilbert and E. M. Wright. Westport, CT: Praeger Publishers.
Gilbert, Dorie J. and Ednita M. Wright. 2003. *African American Women Living with AIDS: Critical Responses for the New Millennium*. Westport, CT: Praeger Publishers.
Gilbert, Keon and Rashawn Ray. 2015. “Why Police Kill Black Males with Impunity: Applying Public Health Critical Race Praxis (PHCRP) to Address the Determinants of Policing Behaviors and “Justifiable” Homicides in the USA.” *Journal of Urban Health*, vol. 10:1-19.
Gilkes, Cheryl Townsend. 2003. “‘Together and in Harness:’ Women’s Tradition in the Sanctified Church.” Pp. 629-650 in *African American Religious Thought: An Anthology*, edited by C. West and E. S. Glaude. Louisville, KY: Westminster John Knox Press.
—. 2010. “Still the ‘Most Segregated Hour’: Religion, Race and the American Experience.” Pp. 415-443 in *The Sage Handbook of Race and Ethnic Studies*, edited by P.H. Collins and J. Solomos. Thousand Oaks, CA: Sage Publications Ltd.
Gillum, Tameka L. 2008. “Community Response and Needs of African American Female Survivors of Domestic Violence.” *Journal of Interpersonal Violence* 23:39-57.
Glaude, Eddie S. 2010. “Scholar Signal the End of the Black Church.” National Public Radio (NPR). Retrieved November 10, 2012 (http://www.npr.org/templates/story/story.php?storyId=126219404).
Goldberg, David Theo. 2002. *The Racial State*. Malden, Mass: Blackwell.
Gordon, Linda. 2002. *The Moral Property of Women: A History of Birth Control Politics in America*. Chicago: University of Illinois Press.

Gould, Deborah B. 2009. *Moving Politics: Emotions and ACT UP'S Fights Against AIDS*. Chicago: University of Chicago Press.
Gramsci, Antonio. 1971. *Selections from the Prison Notebooks*. New York: International Publishers.
Grant, Jacquelyn. 1995. "Black Theology and the Black Woman." Pp. 319-36 in *Words of Fire: An Anthology of African-American Feminist Thought*, edited by Beverly Guy-Sheftall. New York: The New Press.
Guy-Sheftall, Beverly. 2009. "Black Feminist Studies: The Case of Anna Julia Cooper." *African American Review* 43:11-15.
Hahn, Robert A and Marcia C. Inhorn. 2009. "Introduction." Pp. 1-31 in *Anthropology and Public Health: Bridging Differences in Culture and Society*, edited by R. A. Hahn and M. C. Inhorn. New York: Oxford University Press.
Hammonds, Evelynn M. 1995. "Missing Persons: African American Women, AIDS, and the History of Disease." Pp. 434-449 in *Words of Fire: An Anthology of African-American Feminist Thought*, edited by B. Guy-Sheftall. New York: New Press.
—. 1997. "Seeing AIDS: Race, Gender, and Representation." Pp. 113-126 in *The Gender Politics of HIV/AIDS in Women: Perspectives on the Pandemic in the United States*, edited by N. Goldstein and J. L. Manlowe. New York: New York University Press.
—. 1999. "Toward a Genealogy of Black Female Sexuality: The Problematic of Silence." Pp. 93-104 in *Feminist Theory and the Body: A Reader*, edited by J. Price and M. Shildrick. New York: Routledge.
Harris, Angelique C. 2010. "Panic at the Church: The Use of Frames, Social Problems, and Moral Panics in the Formation of an AIDS Social Movement Organization." *Western Journal of Black Studies* 34:337-346.
Harris, Fredrick. 2012. *The Price of the Ticket: Barack Obama and Rise and Decline of Black Politics*. New York: Oxford University Press.
Harris-Perry, Melissa. 2011. *Sister Citizen: Shame, Stereotypes, and Black Women in America.* New Haven, CT: Yale University Press.
Higgins, Jenny A., Susie Hoffman, and Shari L. Dworkin. 2010. "Rethinking Gender, Heterosexual Men, and Women's Vulnerability to HIV/AIDS." *American Journal of Public Health* 100:435-445.
Hinkson, Leslie. 2015. "The Right Profile? An Examination of Race-based Pharmacological Treatment of Hypertension." *Sociology of Race & Ethnicity* 1:255-269.
Hooks, bell. 1989. *Talking Back: Thinking Feminist Thinking Black*. Boston, MA: South End Press.
Hull, Gloria T and Barbara Smith. 1982. "Introduction: The Politics of Black Women's Studies." Pp. xvii-xxxii in *But Some of Us Are Brave: All the Women are White*, edited by G. T. Hull, P. B. Scott, and B. Smith. New York: The Feminist Press.
James, Joy. 1997. "Sexual Politics: An Antilynching Crusader in Revisionist Feminism." Pp. 61-82 in *Transcending the Talented Tenth: Black Leaders and American Intellectuals.* New York: Routledge.

Jenkins, Craig J. and William Form. 2005. “Social Movements and Social Change.” Pp. 331-349 in *The Handbook of Political Sociology: State, Civil Societies, and Globalization*, edited by T. Janoski, R. Alford, A. M. Hicks, M.A. Schwatz. New York: Cambridge University Press

Jensen, Robin E. 2010. *Dirty Words: The Rhetoric of Public Sex Education 1870-1924*. South Oak Street: University of Illinois Press.

Jordan, W. C, A. C Vaughn and R. G Hood. 2004. “African Americans and HIV/AIDS: Cultural Concerns.” *AIDS Read* 2004 (10 Suppl):S22-25.

Johnson, Ollie A. III and Karin L. Stanford. 2002. *Black Political Organizations in the Post Civil Rights Era*. New Brunswick, NJ: Rutgers University Press.

Kaiser Family Foundation. 2013. “Proportion of AIDS Diagnoses, by Race/Ethnicity, United Sates, 1985-2011.” Washington, D.C.: Kaiser Family Foundation. Retrieved February 10, 2014. (http://kff.org/slides/hivaids/?paged=4)

—. 2014. “Women and HIV/AIDS in the United States.” vol. 2015. Washington D.C.: Kaiser Family Foundation. Retrieved January 2016 (http://kff.org/hivaids/fact-sheet/women-and-hivaids-in-the-united-states/)

Kane, Melinda D. 2013. “LGBT Religious Activism: Predicting State Variations in the Number of Metropolitan Community Churches, 1974-2000.” *Sociological Forum* 28:135-158.

King, Deborah K. 1988. “Multiple Jeopardy, Multiple Consciousness: The Context of a Black Feminist Ideology.” *Sign* 14:42-72.

Klawiter, Maren. 2008. *The Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism*. Minneapolis: University of Minnesota Press.

Kochanek, Kenneth D, Elizabeth Arias, and Robert N Anderson. 2015. “How Did Cause of Death Contribute to Racial Differences in Life Expectancy in the United States in 2010?” *NCHS Data Brief* 125:1-8.

Kornbluh, Felicia. 2007. *The Battle for Welfare Rights: Politics and Poverty in Modern America* Philadelphia: University of Pennsylvania Press.

Larana, Enrique, Hank Johnston and Joseph Gusfield. 1994. *New Social Movements: From Ideology to Identity*. Philadelphia: Temple University Press.

Lassiter, JM. 2014. “Extracting Dirt from Water: A Strengths-Based Approach to Religion for African American Same-Gender-Loving Men.” *J Relig Health* 53:178-189.

Lawson, Steven F. and Charles Payne. 1998. *Debating the Civil Rights Movement, 1945-1960.* Lanham, MD: Rowman & Littlefield.

Leong, Pamela. 2005. “The African-American Church and the Politics of Difference: Creating and Oppositional Religious Culture in the Context of HIV/AIDS.” *Race, Gender & Class* 12:139-154.

—. 2006. “Religion, Flesh, and Blood: Re-creating Religious Culture in the Context of HIV/AIDS.” *Sociology of Religion* 67:295-311.

Lincoln, C. Eric and Lawrence H. Mamiya. 1990. *The Black Church in the African American Experience*. Durham, NC: Duke University Press.

Lune, Howard. 2007. *Urban Action Networks: HIV/AIDS and Community Organizing in New York City*. Lanham, MD: Rowman & Littlefield Publishers Inc.

Lupton, Deborah. 1995. *The Imperative of Health: Public Health and the Regulated Body*. Thousand Oaks, CA: SAGE Publications Ltd.

Marable, Manning. 2000. *How Capitalism Underdeveloped Black America: Problems in Race, Political Economy and Society*. Cambridge, MA: South End Press.
—. 2002. *The Great Wells of Democracy: The Meaning of Race in American Life*. New York: BasicCivitas.
Marx, Anthony. 1998. *Making Race and Nation: A Comparison of the United States, South Africa, and Brazil*. Cambridge University Press.
McCree, Donna Hubbard and Matthew Hogben. 2010. "The Contribution to and Context of Other Sexually Transmitted Diseases and Tuberculosis in the HIV/AIDS Epidemic Among African Americans." Pp. 9-14 in *African Americans and HIV/AIDS: Understanding and Addressing the Epidemic*, edited by D. H. McCree, K. T. Jones, and A. O'Leary. New York: Springer Science.
McGovern, Theresa. 1997. "Barriers to the Inclusion of Women in Research and Clinical Trials." Pp. 46-62 in *The Gender Politics of HIV/AIDS in Women: Perspectives on the Pandemic in Women*, edited by N. Goldstein and J. L. Manlowe. New York: New York University Press.
McKeown, Thomas. 1979. *The Role of Medicine: Dream, Mirage, or Nemeis?* Oxford: Basil Blackwell Publisher Ltd.
McKinlay, JB and SM McKinlay. 1977. "The Questionable Contributions of Medical Measures of the Decline of Morality in the United States in the Twentieth Century." *Milbank Mem Fund Q Health Soc* 55:405-428.
McQueeney, Krista. 2009. "'We are God's Children, Y'All:' Race, Gender, and Sexuality in Lesbian-and Gay-Affirming Congregations." *Social Problems* 56:151-173.
Merriam, Sharan B. *1998. Qualitative Research and Case Study Applications in Education. San Francisco: Jossey-Bass Publishers*
—. 2009. *Qualitative Research: A Guide to Design and Implementation*. San Francisco, CA: Jossey-Bass.
Miller Robert, L Jr. 2007. Legacy Denied: African American Gay men, AIDS, and the Black Church. *Social Work*, *52*(1), 51-61.
Morgen, Sandra. 2002. "On Their Own: Women of Color and the Women's Health Movement." Pp. 41-69 in *Into Our Own Hands: The Women's Health Movement in the United State, 1969-1990*. New Brunswick, NJ: Rutgers University Press.
Morone, James A. 1997. "Enemies of the People: The Moral Dimensions to Public Health." *Journal of Health Politics, Policy and Law* 22:993-1020.
—. 2005. "Morality, Politics Health Policy." Pp. 13-25 in *Policy Challenges in Modern Health Care*, edited by D. Mechanic. Rutgers, NJ: Rutgers University Press.
Morris, Aldon D. 1984. *The Origins of the Civil Rights Movement: Black Communities Organizing for Change*. New York: The Free Press.
—. 2015. *The Scholar Denied: W. E. B. Du Bois and the Birth of Modern Sociology*. Oakland, CA: University of California Press.
Morris, Aldon D. and Naomi Braine. 2001. "Social Movements and Oppositional Consciousness." Pp. 20-37 in *Oppositional Consciousness: The Subjective*

Roots of Social Protest, edited by J. Mansbridge and A. Morris. Chicago: The University of Chicago Press.
Morris, Aldon D. and Suzanne Staggenborg. 2007. “Leadership in Social Movements.” Pp. 171-196 in *The Blackwell Companion to Social Movements*, edited by D.A. Snow, S.A. Soule and H. Kriesi. Malden, MA: Blackwell Publishing.
Olzak, Susan, and Suzanne Shanahan. 1996 “Deprivation and Race Riots: An Extension of Spilerman's Analysis.” *Social Forces* 74(3): 931-961.
Owens, Michael Leo. 2007. *God and Government in the Ghetto: The Politics of Church-State Collaboration*. Chicago: The University of Chicago.
Omi, Michael and Howard Winant. 2015. *Racial Formation in the United States*. New York: Routledge.
Parsons, Talcott. 1951. “Social Structure and Dynamic Process: The Case of Modern Medical Practice.” Pp. 428-479 in *The Social System*. London: Routledge.
Pattillo-McCoy, Mary. 1998. “Church Culture as a Strategy of Action in Black Community.” *American Sociological Review* 63:767-784.
Patton, Cindy. 1990. *Inventing AIDS*. New York: Routledge.
—. 1994. *Last Served? Gendering the HIV Pandemic*. London: Taylor & Francis.
Patton, Michael Quinn. 2002. *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage.
Pichardo, Nelson. 1988. “Resource Mobilization: An Analysis of Conflicting Theoretical Variations.” *The Sociological Quarterly* 29(1):97-110.
Piven, Frances Fox, and Richard A. Cloward. 1979. *Poor People's Movements: Why They Succeed, How They Fail*. New York: Vintage Books.
—. 1993. *Regulating the Poor: The Function of Public Welfare Updated Edition*. New York: Vintage Books.
Quimby, Ernest and Samuel R. Friedman. 1989. “Dynamics of Black Mobilization against AIDS in New York City.” *Social Problems* 36:403-415.
Quinn, Sandra Crouse and Stephen B Thomas. 2001. “The National Negro Health Week, 1915 to 1951: A Descriptive Account.” *Minority Health Today* 2:44-49.
Riegelman, Richard. 2010. *Public Health 101: Healthy People-Healthy Populations*. Sudbury MA: Jones and Bartlett Publishers.
Roberts, Dorothy. 1997. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Pantheon Books.
Rohlinger, Deana A. 2015. *Abortion Politics, Mass Media, and Social Movements in America*. New York: Cambridge University Press.
Rosen, George. 1993. *The History of Public Health*. Baltimore, MD: The Johns Hopkins University Press.
Shaw, Donna. 1996. "Pass Ricky Ray Bill, Families Urge House is Asked to Vote $1 Billion Over Hemophiliacs' AIDS Cases." in *The Inquirer*. Philadelphia.
Shilts, Randy. 1987. *And the Band Played On: Politics, People and the AIDS Epidemic*. New York: St. Martin's Press.
Shim, Janet K. 2014. *Heart-Sick: The Politics of Risk, Inequality, and Heart Disease*. New York: New York University Press.

Simmons, Christina. 1993. "African American and Sexual Victorianism in the Social Hygiene Movement, 1910-40." *Journal of the History of Sexuality* 4:51-75.
Smedly, Brian D., Adrienne Y. Stith, and Alan R. Nelson. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D.C.: National Academies Press.
Smith, Raymond A. and Patricia D. Siplon. 2006. *Drug Into Bodies: Global AIDS Treatment Activism*. Westport, CT: Praeger.
Smith, Susan. 1995. *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950*. Philadelphia: University of Pennsylvania Press.
Spade, Dean. 2013. "Intersectional Resistance and Law Reform." *Signs* 38:1031-1055.
Springer, Kimberly. 2005. *Living for the Revolution: Black Feminist Organization, 1968-1980*. Charlotte, NC: Duke University Press.
Stockdill, Brett C. 2003. *Activism Against AIDS: At the Intersections of Sexuality, Race, Gender, and Class*. Boulder CO: Lynne Rienner Publisher.
Szreter, S. 1988. "The Importance of Social Intervention in Britain's Mortality Decline c. 1850-1914: A Reinterpretation of the Role of Public Health." *Soc Hist Med* 1:1-38.
Tarrow, Sidney. 1996. "States and Opportunities: The Political Structuring of Social Movements." Pp. 41-61 in *Comparative Perspectives on Social Movements*, edited by D. McAdam, J. McCarthy, and M. Zald. New York: Cambridge University Press.
Taylor, Nikki M. 2005. *Frontiers of Freedom: Cincinnati's Black Community, 1802-1868*. Athens: Ohio University Press.
Thomas, Stephen B. and Sandra Crouse Quinn. 1991. "The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV Education and AIDS Risk Education Programs in the Black Community." *American Journal of Public Health* 81:1498-1516.
Thomas, Stephen B., Sandra Crouse Quinn, James Butler, Craig S. Fryer, and Mary A. Garza. 2011. "Toward a Fourth Generation of Disparities Research to Achieve Health Equity." *Annual Review of Public Health* 32:399-416.
Tilly, Charles. 1978. *From Mobilization to Revolution*. Reading, MA: Adison-Wesley.
Treichler, Paula. 1999. *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham: Duke University Press.
Tucker-Worgs, Tamelyn N. 2011. *The Black Mega-Church: Theology, Gender, and the Politics of Engagement*. Waco Texas: Baylor University Press.
Tucker-Worgs, Tamelyn and Donn C Worgs. 2014. "Black Morality Politics: Preachers, Politicians, and Voters in the Battle Over Same-Sex Marriage in Maryland." *Journal of Black Studies* 45(4): 338-362.
Useem, Bert. 1998. "Breakdown Theories of Collective Action." *Annual Review of Sociology* 24:215-238.
Urban Institute. 2012. "Neighborhood Info DC_ A Project of the Urban Institute and a Partner of the National Neighborhood Indicators Partnership. Washington

D.C." Date Accessed June 12, 2013. (http://www.neighborhoodinfodc.org/wards/wards.html)
U.S. Census Bureau. 2015. *QuickFacts: District of Columbia*. Retrieved April 01, 2016 (http://www.census.gov/quickfacts/table/PST045215/11)
Wacquant, Loïc. 2002. "From Slavery to Mass Incarceration." *New Left Review* 13:41-60.
—. 2008. *Urban Outcasts: A Comparative Sociology of Advanced Marginality*. Malden, MA: Polity Press.
Washington, Harriet A. 2006. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Doubleday.
Watkins-Hayes, C. 2008. "The Social and Economic Context of Black Women Living with HIV/AIDS in the US: Implications for Research." Pp. 33-66 in *Sex, Power and Taboo: Gender and HIV in the Caribbean and Beyond*, edited by D. Roberts, R. Reddock, D. Douglas, and S. Reid. Kingston, Jamaica: Ian Randle.
West, Cornel. 1999. "On Sexuality." Pp. 514-520 in *The Cornel Wes Reader*. New York: Basic Civias Books.
White, Gilbert C. 2010. "Hemophilia: An Amazing 35-Year Journey from the Depths of HIV to the Threshold of Cure." *Transactions of the American Clinical and Climatological Association* 121:61-75.
Williams, Brett. 2009. "Deadly Inequalities: Race, Illness, and Poverty in Washington D.C., since 1945." Pp. 123-141 in *African American Urban History Since World War II*, edited by K.L. Kusmer and JW Trotter. Chicago: The University of Chicago Press.
Williams, David R. and Michelle Sternthal. 2010. "Understanding Racial/ethnic Disparities in Health: Sociological Contributions." *J Health Soc Behav.* 51 (Suppl):S15-S27.
Williams, David R. and Ronald Wyatt. 2015. "Racial Bias in Health Care and Health Challenges and Opportunities." *JAMA* 314:555-556.
Williams, Delores S. 1989. "Womanist Theology: Black Women's Voices." Pp. 179-186 in *Weaving the Visions: New Patterns in Feminist Spirituality*, edited by J. Plaskow and C. P. Christ. New York: HarperCollins Publishers.
Wilson, D. Mark. 2008. "Too Gay for the Church, but Always at Home in the Club: Health, Spirituality, and Social Support among Adult Black Gay Men at Oakland's Cable Reef." Pp. 160-180 in *Faith, Health, and Healing in African American Life*, edited by S. Y. Michem and E. M. Townes. Westport, CT: Praeger Publishers.
Wingood, Gina M and Ralph J DiClemente. 2010. "HIV Prevention for Heterosexual African-American Women." Pp. 211-222 in *African Americans and HIV/AIDS: Understanding and Addressing the Epidemic*, edited by D. H. McCree, K. T. Jones, and A. O'Leary. New York: Springer.
Yin, Robert K. 2009. *Case Study Research: Design and Method, 4th edition*. Thousand Oaks: Sage: Sage.

[1] Acquired Immune Deficiency Syndrome (AIDS) is defined by the World Health Organization (WHO) as a health condition which is caused by the introduction of the Human Immunodeficiency Virus (HIV) to the body. This condition results in the deterioration of the human immune system—leaving the body susceptible to opportunistic infections and tumors. The virus is transmitted through infected bodily fluid containing HIV—semen, vaginal fluid, blood, breast milk, and thus can be introduce to the body through anal or vaginal sex, contaminated hypodermic syringes, blood transfusion or exchanged from mother to child during pregnancy, childbirth, or breastfeeding.

[2] While the Civil Rights Movement is well documented, other movements have been essential to Black liberation struggles. The Black Power Movement is another example of Black protest traditions. This included an oppositional movement where people, some who were a part of the Civil Rights Movement gave up on the belief that the United States would ever grant them full citizenship and rights (Omi and Winant 2015). Power activists called for a separation and the development of a sovereign Black nation. In addition, studies note the contribution of the Black Power Movement to Black cultural activism (Lincoln and Mamiya 1990, Omi and Winant 2015). For example, activists contested White cultural hegemony which viewed Black bodies, language, art form, and knowledge as inferior by fostering sense of Black cultural pride.

[3] As one of the only institutions that was largely independent from White control, churches provided meeting places for activists to plan resistance strategies and tactics as well as to provide financial and human resources (McAdam 1999). The Southern Christian Leadership Conference (SCLC) served as the decentralized arm of Black church throughout the south which allowed for the coordination and distribution of information and resources for the movement (Morris 1984). Moreover, the charismatic leadership of Black religious leaders such as Martin Luther King were essential in bridging democratic and religious ideals in ways that proved essential to the oppositional framing of civil rights (Morris and Staggenborg 2007).

[4] The advances made after the Civil Rights Movement largely benefited the Black middle class who gained access to higher education, jobs, political office and power in the other public spheres of society. Despite progress in the public sphere of society, the Black middle class continued to hold marginalized status in the United States (Marable 2000; Patterson 2015; Wilson 1996).

[5] This is often done through the volunteer arm of the church such as the soup kitchens and food and clothing banks often geared towards the poor. However, some churches provide social services through a separate entity that offers education, housing, mental health and health care.

[6] Patton (2002) uses the term "information-rich cases" in his description of the purposeful sampling. Information-rich cases include those from which one "can learn a great deal about issues of central important to the purpose of the research" (Patton 2002:230).

[7] The Black AIDS Institute is the largest HIV/AIDS think tank in the United States that exclusively provides resources and information from a Black perspective. One of the resources the institute provides is a list of AIDS organizations in major cities in the United States in which Black people represent a disproportionate percentage of the population affected by AIDS. The website provides lists for seven cities and Washington, D.C. is listed as one of those cities for which resources are provided about AIDS organizations.

[8] These eight individuals are a part of a larger network of activist that the organizations in this study are directly connected. They include people who specialize in issues like HIV/AIDS housing and substance abuse.

[9] I was unable to acquire the same demographic information that I got for the churches in terms of the organization's constituents.

[10] Like Community Alliance, I was unable to acquire demographic information of the constituents of Brothers United. The individual with that information would not return my call.

[11] As mentioned in chapter 4, Community Alliance has its roots in the reproductive rights movement, which was initially slow to provide resources to address HIV/AIDS, despite the discovery of the threat of the epidemic to the lives, health, and well-being of poor women of color, some of whom had a history of substance abuse.