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More Than Pushing Pills: Black AIDS Activism in the Bay Area, 1981-1996

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Acknowledgments

Throughout the process of writing and researching for this dissertation, I relied heavily on countless people. It took a village bringing this project into existence. Unfortunately, I have also lost many friends and family members along the way. For that reason, I want to dedicate this dissertation to three people. My closest friend, Omar Abdallah, who was murdered on my mother's birthday—October 9th, 2017. Omar was taken from us less than a month into me starting my PhD program. We vowed to "take over the world" together. It has been a rather lonely journey without him but may his memory live on.

I would also like to single out my aunt, Loreen Jackson, and my uncle, Albert "Ronnie" Johnson. Auntie Lori transitioned on February 8th, 2022, and Uncle Ronnie on March 20, 2022. I looked forward to celebrating as the first in our family to earn a PhD with my family. The celebration will be different without these two. I hope I made all three proud before their transition. This is for them.

ABSTRACT

MORE THAN PUSHING PILLS:
BLACK AIDS ACTIVISM IN THE BAY AREA, 1981-1996

ANTOINE S. JOHNSON

This dissertation traces Black AIDS Activism in the Bay Area and how the layered crises of the crack cocaine epidemic, chronic joblessness, and poverty shaped HIV/AIDS prevention and education efforts. It also compares Black health activism with ways policymakers, local media outlets, and health professionals' interventions and perspectives helped or hindered Black communities. Many public health officials and journalists purported that poor and working-class African Americans' behavior—particularly that of drug users, sex workers, gay men and men who had sex with men (but did not identify as being gay)—placed them at greater risk of infection. This approach ignores ways chronic joblessness, police surveillance, inadequate access to health care, and other structural inequities, disregarded by the medical community before HIV/AIDS was identified, contributed to African Americans' disease susceptibility. As a result, Black activists paved the way for new, alternative, relevant methods to HIV/AIDS prevention, awareness, and outreach throughout the 1980s by contesting the liberalism of the "San Francisco Model of Care." Their community care methods remain helpful for public health departments failing to develop effective harm reduction tactics in low-income communities of color.

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Introduction

I

On June 5, 1981, the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report* (*MMWR*) published the first official account identifying the acquired immune deficiency syndrome (AIDS) in the United States. The report mentioned five previously healthy men, all of whom were white and participating in same-sex sex. The next two cases were men of African descent. The report, however, omitted these cases, thereby framing AIDS as a "gay white disease."[1] This put Black communities at profound disadvantages, as the epidemic exacerbated issues they were already experiencing, especially in the Bay Area. According to the sociologist Chris Rhomberg, from 1981 to 1988, Oakland alone lost twelve thousand jobs from manufacturing, transportation, utility, and communications industries—the job sector that attracted African Americans to the Bay Area during the Second Great Migration after the Second World War. While city unemployed hovered around nine percent by 1990, for African Americans it sat closer to 20 percent with a quarter of Black families living below the poverty line—the same number from the 1980 census. "These conditions left low-income [Black] neighborhoods especially vulnerable to the rising epidemic of drugs and crime," says Rhomberg. Homicide rates almost doubled from 1983 to 1992 with the introduction of crack cocaine, creating additional health and social issues for poor and working-class communities during the AIDS epidemic.[2]

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[1] Center for Disease Control and Prevention, "Pneumocystis Pneumonia," *Morbidity and Mortality Weekly Report* 30, no. 21 (June 5, 1981): 1-3; Linda Villarosa, "America's Hidden HIV Epidemic," *New York Times Magazine* (June 11, 2017), 43.

[2] Chris Rhomberg, *No There There: Race, Class, and Political Community in Oakland* (Berkeley: University of California Press, 2004), 185-187.

Despite AIDS, crack cocaine and heroin, as well as chronic joblessness operating synergistically in poor and working-class African American Bay Area communities, many health professionals failed to develop comprehensive strategies accounting for these cross-cutting problems and instead viewed the AIDS epidemic as an isolate. This trend stemmed from the disproportionate impact of AIDS in gay communities with particular focus on gay white men who had readily access to medical and political decisionmakers.[3] Thus, in tandem, many white activists and health professionals' AIDS activism emphasized safe sex campaigns to prevent new AIDS cases, essentially eroticizing AIDS prevention. That was particularly the case with the San Francisco AIDS Foundation who, according to historian Jennifer Brier, employed "a single-minded focus on the marketing of safe sex," making them ill-equipped to extend outreach to poor and working-class communities whose vulnerability extended beyond sexual intercourse.[4] This had a great deal to do with the conservative turn among San Francisco's gay white communities. As Frances Fitzgerald highlights, by 1978, the city's gay (white) society distanced itself from previous counterculture trends that originated in their shared sexuality, but they now embraced one another as "well-educated young white men."[5]

AIDS was more than an aberration for African Americans who suffered from longstanding health inequities. This was one way the Multicultural AIDS Resource Center (MARC) approached the epidemic. While surveying people living with HIV/AIDS (PLWHA) throughout the Bay Area, MARC found that many local white Bay Area residents benefitted

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[3] J. W. Dilley, "Implications for the San Francisco Model of Care," *AIDS Care* 2, no. 4 (1990); Robert M. Wachter, "AIDS, Activism, and the Politics of Health," *New England Journal of Medicine* 326, no. 2 (January 1992).

[4] Jennifer Brier, *Infectious Ideas: U.S. Political Responses to the AIDS Crisis* (Chapel Hill: University of North Carolina Press, 2009), 44-48.

[5] Frances Fitzgerald, *Cities on a Hill: A Journey through Contemporary American Cultures* (New York: Simon & Schuster, 1987), 116; also see Nick Freudenberg, "Historical Omissions: A Critique of *And the Band Played On*," *Health Policy Advisory Center Bulletin* 18, no. 1 (Spring 1988): 16-20.

from private health care and insurance. Low-income African Americans, on the other hand, relied on overwhelmed, substandard public health care systems, often resulting in long waiting periods to be seen. “Many public [health care] facilities are not equipped to deal with HIV/AIDS in a manner that does not add to the stigmatization of the person seeking care,” argued the MARC collective. Sala Udin, the founder of MARC, had a history of harm reduction and methadone maintenance, which helped the organization work with communities suffering from cross-cutting health issues in addition to HIV/AIDS. Poor and working-class Black PLWHA, said Udin, often had to choose between confronting HIV/AIDS or other life-threatening problems such as drug dependence, housing insecurity, employment, and mental health matters. Thus, Udin and MARC argued, “Effective intervention strategies will seek to link care for HIV/AIDS with services addressing other needs and issues.”[6] These are the bases upon which many Black AIDS activists sought to eradicate new AIDS cases and alleviate the suffering PLWHA experienced. This project offers a glimpse into a number of those organizations.

II

Many scholars of the AIDS epidemic and Black AIDS activism have long contended that the disease is symptomatic of larger systemic problems in American society. Most have used theoretical concepts to situate AIDS along a continuum of health inequities among African Americans. In 1988, the epidemiologist Rodrick Wallace showed how AIDS, drug use, “planned shrinkage,” and urban desertification by the medical community, predatory landlords, and municipal services laid the bases upon which AIDS flourished in dense, majority-Black neighborhoods in the Bronx, New York. Already ravaged by infant mortality, widespread

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[6] MTRC African American Focus Group undated, Box 1, Folder 22, MSS 94-19, Multicultural AIDS Resource Center, 1988-1993, Archives and Special Collections, University of California, San Francisco, San Francisco, California.

intravenous drug use, and homelessness, the communities experienced what Wallace calls a "synergism of plagues" to describe such ecological collapse. "Instability from the first wave of contagious urban decay has already made control of AIDS… extraordinarily difficult," says Wallace. "AIDS now threatens to become convoluted into the very decay cycle which has hastened its spread."[7]

The social psychiatrist Mindy Thompson Fullilove built upon Wallace's conceptual framework of "communal decay and the AIDS epidemic" to make sense of what she saw as deliberate government divestment from public services in Black Bay Area communities. While surveying San Francisco's Bayview district in 1989, which was predominantly Black, Fullilove saw no shortage of teenage crack dealers and no presence of grocery stores, banks, or restaurants.[8] After several individual and joint article publications, Fullilove published her monograph, *Root Shock: How Tearing Up City Neighborhoods Hurts America, And What We Can Do About It*, to explain the proliferation of AIDS among neighborhoods ravaged by illnesses, poverty, homelessness, violence, and chronic joblessness. these processes unfold and how to ameliorate affected communities. Like Wallace, Fullilove shows how one disaster impacts the other, "and the spiral of community disintegration began to spin faster and faster, just as the last domino seems to fall much more quickly than the first."[9]

Other general approaches to describe similar phenomena include the syndemic theory, which focuses on ways multiple health issues interact with socioeconomic and physical

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[7] Rodrick Wallace, "A Synergism of Plagues: 'Planned Shrinkage,' Contagious Housing Destruction, and AIDS in the Bronx," *Environmental Research* 47, no. 1 (1988): 25-28.

[8] Jacob Levenson, *The Secret Epidemic: The Story of AIDS in Black America* (New York: Anchor Books, 2004), 99-102.

[9] Mindy Thompson Fullilove, *Root Shock: How Tearing Up City Neighborhoods Hurts America, And What We Can Do About It* (New York: New York University Press, 2004), 290.

environments. One of the most popular syndemics advanced is the SAVA (substance use, violence, and AIDS) syndemic by Merrill Singer. This approach showed the biological implications of ways structural racism and gender inequality, among other things, influence stress, depression, and drug use, thus systematically making groups vulnerable to AIDS infection.[10] Ethnographers who spent time with Black PLWHA offered additional insight into ways in which systemic racism and medical discrimination impact specific subpopulations. For instance, Michelle Tracy Berger's concept of intersectional stigma elucidates ways impoverished Black women who experienced sexual trauma at a young age eventually resorted to sex work, which increased their susceptibility to HIV/AIDS.[11]

The women's marginality eradicated the perception of "innocent victimhood" that many white men received. Upon entering clinical settings, the women experienced "narratives of injustice" whereby hospital staff refused to provide women information on disease transmission; their clinicians focused on death, essentially telling the women to go home and prepare to die; and women reported poor treatment after drugs were detected in their systems. Providers disregarded or never inquired about the women's shared histories of drug use, homelessness, poverty, and histories of physical and sexual abuse.[12] The sociologist Celeste Watkins-Hayes builds upon Berger's injustice narratives to advance her concept "injuries of inequality" to condense socioeconomic, mental, and physical deterioration women LWHA experienced in her ethnography leading up to, and during, their seroconversion. Short- and long-term injuries—

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[10] Emily Mendenhall et al., "Non-communicable disease syndemics: poverty, depression, and diabetes among low-income populations, *The Lancet* 389, no. 10072 (March 2017): 951-963; Merrill Singer, "AIDS and the health crisis of the U.S. urban poor; the perspective of critical medical anthropology," *Social Science & Medicine* 39, no. 7 (October 1994): 931-948.

[11] Michele Tracy Berger, *Workable Sisterhood: The Political Journey of Stigmatized Women with HIV/AIDS* (New Jersey: Princeton University Press, 2004), 3-4.

[12] Ibid., 87-93.

including but not limited to health, housing, education, socioeconomic status, and community support (or lack thereof) resulting in mass incarceration, chronic joblessness, health inequities, and residential segregation—are largely shaped by race, class, gender, and sexuality, "as the likelihood of occurrence is not random but shaped by where we are on the social hierarchy." Thus, says Watkins-Hayes, "*Injuries of inequality produce, and are produced by, a compromised ability to protect oneself from harm.*"[13]

The chapters that follow attempts to extend these scholars' frameworks by offering insight into Black AIDS activism in the Bay Area from different spheres. Black sex workers, church leaders, queer and trans folks, physicians, elected officials, and everyday folks connected AIDS in Black communities to larger structural and medical problems that increased African Americans' exposure. Although things like crack cocaine use did not necessarily give one HIV/AIDS, the behaviors associated with it encouraged actions that increased one's risk of infection.[14] Many Black AIDS activists created awareness and prevention campaigns from this vantage point. Records of the Bay Area's AIDS epidemic, however, relegate African Americans' efforts and suggest that both HIV/AIDS and Black responses occurred as part of a "second wave" epidemic over five years after the disease's identification.[15]

This structure emanated from AIDS being falsely asserted as a "gay white disease," leading to media attention and resource distribution focusing primarily on white men. Shortly thereafter, the medical community and public health infrastructure moved into what historian

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[13] Celeste Watkins-Hayes, *Remaking a Life: How Women Living with HIV/AIDS Confront Inequality* (Oakland: University of California Press, 2019), 5-14 (emphasis in original).

[14] Rose Appleman, "People of color march against AIDS in Oakland; Citing dramatic rise in numbers of AIDS cases, activists demand immediate action from institutions in communities of color," *Gay Community News* 16, no. 38 (April 1989): 1.

[15] *San Jose Mercury News*, July 22, 1986.

Stephen J. Inrig calls "the battle for AIDS exceptionalism." White men were portrayed as "innocent victims" by authors such as Randy Shilts, Larry Kramer, Norman Rene, and Andrew Holleran, all of whom painted battles over AIDS policy as "a struggle between the forces of rationality and compassion and the forces of fear and moralistic discrimination."[16] The sociologist Steven Epstein portrays white AIDS activists' confrontations with health professionals as a "crisis of credibility." Access to health professionals, many of whom shared many cultural values, allowed many white AIDS activists to contribute to biomedical knowledge production and spearhead clinical trials.[17] As the title of this project suggests, Black AIDS activists elicited approaches to the epidemic that involved more than pushing pills. Some were forced to adopt this approach, as many white AIDS organizations were hostile to Black members or felt African Americans' needs compromised their agendas. In 1991, for instance, journalist Randy Shilts claimed white activists' militance became irrelevant by "being more concerned about poor blacks and Hispanics with AIDS than about gay white men with AIDS."[18] These attitudes were reflected in local epidemiology and AIDS policy initiatives that, by framing the epidemic as one mitigated primarily by safe sex, failed to incorporate poor and working-class African Americans whose exposure increased due to social and environmental factors.

The stories in this project make similar connections by centering the experiences of African Americans in general, and particularly Black AIDS activists, in one of the epicenters of

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[16] Stephen J. Inrig, *North Carolina and the Problem of AIDS: Advocacy, Politics, & Race in the South* (Chapel Hill: The University of North Carolina Press, 2011), 2-4; see also Ronald Bayer, *Private Acts, Social Consequences: AIDS and the Politics of Public Health* (New Jersey: Rutgers University Press, 1989).

[17] Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley: University of California Press, 1996), 8-14.

[18] Deborah Gould, *Moving Politics: Emotion and ACT UP's Fight against AIDS* (Chicago: The University of Chicago Press, 2009), 282; Chris Bull, "Spy Allegations Pit Pennsylvania Police Against Activists," *The Advocate*, February 26, 1991.

the epidemic. The first chapter explores gaps and oversights in the epidemic, asking why and how AIDS falsely became perceived as a "gay white disease," its implications for African Americans, and how Black activists navigated the local AIDS infrastructure that ostensibly rendered them invisible. From the CDC's June 5, 1981 *Morbidity and Mortality Weekly Report* omitting cases involving Black people diagnosed with AIDS in its inaugural report on the disease, to the proliferation of the heralded San Francisco Model of Care, Black activists, clinicians, and PLWHA took umbrage with ways the media and policymakers disregarded ways structural and medical discrimination increased one's vulnerability. Rugged individualism in American public health contributed to these disparities, investing primarily into safe sex campaigns that emphasized behavioral changes to eradicate HIV/AIDS. This, in turn, placed sole responsibility on the individual for their health concerns, turning American citizens into patient-consumers.[19] This chapter attempts to unpack that process amidst rising health problems in poor and working-class Black communities, and how African Americans confronted these inequities.

Chapter two centers the sex workers organization CAL-PEP (California Prostitutes Education Project) and their AIDS activism. Retired sex worker Gloria Lockett founded CAL-PEP in 1984 as an offshoot of its parent organization, COYOTE (Call Off Your Old Tired Ethics) to prevent the spread of HIV/AIDS among people who used drugs intravenously—primarily Black sex workers—as well as drug users' sexual partners, crack cocaine users, unhoused people, and runaway youth. Meeting sex workers in person and on their own terms, CAL-PEP developed culturally appropriate material using language sex workers understood. The organization was run by former and active sex workers who understood that time was literally

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[19] Lester K. Spence, "Live and Let Die: Rethinking Secondary Marginalization in the 21st Century," *Souls* 21, no. 2-3 (July 2019): 195-196.

money. Thus, CAL-PEP offered cash prizes, free condoms, HIV and sexually transmitted disease tests, and often referrals for seropositive women. After registering as a nonprofit organization in 1987 and partnering with Dr. Constance Wofsy from the University of California, San Francisco (UCSF), CAL-PEP secured grants and expanded their outreach to include San Francisco and Oakland neighborhoods. Realizing that street-operating sex workers—who were overwhelmingly Black women and Black trans folks who also used drugs intravenously—worked clandestinely to avoid police harassment, CAL-PEP used grant funds from the Robert Wood Johnson Foundation to purchase a van in which they painted maroon. The color was deliberately painted in a color in which street-based sex workers could recognize CAL-PEP from a distance and seek services, rather than mistaking the organization for police vans.[20]

The next chapter examines Dr. Robert C. Scott and the AIDS Project of the East Bay (APEB) and their fight with the Alameda County Department of Public Health to provide AIDS services to Black people, as well as for the health department to acknowledge the threat of HIV/AIDS among African Americans. Dr. Scott, a UCSF physician, created APEB as a volunteer clinic that became the first place offering AIDS services in the Bay Area outside of San Francisco. Founded in 1983, APEB dispensed pamphlets targeting different Black populations—especially Black queer folks, Black women, drug users, and Black youth—on different ways of contracting HIV/AIDS, as well as how to protect oneself from infection. APEB also used its funds to provide transportation services, buy groceries, and offer rent relief for its clients living with HIV/AIDS. Dr. Scott was also an usher at Oakland's famous Allen Temple Baptist Church, where the lead pastor, Reverend Dr. James Alfred Smith, Sr., reluctantly

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[20] CAL-PEP: 1990-1991 Correspondence, Box 57, Folder 12, SFH 4, San Francisco Department of Public Health Records, San Francisco Public Library, San Francisco, California.

acknowledged the AIDS and crack epidemics among Oakland's Black populations until 1985. Dr. Scott not only suggested the church address the overlapping health crises during church services, but also convinced Pastor Smith to create an AIDS ministry in 1985.[21]

This segues directly into chapter four, which focuses on the complex relationships between African American churches and HIV/AIDS. In addition to Allen Temple, it highlights the nature and extent of the AIDS Ministries at Glide Memorial in San Francisco, Oakland's Love Center Church, and the work of the Black lesbian Bishop Yvette Flunder. Bishop Flunder started doing AIDS work as a member of The Love Center under Pastor Walter Hawkins. In 1991, she left and created her own church, The City of Refuge United Church of Christ, where she practices "radical inclusion" to eradicate not only HIV/AIDS, but more importantly stigma around the behaviors that lead to HIV/AIDS infection, as well as homophobia and transphobia. Flunder's church provides refuge to same gender loving (SGLs) people by centering their experiences and celebrating them and their relationships with Christianity. Shortly after opening the City of Refuge, she also opened the Ark of Refuge, which offered temporary and permanent housing, drug counseling, and AIDS services to people throughout the Bay Area.[22]

III

In March 2020, SARS-CoV-2, also referred to as coronavirus or COVID-19, created an international pandemic. The pandemic shut down countless facilities and businesses, including archives and libraries. As a result, this project's scope has been severely limited, due to the

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[21] *Bay Area Reporter*, December 11, 1986; "Memorandum from J. Alfred Smith Jr. to J. Alfred Smith Sr. re: Status Report of AIDS Ministry Activities 1992-10-21," Box 14, Folder 4, African American Museum & Library at Oakland Vertical File Collection, MS 179, African American Museum & Library at Oakland, Oakland Public Library, Oakland, California.

[22] Elizabeth Perez, "'You Were Gonna Leave Them Out?': Locating Black Women in a Transfeminist Anthropology of Religion," *Feminist Anthropology* 2, no. 1 (May 2021): 97; *Bay Area Reporter*, November 28, 1996; Yvette A. Flunder, *Where the Edges Gather: Building a Community of Radical Inclusion* (Cleveland: The Pilgrim Press, 2005).

author's inability to access archival collections and conduct oral history interviews. Chapter two is without Margo St. James's archive collection. St. James founded CAL-PEP's parent organization, COYOTE, and was a good friend of Gloria Lockett. The two met in 1978 when Lockett was being prosecuted in a "stupid, racist, sexist, and biased" case that indicted Lockett and eight other women of conspiracy for prostitution. Lockett's bail was set at $500,000, and she contacted St. James for support. "Margo St. James went to court with us every day," said Lockett. Upon her release, she joined COYOTE and, with significant support, later created CAL-PEP to focus on Black women in the sex industry. The years 1978-1984 can fill in plenty of gaps and give credence to the St. James and COYOTE's impact on CAL-PEP's foundation. The monograph version of this project will elaborate on COYOTE's fight against the criminalization of sex work, St. James and Lockett's friendship, and the rift that led to the creation of CAL-PEP.[23]

Both chapters three and four would benefit from the records of Pastor James Alfred Smith, Sr., whose collection is housed at the New York Public Library. Pastor Smith worked closely with Dr. Scott and Bishop Flunder and is recognized as one of the Bay Area's most progressive and prestigious pastors. More analysis on his role in local Black church's AIDS activism will be expanded upon in the book manuscript.[24] Moreover, an additional chapter will be added that examines Black elected officials' AIDS activism. Congresswoman Barbara Lee

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[23] Interview with Gloria Lockett, February 14, 1993, Box 5, Folder 35, MSS 2000-6, Nancy Stoller Papers, Archives and Special Collections, University of California, San Francisco, San Francisco, California; Gloria Lockett, "CAL-PEP: The Struggle to Survive," in *Women Resisting AIDS: Feminist Strategies of Empowerment*, ed. Beth E. Schneider and Nancy E. Stoller (Philadelphia: Temple University Press, 1995), 208-209; Margo St. James Papers. 2019-M103-2019-M121, Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Massachusetts; Records of COYOTE, 1962-1989, 81-M32-90-M1, Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Massachusetts.

[24] James Alfred Smith, Sr. Papers, 1942-1992, Sc MG 366, Schomburg Center for Research in Black Culture, The New York Public Library, New York, New York.

agreed to an oral history interview. Material from that recording, as well as newspaper articles and archival ephemera, will focus on Congresswoman Lee and her mentors—Maudelle Shirek and Ron Dellums—all of whom stressed that AIDS was part of larger socioeconomic and environmental problems among poor and working-class African Americans. From a health policy perspective, this chapter will explore the ways in which local policymakers justified withholding funds for which Congresswoman Lee and others clamored to alleviate the conditions leading to HIV/AIDS infection around the Bay Area.[25] That said, this dissertation is the start of many projects amplifying Black AIDS activism in the context of structural violence that perpetuates health inequities, particularly among poor and working-class African Americans.

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[25] Barbara Lee Papers 1977-1998, MS 086, African American Museum and Library at Oakland, Oakland Public Library, Oakland, California.

Chapter 1

Framing AIDS: Race, Syndemics, and Anti-Blackness in the Bay Area's Epidemic

I

In the PBS documentary film *Endgame: AIDS in Black America*, Dr. Michael Gottlieb unveils a startling confession about the first reported cases in the Center for Disease Control and Prevention's (CDC) June 5, 1981, *Morbidity and Mortality Weekly Report* (*MMWR*). Gottlieb is credited with identifying the first cases of the acquired immunodeficiency syndrome (AIDS), which reported in the June 5, 1981, *MMWR* five cases of pneumocystis *carinii* pneumonia (PCP) in otherwise healthy men. Prior to the date, physicians detected PCP primarily in older patients on immunosuppressants or cancer patients. The first five cases were white gay-identifying men. Missing from the report, however, were the sixth and seventh patients with PCP, both of whom were of African descent. One was a heterosexual Haitian American man and the other a gay African American with PCP and cytomegalovirus, another AIDS symptom that causes blindness while attacking the immune system. Gottlieb noticed the sixth and seventh cases after finalization of the June 5th report but considered it "no big deal" and something that, until recently, he wouldn't have thought it mattered.[26] After witnessing the media sensation of a "killer plague" among white gay men, it left the impression that African Americans were immune from infection, allowing them to continue activities like unprotected sex, injecting drugs, and having multiple sex partners—all of which increases one's chances to infection—without considering contracting HIV/AIDS.[27]

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[26] Linda Villarosa, "America's Hidden H.I.V. Epidemic," *New York Times Magazine*, June 6, 2017, https://www.nytimes.com/2017/06/06/magazine/americas-hidden-hiv-epidemic.html; Kevin M. Moseby, "Two regimes of HIV/AIDS: The *MMWR* and the socio-political construction of HIV/AIDS as a 'black disease,'" *Sociology of Health & Wellness* 39, no. 7 (2017): 1074.

[27] *Endgame: AIDS in Black America*, directed by Renata Simone (PBS, July 10, 2012)

Gottlieb's omission of the first Black cases from the CDC's report and subsequent dismissal of its impact on ways in which the epidemic has been perceived racially represent colorblind approaches to the AIDS epidemic that have rendered the Black HIV/AIDS experience invisible. The high volume of early cases involving gay and bisexual men, as well as men who have sex with men (MSMs) who identify as neither, has led to the conflation of gayness with whiteness. For example, University of California, San Francisco (UCSF) psychiatrist and HIV/AIDS specialist J. W. Dilley stated that when AIDS "became a reality in San Francisco in 1982, it did so in a community that was well-organized, well-respected, and politically influential: the gay community." The gay community, said Dilley, "was accustomed to lobbying for and receiving city services specifically targeted to gays and lesbians."[28] San Francisco, however, like gay communities throughout the country during the first decade of the AIDS crisis, experienced racial and class divisions exacerbated by resource distribution.

Compared to their white counterparts, many Black gay and bisexual men and MSMs experienced residential segregation and racial discrimination in hostile environments, while also being overlooked in AIDS resource distribution and prevention efforts.[29] The Black disco singer Sylvester admonished white gay organizers and San Francisco city health officials for hoarding resources and dismissing African Americans' health concerns. "White, gay boys would not give the services to the [Black] queens," said Sylvester. Local white gay communities "have all the money, all the resources, and you're treating [Black] men like slaves. You give us what's left over."[30] Sylvester's comments reflect the failure of colorblind approaches to AIDS outreach that

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[28] J. W. Dilley, "Implications for the San Francisco Model of Care," *AIDS Care* 2, no. 4 (1990): 349.

[29] Dan Royles, *To Make the Wounded Whole: The African American Struggle against HIV/AIDS* (Chapel Hill: University of North Carolina Press, 2020): 25-26.

[30] Mark Grossfeld, "Moments with Sylvester," *PWA Voice* 2, no. 1 (Winter 1989): 9.

divided the epidemic racially without employing culturally-specific interventions across groups. By assessing the needs of African Americans through the lens of white communities, health professionals and policymakers separated HIV/AIDS from other, longstanding health concerns plaguing Black communities that would have created a more urgent response to the threat of HIV/AIDS among African Americans.

When AIDS hit, Black communities already suffered disproportionately from "ailments and structural difficulties, such as sickle-cell anemia, high blood pressure, homelessness, persistent poverty, drugs, crime, and unemployment."[31] Many critics believed these compounding health disparities should have generated more urgent responses from those affected. "Because of the inordinate amount of suffering found in African-American communities," says political scientist Cathy J. Cohen, "we might expect more attention to this crisis" from Black organizers.[32] That perspective ignores state-sanctioned violence that increases poor and working-class Black communities' exposure to diseases and inadequate access to health care. It also, says the political scientist Lester K. Spence, places "primary responsibility for combatting the disease on the populations least likely to have the capacity to do so," a neoliberal form of health promotion. The "new public health," says Spence, incentivizes "individuals to take responsibility for their own health. These strategies are designed to inform individuals about their health, about health-related risks, and the various steps they can take to prevent their health from deteriorating."[33]

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[31] Cathy J. Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of Chicago Press, 1999), 34.

[32] Ibid.

[33] Lester K. Spence, "Live and Let Die: Rethinking Secondary Marginalization in the 21st Century," *Souls* 21, no. 2-3 (2019): 193-195.

Many clinicians, public health officials, and journalists projected white community responses to HIV/AIDS on communities of color, particularly African American communities. Though politicized from its inception among poor and working-class African Americans—particularly by failing, or refusing to, develop culturally specific harm reduction approaches—defining HIV/AIDS and normality through a white lens made the disease a political issue. Sex work and injecting drugs, compounded by structural failures such as inadequate access to quality health care, employment, living conditions, and education, contributed to the politicization of HIV/AIDS. For example, the historian Evelynn M. Hammonds notes that race blindness in the media led to a "failure to develop educational programs and materials that speak in the language of [Black] communities and recognize the position of people of color in relation to the dominant institutions of society."[34] Hammonds' comments highlight the media's—as well as health professionals, policymakers, and majority-white AIDS organizations—failure to understand HIV/AIDS as a continuum of health inequities among African Americans. By individualizing the AIDS epidemic, epidemiologists and clinicians placed vulnerable Black populations at a disadvantage through their refusal to contextualize longstanding health concerns in Black communities and thus avoided how those communities have worked to improve the health of their respected communities.

According to the sociologist Celeste Watkins-Hayes, traditionally speaking, there have been three central approaches to fighting HIV/AIDS: biomedical, behavioral, and structural. The biomedical method relies heavily on "medical technologies, including scientific breakthroughs confirming drug efficiency." The behavioral approach, which arguably has the oldest genealogy

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[34] Evelynn M. Hammonds, "Race, Sex, AIDS: The Construction of 'Other,'" *Radical America* 20, no. 6 (Nov.-Dec. 1987): 30.

in American public health, has victim-blaming undertones through promoting condom use, fewer sexual partners, taking one's medications, and using sterile syringes. Essentially, behavioralists fail to critique structural racism and advance health promotion at individual levels. "Behavioral interventions," says Watkins-Hayes, "have varied significantly in tone and effectiveness, but they encourage individuals to change behaviors that may cut their lives short. Support groups, case management, peer educators, and other tools fall into this category." Lastly, structuralists elucidate the role health determinants play in AIDS vulnerability. From an intersectional perspective, structural interventionists "seek to attack the drivers of the AIDS epidemic by targeting the systematic ways in which social and economic inequality directly and indirectly increase the risk of infection and deleterious post-diagnosis experiences," claims Watkins-Hayes.[35] This chapter examines all three approaches at different junctures to illuminate ways HIV/AIDS has been situated in broader conversations on the health of Black communities[36] by Black organizers and health experts, as well as the strengths and limitations of public health, policy, and epidemiological initiatives.

Scholars continue to create new ways of understanding covariates leading to the spread of HIV/AIDS, particularly among poor and working-class communities of color. Anthropologists have created the syndemic theory to describe cross-cutting epidemics such as drug dependence, HIV/AIDS, and violence that reify health and social inequities.[37] Developed in the early 1990s by medical anthropologist Merrill Singer, syndemics are "useful for understanding how

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[35] Celeste Watkins-Hayes, *Remaking a Life: How Women Living with HIV/AIDS Confront Inequality* (Oakland: University of California Press, 2019), 184-185.

[36] There is no homogenous Black community. Thus, this chapter uses the term "communities" to distinguish between poor and working-class Black communities, Black gay-identifying communities, Black sex worker communities, Black religious organizations, as well as the differences between American-born African Americans and those who migrated from the Caribbean or the African continent.

[37] Watkins-Hayes, *Remaking a Life*, 3.

sociocultural, historical, and geographical realities in urban areas interact with and compound the adverse consequences of diseases." Rather than isolating HIV/AIDS from inequities among low-income populations such as poverty, underemployment, police violence, and inadequate health care, syndemic theory situates HIV/AIDS within the larger setting of impoverished communities facing longstanding health disparities. "As the compendium of knowledge has advanced," says Singer,

> it has become increasingly clear that diseases do not necessarily exist in isolation from other diseases and conditions, that disease interactions are of considerable importance to disease course and consequence, and that the social conditions of disease sufferers are critical to understanding health impacts at the individual and population levels. Rather than existing as discrete conditions, multiple life-threatening diseases often are concentrated in particular populations.[38]

Syndemic theorists see such issues as malnutrition and poor diet as direct correlations to HIV and tuberculosis (TB) exposure and infection. People living in overcrowded areas who also experience food apartheid[39] have higher risk of contracting airborne diseases like TB due to poor ventilation and inadequate space. In *Infectious Fear: Politics, Disease, and the Health Effects of Segregation*, historian Samuel K. Roberts posits that in the early twentieth century, "public health's claims to social expertise did not forcefully extend to the poor living and working conditions at the root of African American tuberculosis." Like AIDS, which was initially wrongfully cast as a "gay white

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[38] Merrill Singer et al., "Syndemics, sex, and the city: Understanding sexually transmitted diseases in social and cultural context," *Social Science & Medicine* 63. No. 8 (2006): 11.

[39] In *Black Food Geographies*, anthropologist Ashanté M. Reese suggests the term "food apartheid" as opposed to "food desert" because apartheid "names the structural conditions that affirm and normalize" not only food systems, but also "race, geography, faith, and economics." Apartheid, says Reese, highlights socially and politically imposed "racial hierarchies and inequities in South Africa and forces us to grapple with how the state, policies, and practices normalize inequality." Ashanté M. Reese, *Black Food Geographies: Race, Self-Reliance, and Food Access in Washington, D.C.* (Chapel Hill: University of North Carolina Press, 2019), 7.

disease," health professionals ignored TB among African Americans while projecting the malady colloquially as "the white plague."[40]

Defining something incorrectly has a lasting impact on public perception and is hard to debunk, causing irreparable damage. For instance, the medical community purported African Americans had higher levels of pain tolerance as early as the antebellum period, a hypothesis still reflected in twenty-first century medical curriculum.[41] The historian Robin Bernstein argues that from Reconstruction to the early twentieth century, American popular culture has "purged innocence" from African Americans' image by fetishizing and commodifying Black peoples' pain.[42] This process contributes to public health officials ignoring the health implications of racial segregation on Black people and rather than addressing the health issues of systemic racism, labeled Black people "incorrigible consumptives," practically blaming African Americans for the effect structural racism had on their health.[43] Thus, syndemic theorists offer alternative perspectives "that recognizes how social realities shape not only individual illness experiences but also the distribution of diseases across populations." Steering clear of biological deterministic hypotheses, syndemics show how socioeconomic inequities and diseases interact and produce poor health outcomes. By providing context, syndemics require "biomedical conceptions of diseases at the individual- and population-levels critically examine the comorbid social problems."[44]

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[40] Samuel K. Roberts, *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (Chapel Hill: University of North Carolina Press, 2009), 5-6.

[41] Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: The University of Georgia Press, 2017), 42-47; Kelly M. Hoffman et al., "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites," *PNAS* 113, no. 16 (April 2016).

[42] Robin Bernstein, *Racial Innocence: Performing American Childhood from Slavery to Civil Rights* (New York: New York University Press, 2011), 34-35.

[43] Roberts, *Infectious Fear*, 155.

[44] Emily Mendenhall, "Beyond Co-Morbidity: A Critical Anthropological Perspective of Syndemic Depression and Diabetes in Cross-Cultural Contexts," *Medical Anthropology Quarterly* 30, no. 4 (December 2016): 464.

In the Bay Area, many Black grassroots AIDS organizers, professionals, and everyday people understood HIV/AIDS as part of what Celeste Watkins-Hayes calls "injuries of inequality." For Watkins-Hayes, "Injuries of inequality have dimensions shaped by gender, race, class, and sexuality, as the likelihood of occurrence is not random but shaped by where we are on the social hierarchy." Unable to protect oneself from state-sanctioned violence—including but not limited to underemployment, mass incarceration, sexual abuse, and residential segregation—individuals and communities respond to injuries of inequality by "identifying processes of identity formation, everyday survival, struggles for mobility, and political resistance in a context of constraint and confinement."[45] Others, who find the weight of syndemics overbearing, resort to self-medicating. Depression is common in people living with HIV, diabetes and cancer, and presents psychobiological effects on poor and working-class people.[46] As such, syndemics compounded by HIV and food insecurity increases "risky behavior" exposing individuals to diseases. Some epidemiologists, however, "overlook the implicit social and environmental factors that could promote disease clusters among socially and economically disadvantaged populations."[47]

This chapter argues that African Americans contested the liberalism of the San Francisco Model of Care, a network that rallied social workers, nurses, physicians, psychiatrists, and community members to work with and as embedded members of the "gay community," which experts understood theoretically and practically to be limited to white middle-class men. With

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[45] Watkins-Hayes, *Remaking a Life*, 13.

[46] In *Syndemic Suffering*, syndemic theorist and medical anthropologist Emily Mendenhall states depression and diabetes are two diseases that "abide by three rules implicit in syndemic theory: the clustering of two diseases exists within a specific population; fundamental contextual and social factors are co-constructed with that cluster; and the disease cluster creates the potential for adverse disease interaction, increasing the burden of impacted populations." As such, the two offer "a model for the analysis of how disease clustering may be historically situated, socially driven, and co-constructed." Emily Mendenhall, *Syndemic Suffering: Social Distress, Depression, and Diabetes among Mexican Immigrant Women* (New York: Routledge, 2012), 13.

[47] Merrill Singer et al., "Syndemics and the Biosocial Conception of Health," *The Lancet* 389, no. 1 (2017): 945-947.

minimal resources, Black AIDS organizers took, adapted, and abandoned parts of the Model to fit the needs of Black communities by creating services for vulnerable Black populations, while simultaneously critiquing San Francisco Model affiliated organizations—professional and grassroots—of their negligence of African Americans' AIDS exposure. This chapter first applies the syndemic theory and related methods—such as Watkins-Hayes' "injuries of inequality" and Adam M. Geary's "state intimacies"—to Black health activism in the Bay Area from the late 1960s to the AIDS epidemic and explores how multiple health crises intensified African Americans' disease vulnerability. I then examine the San Francisco Model from the early 1980s to 1990. While some journalists and physicians perpetuated colorblind narratives of HIV/AIDS separating Black and white communities' disease risks without explaining how the disease affected groups different racially and economically, many white volunteers gave up on the Model by 1990.

From there, the chapter transitions to spotlight African Americans' awareness, education, and prevention efforts in the face of the Model's embrace of individualized health promotion under the guise of the new public health. Health promotion strategies, which included warning individuals of morbidity risks, pathologized many behaviors, including but not limited to having multiple sex partners and drug use. These appeared in advertisements and public service announcements and operated largely from a culturally insensitive viewpoint that prioritized techniques deemed effective that were devised among gay white populations.[48] Low-income African Americans' HIV/AIDS risk included the crack cocaine epidemic, poverty, and joblessness. The compounding issues qualified as a syndemic to anthropologist Emily Mendenhall, who contests that syndemics comprise of two or more disease clusters; social factors constructing the disease clusters "insofar as they help create the conditions in which two diseases cluster and

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[48] Spence, "Live and Let Die," 195.

contribute to the further [immiseration] of the afflicted and affected;" and the clustering results in adverse conditions for the affected populations. "If we accept these three guiding principles for syndemic clustering," says Mendenhall, "then we will be able to better understand why and how two diseases come together to form co-occurring maladies within a specific time and place."[49] With Mendenhall's example the syndemic for this study constitutes structural (poverty and joblessness) and medical (norming of whiteness in HIV/AIDS responses, medical neglect) racism producing the fundamental contextual and social factors that worsened substance use and HIV/AIDS at this time.

These issues, as well as analyses as critical as syndemic theory, fell outside of the purview of many local epidemiologists, majority-white AIDS organizations, and other health professionals. As the social psychiatrist Mindy Thompson Fullilove suggested, if prevention models working in gay white communities failed with African Americans, the CDC and local health departments needed to reexamine their approaches.[50] Thus, the final section addresses the limitations to HIV/AIDS responses sponsored by policymakers and the medical community that did not include federal intervention. Many volunteers and activists clamored for the epidemic to be taken seriously by the federal government and highlighted the problems funding caused, as organizations battled for grants that reinforced hierarchal approaches to understanding AIDS activism. Failing to mention the exhaustion activists experienced in place of kind gestures for their efforts worsened matters and increased criticism of the medical community and federal government.

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[49] Mendenhall, "Beyond Co-Morbidity," 465.

[50] Jacob Levenson, *The Secret Epidemic: The Story of AIDS and Black America* (New York: Anchor Books, 2004), 100.

II

In 1963, St. Louis, Missouri city officials broke ground on the notorious Gateway Arch that has come to symbolize the city. To make it, residents of a majority-Black neighborhood were displaced "with the promise that the arch would create jobs" for locals, including government positions. By the next year, not a single Black person was employed to work on the arch's construction, nor did one land a new government job. Frustrated by the empty promises, locals staged protests over the next few years addressing state-sanctioned violence amidst government expansion. Percy Green, for instance, climbed the arch and demanded jobs for Black people. The demonstration lasted until officials agreed to offer African Americans employment, leading to Green's arrest. Another resident staged a die-in to illuminate police brutality against African Americans and got local officials "to acknowledge the relationship between local child mortality and lead [poison]." Black residents continued to voice their concerns throughout the 1960s, culminating with a rent strike comprising of 20,000 public housing tenants in 1969. [51]

Robert Rayford, an African American teenager who died of AIDS in 1969, grew up in this context. In 1968, then-fifteen-year-old Rayford checked himself into St. Louis City Hospital with an extreme case of chlamydia, swollen legs, and purple lesions on his body from Kaposi's sarcoma, an opportunistic infection associated with HIV. Popular lore identified HIV/AIDS' origins to the CDC's June 5, 1981, *MMWR* that found mysterious cases of pneumocystis *carinii* pneumonia (PCP) in five men, all of whom reportedly identified as homosexual. News tracing Rayford's death to HIV/AIDS debuted on nightly news in 1987, the same month and year of journalist Randy Shilts' famous book *And the Band Played On: Politics, People and the AIDS*

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[51] Theodore Kerr, "AIDS 1969: HIV, History, and Race," *AIDS and Memory*, ed. Ricky Varghese, *Drain* Magazine 13, no. 2 (2016): http://drainmag.com/aids-1969-hiv-history-and-race/.

Epidemic. Shilts' monograph, like the first AIDS *MMWR* report and other public outlets at the time, elides race in its analysis of HIV/AIDS vulnerability and risk assessment. "As is often the case in the United States and elsewhere," says the writer Theodore Kerr, "when race is not mentioned it is because white is understood as the default." In the AIDS epidemic's first decade, gayness was perceived synonymously with whiteness, thus casting white gay men's suffering as a template for understanding HIV/AIDS and contributing to the erasure of Black stories like Rayford's.[52]

Many were skeptical of the date tracing Rayford's untimely death to AIDS. In 1988, however, the *Journal of the American Medical Association* (or *JAMA*) confirmed that Rayford died from complications of the disease. The *JAMA* article noted that Rayford developed herpes simplex virus, Epstein-Barr virus, and cytomegalovirus, which mostly causes blindness when one's white blood cell count drops below 200 and patients experience full-blown AIDS. Upon a second autopsy conducted in 1988, doctors commented that Rayford's Kaposi's sarcoma lesions were "indistinguishable" from their contemporary AIDS patients. This bombshell of information should have changed the discourse on HIV/AIDS and speaks to the state-sanctioned violence wrought by medical and structural racism poor and working-class African Americans experienced as part of their disease susceptibility. Most epidemiologists and journalists, however, elided structural racism from their explanations of AIDS vulnerability and perpetuated behavioral narratives.[53]

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[52] Ibid.

[53] Robert F. Garry et al., "Documentation of an AIDS Virus Infection in the United States in 1968," *Journal of the American Medical Association* 260, no. 14 (October 1988): 2085-2087; Min Zhao et al., "Cytomegalovirus (C<V) infection in HIV/AIDS patients and diagnostic values of CMV-DNA detection across different sample types," *Annals of Palliative Medicine* 9, no. 5 (September 2020): 2710-2715.

Randy Shilts and others' construction of HIV/AIDS circumvents what theorist Adam M. Geary calls "state intimacies."[54] Medical and scientific discourse on the diseases from the behavioralist perspective centers individual actions like drug use and sex as factors increasing one's disease susceptibility. For Black Americans, says Geary, American racism—state and violent intimacy—are the primary factors determining infection.

> From structured impoverishment to racial segregation, and from mass incarceration to the "political death" meted out to former prisoners, the state has structured the ways in which [Black] Americans have been made vulnerable to HIV exposure and infection far beyond the capacity of any individual or community mitigation or control. This structured vulnerability entirely exceeds questions of so-called risk behaviors or their social construction.[55]

State intimacies create conditions like unstable housing, medical racism, and exposure to toxic waste that makes one vulnerable to HIV/AIDS and other diseases. In New York, urban decay throughout the 1970s exposed African Americans to HIV/AIDS by displacing Black residents and cutting resources in majority-Black communities. The epidemiologist Rodrick Wallace notes that as demands for fire services increased, the city reduced the number of firefighters by 20 to 25 percent. Fires and housing abandonment had a symbiotic relationship in New York, particularly the South Bronx, that locals saw as "a highly contagious form of urban decay, triggered into fulminating epidemic spread precisely by the deep 'planned shrinkage' fire service cuts." Close studies of citywide data showed "a fire/housing abandonment outbreak concentrated in the city's poorest, most overcrowded, and most deteriorated minority neighborhoods."[56] Most

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[54] Geary defines state intimacies as "the structured forms of violence and inequality mediated by the state that have produced conditions of embodied vulnerability to disease and ill health for [Black] people in particular, but also other queers." Adam M. Geary, *Antiblack Racism and the AIDS Epidemic: State Intimacies* (New York: Palgrave Macmillan, 2014), 21.

[55] Geary, *Antiblack Racism and the AIDS Epidemic*, 2.

[56] Rodrick Wallace, "A Synergism of Plagues: 'Planned Shrinkage,' Contagious Housing Destruction, and AIDS in the Bronx," *Environmental Research* 47, no. 1 (1988): 3-16.

of the poor and congested areas comprised of Black and Latinx residents that, from 1978 to 1985, had the highest deaths related to drug overdose and AIDS.[57]

Another study examining the syndemic of HIV/AIDS, homicide, and tuberculosis in New York City from 1975 to the early 1990s made similar conclusions. The aforementioned triumvirate—compounded by dismantling the health, public safety, and social services infrastructure, as well as substandard living conditions, exacerbated poor health outcomes in New York communities with the highest HIV/AIDS cases. Deindustrialization and "white flight" added to the problems, as the city earmarked funds for white suburbanization. These policy decisions pushed vulnerable populations, including but not limited to single mothers, unhoused people, drug users, the unemployed, and recently-incarcerated folks, "into living situations that put them squarely in the path of TB, HIV infection, and violence."[58] Despite these correlations, many reports continued to describe AIDS as a behavior-driven epidemic independent of structural violence.

Disrupting community networks through redlining and what Wallace calls "planned shrinkage"—systemic denial of municipal services to maintain population density primarily in Black and Latinx low-income neighborhoods—concentrated drug dependence and drug-related deaths, instable housing, and HIV/AIDS.[59] Despite consistent patterns stretching almost two decades, many social scientists, along with academic scientists and the medical community, failed to explore the public health implications of state-sanctioned violence that placed African Americans at increased risk for HIV/AIDS. Instead, many health professionals expressed

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[57] Ibid.

[58] Nicholas Freudenberg et al., "The Impact of New York City's 1975 Fiscal Crisis on the Tuberculosis, HIV, and Homicide Syndemic," *American Journal of Public Health* 96, no. 3 (March 2006): 424-432.

[59] Ibid., 18-19; Rodrick Wallace, "Urban Desertification, Public Health and Public Order: 'Planned Shrinkage,' Violent Death, Substance Abuse and AIDS in the Bronx," *Social Science and Medicine* 31, no. 7 (1990): 801.

frustration trying to comprehend why Black people would not change their behaviors to prevent AIDS from spreading in their communities. A structural approach that analyzed persistent syndemics in Black communities, while working with African American activists and organizers, would have helped the public health sector develop "a more focused strategy to prevent AIDS from tightening its grip on [Black] neighborhoods."[60] On the contrary, some local epidemiologists suggested a "second wave" epidemic among injection drug users five years into the AIDS crisis. "We're on the verge of a second epidemic," said Dr. Richard Chaisson, then of San Francisco General Hospital. The Black social psychologist Dr. Calu Lester offered an alternative explanation for AIDS among Black drug users, citing insufficient AIDS outreach programs that failed to speak in languages target populations understood. "There is plenty of fear" among drug users, said Dr. Lester, "but they don't know what to be fearful of. They don't understand what AIDS is, or how to prevent it."[61]

Black health activists in the Bay Area highlighted systemic racism as a public health issue as early as the late 1960s. The Black Panther Party for Self-Defense's (BPP) Ten Point Program, for instance, laid out health determinants affecting low-income African Americans in Oakland—and later throughout the nation—demanding government intervention. The program drew heavily from Malcolm X's 1963 ten-point platform crafted for Elijah Muhammad and the Nation of Islam (NOI). The Panthers, omitting the Islamic language of the NOI's document, listed ten demands followed by ten things in which they believed would hasten social transformation, including decent housing, employment, and education. "We believe that the federal government is responsible and obligated to give every man employment or a guaranteed

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[60] Levenson, *The Secret Epidemic*, 202-203.

[61] *Los Angeles Times*, July 22, 1986; *Daily Breeze* (Torrance, CA), July 22, 1986.

income," the document states.[62] The BPP did not wait for the federal, state, or local government to answer its demands. Rather, they applied practice to their theory and addressed the health concerns affecting their communities. The Party implemented free breakfast for children programs and started their own free health clinics. "The Panthers believed that serving the poor and enabling local communities to help themselves had transformative potential," says the sociologist Alondra Nelson. Providing basic services such as food and health care, the BPP also illuminated the failure of state welfare to alleviate poverty.[63]

Federal antipoverty programs moved too slowly and proved ineffective to the Panthers' liking. As the Panthers observed poor Black people's health continue to deteriorate, they modified their ten-point program to incorporate an explicit message addressing medical racism and calling for health equity. In 1972, the revised point 6 stated their belief "that mass health education and research programs must be developed to give Black and oppressed people access to advanced scientific and medical information, so we may provide ourselves with proper medical attention and care."[64] Their commitment to health equity as health activists reinforced the failures of policymakers and the medical community to advance the health of poor and working-class African Americans. The groups' health clinics, for instance, addressed "pressing health care concerns of poor [Black] communities that sorely lacked adequate medical facilities and professionals."[65]

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[62] Joshua Bloom and Waldo E. Martin, *Black Against Empire: The History and Politics of the Black Panther Party* (Berkeley: University of California Press, 2013), 70-72.

[63] Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011), 58; Donna Jean Murch, *Living for the City: Migration, Education, and the Rise of the Black Panther Party in Oakland, California* (Chapel Hill: University of North Carolina Press, 2010), 10.

[64] Ibid., 73.

[65] Bloom and Martin, *Black Against Empire*, 187-193.

Other mutual aid programs, like its free breakfast for schoolchildren, free emergency ambulance service, and Free Busing to Prison Programs, further “highlighted the American government’s negligence” towards poor Black people. Unfortunately for the Panthers and those they served, this only resulted in more harm from government entities. In 1968, Federal Bureau of Investigation (FBI) director J. Edgar Hoover labeled the BPP the “greatest threat to the internal security of the country.” This led to increased police violence, infiltration of the Party, and assassinations. The FBI made a concerted effort to “relentlessly” target the Panthers’ survival programs, spreading misinformation declaring the Panthers as an anti-white organization engaged in illegal activities. These included FBI memos to local public health departments purporting food contamination from the Panthers’ breakfast programs and suggesting their locations being sites of increased cases of venereal disease.[66] The FBI’s infiltration, assassinations, and disruptions eventually crumbled the Black Panther Party, leaving a void in Black health activism in the Bay Area and sustained failure of policymakers and the medical community to address health inequities among low-income African Americans.

Although the FBI made the Black Panther Party a shell of itself by the mid-1970s, the Party officially dismantled in 1980, a year before AIDS was first officially identified. During that time, many major employers began withdrawing labor where African Americans benefitted from the post-World War II economy. In Oakland alone, Kaiser Industries, The Dodge Truck Division of Chrysler Motors, Chevrolet Cars, and Nordstrom Valve all moved plants elsewhere. The disappearance of employment was compounded by so-called urban renewal, including federal highway and housing programs expanding road access to new economic and residential developments, and federal home loan policies that created suburban communities along the new

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[66] Murch, *Living for the City*, 83-89;

highway corridors. Black Bay Area residents were shut out of these opportunities "by racial discrimination in mortgage loans and by real estate agents 'steering' of [Black] prospective buyers from new 'white' communities."[67]

The absence of work, compounded by a decade of protests during the 1960s iteration of the Civil Rights and Black Power Movements, made white employers discriminate against hiring Black labor forces. This created a permanent Black underclass, particularly in Oakland. Overwhelmed by poverty and the absence of opportunities to provide for their families, many Black young adults resorted to committing crimes and using and selling drugs. The syndemic model posits that neoliberal governments resort to identifying poor communities through "victim-blaming, implying that individuals select their 'lifestyle' from a range of equally accessible options." Poor people's health, says Singer, comes to be defined "in terms of self-control and a set of related concepts that include self-discipline, self-denial, and will power." [68] This is the lens through which city officials perceived poor and working-class African Americans after the demise of the Black Panther Party and the process of deindustrialization. "Lack of an apparent work ethic," says Bowser and Hill, "became the explanation for their poverty and troubles."[69]

Without meaningful employment, adequate access to health care and education, and living in abject poverty, crime rates soared in Oakland's concentrated Black communities. Serious crimes—including home invasions, muggings, and violence from neighboring drug

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[67] Benjamin P. Bowser and Barbara Hill, "Rapid Assessment in Oakland: HIV, Race, and Bureaucracy," in *When Communities Assess Their AIDS Epidemics: Results of Rapid Assessment of HIV/AIDS in Eleven Cities*, eds. Benjamin P. Bowser, Ernest Quimby, and Merrill Singer (Lanham, MD: Lexington Books, 2008), 130-131.

[68] Merrill Singer, "AIDS and the Health Crisis of the U.S. Urban Poor: The Perspective of Critical Anthropology," *Social Science and Medicine* 39, no. 7 (1994):

[69] Bowser and Hill, "Rapid Assessment in Oakland," 133.

wars—jumped from 28,712 in 1972 to 42,883 in 1977, and to almost 45,000 by 1983. It is no coincidence that crime increased with the influx of heroin trafficking and the introduction of crack cocaine in Black communities. Many heroin and crack dealers sold the drugs to survive economically, while users self-medicated to cope with their dire living conditions. “People shut off from legitimate participation in the economy still have to pay rent, buy food, and have money to survive,” warns Bowser and Hill. The same areas in which Black people’s living circumstances became concentrated, particularly West and East Oakland, also saw the highest numbers of HIV/AIDS cases. By the mid-1990s, African Americans accounted for 69% and 55% of AIDS cases in Oakland and Alameda County, respectively.[70] The social psychiatrist Mindy Thompson Fullilove suggests neighborhood quality and socioeconomic status as driving factors for depression, sexual activity, and subsequent sexually transmitted infections, notably HIV/AIDS.[71] To alleviate the conditions among poor and working-class communities, Fullilove suggests job development and apprenticeship, along with after school programs to occupy Black youth. These recommendations ran counter to her colleagues at the Center for AIDS Prevention Studies’ proposals of focusing on personal responsibility. The respectability approach, which posited that African Americans’ behaviors exposed them to disproportionate suffering, omitted consideration of government policies addressing structural barriers that increased African Americans’ disease vulnerability. “If the prevention model that was working in the gay [white] community was failing with African Americans, then she [Fullilove] felt they needed to

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[70] Ibid., 135.

[71] Benjamin P. Bowser, Mindy Thompson Fullilove and Robert E. Fullilove, “African-American Youth and AIDS High-Risk Behavior: The Social Context and Barriers to Prevention,” *Youth & Society* 22, no. 1 (September 1990): 59.

fundamentally reexamine their methods. individual decision-making which, to her, "was profoundly compromised in the chaotic context of the ghetto."[72]

Michael "Cetewayo" Tabor, former Black Panther member and political prisoner of the New York "Panther 21" who were arrested and accused of conspiring to blow up police stations, made more explicit observations of the relationships between state-sanctioned violence and drug dependence.[73] In his pamphlet "Capitalism Plus Dope Equals Genocide," Tabor argued that drug dependence among poor and working-class people of color, while reaching "epidemic proportions" had largely been ignored by the United States government "as long as the plague was confined to the ghetto." Government intervention, including drug prevention and rehabilitation programs, were unsuccessful due to its "archaic, bourgeois Freudian approach and their unrealistic therapeutic communities" that ignored the root causes of such problems. "These programs," said Tabor, "sanctimoniously deny the fact that capitalist exploitation and racial oppression are the main contributing factors to drug addiction in regard to Black people." Tabor later explained how drug and alcohol use, as well as the rise of street-gang violence and drug distribution among Black youth, were forms of escapism for people to release their "rage, frustrations and despair." To this end, diseases manifest and spread in concentrated communities, emerging from the intersections of "racism, biology, and neglect."[74] Despite a long history of Black health activism centering structural violence in the Bay Area, the medical community embraced neoliberal versions of health promotion that disregarded historical context to the AIDS epidemic and social and environmental factors that determined African Americans'

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[72] Levenson, *The Secret Epidemic*, 99-101.

[73] Bloom and Martin, *Black Against Empire*, 209-215.

[74] Michael Cetewayo Tabor, "Capitalism Plus Dope Equals Genocide,"; Nelson, *Body and Soul*, 157.

susceptibility. The San Francisco Model emerged against this backdrop, failing to consider the epidemic's implications for impacted communities of color.

III

The San Francisco Model required extensive services from government officials and health professionals. At San Francisco General Hospital's Ward 86—the first AIDS Ward in the country, optimal care emphasized outpatient care that required community involvement. This approach attempted to limit hospital costs, particularly among patients with AIDS-related complex (or ARC, now known as the human immunodeficiency virus, or HIV) and not full-blown AIDS. Until 1991, the CDC's AIDS definition allowed patients with AIDS to receive disability benefits. ARC patients' symptoms persisted for months and sometimes over a year before presenting the same debilitating illnesses seen in AIDS patients.[75] This is where health professionals relied on community organizers' volunteer efforts to assist with outpatient care. The inpatient services, which opened in early 1983 and is regarded as the first AIDS ward in the nation, invited the gay white community "to participate in the unit's development, thus increasing open communication and a sense of mutual trust," says UCSF AIDS specialist Paul Volberding. That included journalists who cooperated with medical and nursing staff to disseminate "accurate and educational" messages in the media about the then-obscure disease's impact on patients.[76]

Black and Latinx PLWHA highlighted many of the Model's flaws, including racism among some of its staff members. The historian Dan Royles notes that Ward 86's staff poorly reflected the clinic's patients, especially their inability to provide a translator for Spanish-

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[75] Paul Volberding, "The Clinical Spectrum of the Acquired Immunodeficiency Syndrome: Implications for Comprehensive Patient Care," *Annals of Internal Medicine* 103, no. 5 (November 1985): 730-731.

[76] Ibid., 732.

speaking patients. The Ward's AIDS data consisted almost exclusive of white patients. "This statistical erasure," says Royles, "was used to further justify the facility's lack of minority AIDS education." Equally alarming was doctors suggesting the disease's etiology stemming from African men having sexual intercourse with monkeys, some physicians even asking only their Black patients "'if they engaged in bestiality.'"[77] Dr. Calu Lester, a Black social psychologist, lamented the Model's outreach and treatment of Black patients. Formerly a volunteer with the Shanti Project, a volunteer-based AIDS organization that worked closely with the San Francisco AIDS Foundation and Ward 86, Lester blamed white-dominant AIDS organizations and the San Francisco Department of Public Health for its poor communication with communities of color, which catered overwhelmingly "to a white gay clientele."[78]

Race compounded by injuries of inequality such as drug use, poverty, and inadequate access to health care left these majority-white organizations ill-prepared to care for Black PLWHA from a culturally specific approach. In early 1986, with the Model already implemented, some Black activists continued to illuminate the lack of inclusion in AIDS resources. Sala Udin, a drug treatment specialist and member of the Multicultural AIDS Resource Center (MARC), looked askance at the authors of a National Institute of Mental Health grant proposal that consisted of physicians, psychologists, and epidemiologists from UCSF, San Francisco General Hospital, and the local public health department—all of whom were white. Udin urged the lead investigators—UCSF's Dr. Stephen Hulley and Dr. Tom Coates—to include people of color in their research, but they "promised to do so only in an advisory capacity." This approach reinforced AIDS as a "gay white disease" by neglecting people of color in decision-

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[77] Royles, *To Make the Wounded Whole*, 52-53.

[78] *San Francisco Chronicle*, October 26, 1985.

making capacities. Before AIDS was identified, Udin had twenty years of developing and teaching culturally specific approaches to heroin treatment and prevention, including among family members. Ignoring his suggestions in grant-writing capacities represents. White scientists, he believed, "were naïve if they thought they could walk into the ghetto, perform a couple of studies, figure out a way to get addicts to stop using, and thereby prevent AIDS from spreading throughout the [Black] community."[79]

The erasure of people of color convinced Udin to organize with other activists in ways that addressed Black erasure wrought by the San Francisco Model. One solution proposed by Udin was organizing a conference that critiqued the Model and health professionals' avoidance of Black people's AIDS risks. In February 1986, Udin and MARC partnered with the Third World AIDS Advisory Task Force (TWAATF) for a three-day "Western Regional Conference on AIDS and Ethnic Minorities." From April 25-27, the organizers led panels designed "primarily for health care and service providers serving ethnic minority communities." Their objectives included educating the medical community and AIDS service providers on culturally competent ways of engaging with communities of color; addressing the specific needs of vulnerable ethnic minority populations; and examining the legal, political, and health implications of the AIDS epidemic on Black and Latinx women, incarcerated people, injection drug users, gay men and MSMs, and young people.[80]

Conversations on the political and financial "distribution of available resources on a federal, state, and local level" attracted conference attendees such as Senator Alan Cranston,

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[79] Levenson, *The Secret Epidemic*, 30-34.

[80] Box 1, Folder 40, "Western Regional Conference on AIDS and Ethnic Minorities; Third World AIDS Advisory Task Force April 1986," Multicultural AIDS Resource Center, 1988-1993, MSS 94-19, University of California, San Francisco Archives & Special Collections, San Francisco, California.

then-Assemblyman Willie Brown, and Gary Titus from the San Francisco Department of Public Health. Organizers used the attendance of medical and political decisionmakers to illuminate AIDS funding disparities. From 1984 to 1986, Udin and others calculated that $20 million in public funds were spent in San Francisco towards AIDS programs. However, “no contracts for research treatment support or prevention services have been given to Third World professionals or agencies.” To rectify these problems, MARC and TWAATF members suggested increasing culturally specific prevention and educational material, raising awareness on the political and health ramifications of AIDS on “Third World Communities,” and “Improving the delivery of AIDS Related Services to Third World Clients.” They pressured local majority-white organizations, as well as medical and political decisionmakers, to answer their demands during the three-day conference.[81]

To some of their surprise, the material conditions of poor and working-class vulnerable people of color in the Bay Area did not change after the conference. This led to the Third World coalition of organizers expressing their frustration with Mayor Dianne Feinstein. In one letter, the activists addressed false pretenses that Black, Latinx, and Asians were “not interested in dealing with AIDS, that there is massive homophobia and denial among our leadership,” which they believed were preconceived notions held by Dr. David Werdegar, San Francisco’s Director of Public Health, and the AIDS Activity Office. “Although they often say that they are in contact with our organizations,” the letter read, “they neglect to mention that the contact consists largely of our unheeded pleas for action or our criticisms of their blatant neglect.” They also took offense to being conceived as “community people” with little to no expertise, despite their membership consisting of AIDS educators, health providers, administrators, and organizers. “We

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[81] Ibid.

expect the Department to treat us and the communities we represent no differently than the white gay community was and is treated," they noted.[82] By mentioning the Health Department's favorable treatment of the white gay community's AIDS experiences, the TWAATF and others highlighted structural problems not only with the San Francisco Model and the city's AIDS programs, but also flaws in isolating the white gay community from broader perspectives of power relations. Indeed, early misinformation campaigns of AIDS as a "gay white disease" contributed to initial misconceptions of disease vulnerability. However, persistent neglect of poor and working-class communities of color while championing white gay activists' efforts, despite white activists' mounting frustrations with the Model's overreliance on volunteerism, exemplifies the neoliberal forms of health promotion that individualizes systemic issues.

IV

"San Francisco consistently is leading the pack as far as being the cheapest," said Kenneth Kizer, director of the California Department of Health Services. Kizer led a 1988 study on Medi-Cal expenses that concluded in January 1989. The report showed that San Francisco's AIDS patients expended $1,514 per month, compared to $2,953 in Los Angeles and a state average of $2,312. "If I was a state legislator," Kizer continued, "I would raise some questions about why San Francisco is able to do it for half of what Los Angeles does."[83] Kizer's comments were not unique for government officials and legislators to question differences in health care costs and why some cities spend more than others, as similar arguments have been made about surgeries and hospital births.[84] They do, however, reflect the local medical community and

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[82] Box 1, Folder 9, "Correspondence From TWAATF 1986-1990," Third World AIDS Advisory Task Force Records, 1985-1992, MSS 94-49, University of California, San Francisco, Archives and Special Collections, San Francisco, California.

[83] *San Francisco Chronicle*, January 26, 1989.

[84] *Washington Post*, September 16, 2020;

policymakers' appreciation for the San Francisco Model's volunteer efforts. The Shanti Project and the San Francisco AIDS Foundation—two of the catalysts relying on volunteerism during the 1980s—had budgets that increased annually until the end of the decade. This created problems, leaving community organizations to compete for limited funds in the absence of federal government intervention. It also increased activists of color's frustration with the San Francisco Model, which many believed hoarded resources and catered exclusively to a white clientele. "There is a feeling that the San Francisco [Model] is a gay, white model," lamented Adolfo Mata of Instituto Familiar de la Raza (the Latino AIDS Project).[85]

Praise given towards the San Francisco Model was ensnared in racial capitalism logic that differentiated primarily gay white volunteers from poor and working-class people of color. Organizations receiving donations and state funding differed across ethnicities. The majority-Black Bayview-Hunters Point Foundation, Instituto Familiar de la Raza, and the Multicultural Training Resource Center received slightly over $650,000 combined in fiscal year 1988-1989. Both the Shanti Project and the San Francisco AIDS Foundation received over $1 million each.[86] Both organizations were accused of racism and sexism within their ranks, largely tied to dispensing funds almost exclusively to white PLWHA. Some Black activists saw the Model "as a paean to Reaganite private sectorism," successful largely because of gay white men's organizing power within the city from the 1970s gay liberation movements. "Most gays of San Francisco's Castro district had good jobs with benefits, and many had gay private doctors who knew their lifestyle and provided excellent care tempered with understanding and devoid of judgment," said the Black journalist Rosslyn (no surname provided).[87]

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[85] *San Francisco Chronicle*, June 14, 1989.

[86] Ibid.

[87] Rosslyn, "AIDS: We Are Not Immune," *Emerge*, November 1990.

Rosslyn's comments build upon the sociologist Paul Starr's observations on the medical profession's sovereignty through poor and working-class patients' dependence. Low-income African Americans have significant cultural differences with white physicians that resemble their interactions with other authority figures, including social workers, lawyers, and judges. Many Black patients' feelings of powerlessness are exacerbated by white doctors' socioeconomic status. Physicians claim authority "not as individuals," says Starr, "but as members of a community that has objectively validated their competence." During the San Francisco Model's iteration, that community competence was shared, largely by white middle-class AIDS activists, many of whom were living with HIV/AIDS. Starr notes that many middle-class white patients

> see professionals under circumstances that are more often voluntary than coerced, and they are more likely to pay for sessions in private settings than receive them in public institutions paid for by the state. They are also more than likely to share the same cultural framework as the professionals they consult. Sharing the same assumptions, they can speak openly with them and will regard the competence that professionals claim as valid.[88]

The structure of the San Francisco Model, compounded by Kenneth Kizer's comments on medical scarcity and saving money through Medi-Cal expenditures, had racial undertones implicitly marginalizing poor and working-class people of color, particularly African Americans. The comments also reinforce colorblind narratives of HIV/AIDS that projects middle-class white AIDS activists' approaches onto communities of color, while also ignoring the financial disparities of AIDS organizations.

Challenging authority made many white organizations popular with health professionals. The UCSF AIDS physician Robert M. Wachter lauded white activists' demonstrations, which increased their access to local decisionmakers. This process developed rather quickly, says

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[88] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 11-13.

Wachter, because white middle-class gay communities "contained sizable numbers of young, well-educated professionals able to seize an opportunity to make their points," while also representing "large and powerful voting blocs with considerable political clout." [89] Dr. Paul Volberding also identified closely with many of his white patients. It was difficult to separate oneself from his patients, says Volberding, "when you realize that the patients had gone to the same schools, they listened to the same music, they went to the same restaurants. So they were really us… which added to the commitment that I think all of us had."[90] White, middle-class men, says the scholar Steven Epstein, "provided settings for the face-to-face interactions that are so important in drawing individuals into activism."[91] Focusing on one demographic, however, isolates other marginalized groups and perpetuates individual-level risk reduction through a neoliberal framework.

The demands of volunteerism without federal intervention, as people continued to lose friends and family from AIDS, reached its peak by 1990. At the Sixth International AIDS Conference, held in San Francisco from June 20-24, activists marched to City Hall and staged an "exhaust-in." The demonstration was designed to show that the San Francisco Model "is crumbling due to lack of adequate government funding and overworked volunteers." Others returned to City Hall each day of the conference "to protest the lack of care for women, non-whites and drug users fighting AIDS."[92] The Center for Disease Control and Prevention's (CDC)

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[89] Robert M. Wachter, "AIDS, Activism, and the Politics of Health," *New England Journal of Medicine* 326, no. 2 (January 1992): 129.

[90] Polina Ilieva, "They Were Really Us, AIDS History Exhibit, Opens on October 1," *Brought to Light: Stories from UCSF Archives & Special Collections*, September 30, 2019, accessed October 13, 2021, https://blogs.library.ucsf.edu/broughttolight/2019/09/30/they-were-really-us-aids-history-exhibit-opens-on-october-1/.

[91] Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley: University of California Press, 1996), 12-14.

[92] *Philadelphia Daily News*, June 19, 1990.

AIDS definition decided who received treatment based on their insurance plan. Women like the Black activist Katrina Haslip suffered from pulmonary tuberculosis and invasive cervical cancer, two infections caused by AIDS. The CDC's definition was not updated until January 1993. Haslip died from AIDS complications in December 1992.[93] If the CDC's definition was updated sooner, Haslip may have received better medical care that allowed her to live longer with the disease, rather than die alone with a white blood cell count of six.

Doctors' unwillingness to work with poor and working-class AIDS patients added insult to injury, not just for people of color but also white volunteers helping local physicians with outpatient care. One staff member of Ward 86, San Francisco's outpatient clinic and the first of its kind in the nation, told a local reporter, "If you don't have money, you're lost in the city."[94] Dr. R. Eugene Tolls, President of the San Francisco Medical Society, documented 35-40 AIDS patients per day. Tolls suggested 500 physicians take 10 AIDS patients each, irrespective of their health insurance plans. This plan was met with hostility from many physicians. "Medi-Cal reimbursements are so low," said Tolls, "that many doctors will not want to treat AIDS patients, many of whom lose their private health insurance once they fall ill and lose their jobs."[95] Placing profit before people, compounded by inadequate federal intervention and overwhelmed volunteers, brought more scrutiny upon the San Francisco Model's beloved approach. Volunteers' burnout, moreover, highlighted problems that existed from the disease's inception, as the federal government's poor response to the crisis was mitigated by free labor and kind gestures cast upon friends and family members of AIDS patients. "It is now time for the federal

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[93] *New York Times*, November 15, 1992; *New York Times*, December 3, 1992.

[94] *San Francisco Examiner*, June 19, 1990.

[95] *San Francisco Chronicle*, August 3, 1987.

government to explicitly assume the responsibility for patient care, as it would in any other type of natural disaster," said Dr. Tom Peters, San Francisco's Associate Health Director.[96]

V

The perception of and responses to diseases, says Paul Starr, "show the imprint of our particular culture, especially its individualist and activist therapeutic mentality."[97] From the disease's inception, journalists, policymakers, and health professionals entered individualistic phases to describe HIV/AIDS activism devoid of state intervention or critical of structural racism. Approaches like the San Francisco Model were pivotal for many PLWHA, their support networks, and physicians struggling in overcrowded hospitals. They were also, however, scapegoated as the federal government sat idly as the disease spread rapidly and deaths mounted at unprecedented rates. Behavioral approaches to the epidemic worked tremendously for local gay white communities whose main susceptibility involved unprotected sex with multiple partners. As such, organizations like the San Francisco AIDS Foundation marketed safe sex campaigns to prevent new infections that eventually worked well with many vulnerable white populations.[98]

State-sanctioned violence placed African Americans at increased risk for infection, meaning behavioral and biomedical advances were useless without addressing structural racism. The root causes of injuries of inequality, says Celeste Watkins-Hayes, are "growing economic, social, and political inequities that exact devastating consequences on the lives of those with limited power."[99] Many Bay Area AIDS service organizations ignored these inequities while

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[96] *Los Angeles Times*, May 12, 1989.

[97] Starr, *The Social Transformation of American Medicine*, 3.

[98] Brier, *Infectious Ideas*, 45-77.

[99] Watkins-Hayes, *Remaking a Life*, 230.

lauding volunteer efforts without compensating individuals for their work. Dr. James Dilley, a San Francisco psychiatrist and architect of the Model, said “gay men and lesbians provided much of the care to gay men,” failing to include race in his observation.[100] By not mentioning ethnicity in his analysis, whiteness is presumed as gayness through a colorblind, neoliberal lens that applauds one group and implicitly denigrates other ethnicities’ HIV/AIDS efforts.

Multiple intersecting social issues and illnesses overwhelmed poor and working-class Black communities before the syndemic of HIV/AIDS, substance use, and medical-structural racism emerged and was ignored in public health assessments during the AIDS epidemic of the 1980s and 1990s. The medical community’s refusal and inability to confront issues involving poverty, inadequate access to health care, and housing discrimination left poor and working-class people, particularly African Americans, vulnerable to HIV/AIDS. As such, epidemiological reports and newspaper articles suggesting low-income Black communities needed an urgent response commensurate with gay white communities, or that Black drug users rejected help, were inadequate and immoral assessments.[101] Asking powerless people to alter their behaviors, as opposed to demanding powerful institutions provide help to vulnerable populations suffering disproportionately from a social disease, highlighted problems at the core of American health professions. Black HIV/AIDS activists showed that it is imperative to provide historical context to public health initiatives. Otherwise, patchwork solutions were proposed that perpetuated an already-defunct system that failed poor and working-class people by design.

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[100] Dilley, “Implications for the San Francisco Model,” 349-350.

[101] *Sacramento Bee*, October 29, 1985; *Lexington Herald-Leader*, April 1, 1986.

Chapter 2

Tricking the System: Gloria Lockett and CAL-PEP's Fight Against AIDS and Systemic Racism

I

In January 1985, a San Francisco sex worker put on full display the city's negligence toward poor and working-class people at risk to the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS), particularly women in the sex industry. Known as Silvana, the woman had a record consisting of over thirty arrests, thirteen felony charges, and over thirty misdemeanors. On January 3, she was picked up by San Francisco police for "obstructing a sidewalk."[102] Despite the petty offense, she knew this arrest was different from others. Officers had previously picked up her boyfriend who locals learned was seropositive. Both Silvana and Tony, her partner, had heroin addictions and were known to share needles. Yet because of her precarious situation, Silvana had no intentions to stop working. "I don't like the idea of maybe giving this to someone else," but I don't have any other way to survive other than to work the street," she told the *San Francisco Chronicle*. "I have to keep working or else I won't even have the money to buy food with."[103] Her dilemma highlights not only the precarious political economy of sex work, but also marginal treatment industry women received at the hands of health professionals, law enforcement, policymakers, and in many instances AIDS organizations.

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[102] Randy Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (New York: St. Martin's Press, 1987), 508.

[103] *San Francisco Chronicle*, January 5, 1985.

Silvana's drug dependence, HIV/AIDS exposure, and financial scarcity were rendered invisible, as San Francisco's political and medical decisionmakers instead focused on criminalizing sex work while worrying about the chances industry women could infect heterosexual men. Captain Jack Jordan, the head of San Francisco's vice unit, told the *Chronicle*, "If she is out on the streets breaking the law, she may very well get arrested." Dr. Paul Volberding, the head of San Francisco General Hospital's AIDS Clinic, said Silvana presented "a monster" public health issue "where civil rights and the public health were in conflict."[104] The fear of positive cases among the heterosexual population by health officials and police officers existed for months. In the previous November, two supposedly heterosexual men tested positive for the virus. This prompted Dr. Volberding to hold a press conference, creating a new task force examining disease transmission between men and women.[105]

While Volberding and other San Francisco physicians' intentions might have been pure, their outreach strategies increased stigma among sex workers. Little action was taken by professionals to mitigate industry women's disease susceptibility. Instead, local decisionmakers, including journalists, expressed concern for the safety of sex workers' clients—particularly middle-class white men. This did significant damage to industry women, particularly Black sex workers, whose socioeconomic position placed them outside the realm of receiving adequate health care or compassion from health professionals. Condemnation, however, mobilized many Black sex workers in the Bay Area to dispute degrading comments and construct new ways of understanding the disease's transmission, while also bettering industry women's disease susceptibility. As Priscilla Alexander, co-founder of the sex workers organization CAL-PEP (the

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[104] Ibid.

[105] Shilts, *And the Band Played On*, 511.

California Prostitutes Education Project) evinced in one of her many published pieces, "If prostitutes were effectively transmitting the AIDS virus to their customers, there would be far more cases of white, heterosexual males diagnosed with AIDS than is reflected in the current statistics."[106] Given America's historical animus towards sex work, CAL-PEP knew the obstacles they would face trying to persuade the public and health professionals of industry women's humanity. Thus, CAL-PEP mobilized active and retired industry women, as well as some health professionals, to provide educational and prevention resources among Black industry women in some of the Bay Area's most neglected communities.[107] As an organization run by industry women, CAL-PEP understood the importance of trust among sex workers and consistently emphasized the historical context of state violence that influenced low-income Black women to join the profession, all of which they incorporated in their correspondences with health professionals, media outlets, and in their own publications.

Viewing sex workers and other impoverished vulnerable groups as their peers gave CAL-PEP a level of credibility in areas where trust was hard to receive. "If you've got another peer to talk with them," says co-founder Gloria Lockett, "then they can get the word better than any other way." Yet active women were not the only group whose trust CAL-PEP had to gain. Most areas frequented by Black industry women in the Bay Area were overrun with poverty, drug transactions, and intense neighborhood politics. These forces made Lockett ensure that her and other outreach workers established rapport with locals, including drug dealers and many of them

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[106] Priscilla Alexander, "Prostitutes Are Being Scapegoated for Heterosexual AIDS," in *Sex Work: Writings by Women in the Sex Industry*, ed. Frédérique Delacoste and Priscilla Alexander (San Francisco: Cleis Press, 1987), 248.

[107] The term "prostitute" carries negative connotations deeply rooted in American culture. For that purpose, this paper intentionally uses "sex work/worker" and "industry women" interchangeably. Scholar Samantha Majic, who will be quoted repeatedly in this chapter, credits COYOTE member Carol Leigh for the popularization of the term to refer "to the exchange of any commercial sexual services for material compensation" (Samantha Majic, *Sex Work Politics: From Protest to Service Provision*, 15).

women's pimps. "The services provided by the workers further enhance their credibility on the streets, thereby facilitating their introduction to new potential clients," the organization's outcome objectives states. "As their reputations in the community expand, their ability to impact the entire community grows as well."[108] CAL-PEP's outreach included visiting working-class Black industry women on strolls, in crack houses, dark alleys and hotels to teach them ways in which their positionality increased their risks for infection.[109]

These tactics eventually caught the attention of physicians with less credibility among industry women, many of whom perpetuated demeaning perceptions of sex work. In order to allow health professionals to use the organization's clients for their biomedical research, CAL-PEP used this opportunity to convince their medical allies to help invert popular narratives marginalizing industry women. Besides, "Working prostitutes resent being studied," says Alexander, "especially since most researchers view them as deviant." By establishing trust, active women "are even more likely to respond positively to outreach workers and health educators with whom they can identify in a positive way." It is through this lens that, in 1984, CAL-PEP was created, utilizing their resources to prevent new HIV cases and provide social services to seropositive women with little knowledge of HIV/AIDS' etiology.

Few scholars have documented CAL-PEP's fight against stigma and advocacy for sex workers amidst the AIDS epidemic, while others have documented sex workers' obstacles to reclaiming their humanity as policymakers, law enforcement and health professionals disregarded or minimized sex workers as a vulnerable population. Sociologist Valerie Jenness

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[108] CAL-PEP: 1990-1991 Correspondence, Box 57, Folder 12, SFH 4, San Francisco Department of Public Health Records, San Francisco Public Library.

[109] Interview with Gloria Lockett, February 14, 1993, Box 5, Folder 35, MSS 2000-6, Nancy Stoller Papers, Archives and Special Collections, University of California, San Francisco.

has written extensively on COYOTE (Call Off Your Old Tired Ethics), a sex workers advocacy organization established in 1973 that introduced CAL-PEP's Lockett and Alexander to sex work activism.[110] Founded by Margo St. James, COYOTE focused primarily on decriminalizing sex work, often falling short of comprehending ways in which anti-Black racism increased their Black members' disease susceptibility.[111] This chapter elucidates the intersectional dynamics of CAL-PEP's fight against racism, sexism, anti-prostitution laws, and its socioeconomic impact on Black sex workers in the Bay Area.

The political scientist Samantha Majic's comparative ethnographic study of CAL-PEP and the St. James Infirmary's sex work advocacy while receiving government funding is another invaluable contribution to this project. In *Sex Work Politics: From Protest to Service Provision*, Majic examines how the organizations developed and sustained "themselves as spaces that offer services *and* support oppositional political stances," particularly claiming the legitimacy of sex work.[112] Race is ancillary in Majic's analysis and central to this project. This chapter builds upon the works of historian LaShawn Harris and anthropologist Michele Tracy Berger who offer historical context of Black women in the informal labor economy and the unique experiences of HIV/AIDS-infected Black sex workers with a history of drug use whose seropositivity influenced their entrance into activism, respectively.[113]

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[110] Valerie Jenness, "From Sex as Sin to Sex as Work: COYOTE and the Reorganization of Prostitution as a Social Problem," *Social Problems* 37, no. 3 (August 1990): 403-420.

[111] Gloria Lockett, "CAL-PEP: The Struggle to Survive, in *Women Resisting AIDS: Feminist Strategies of Empowerment*, ed. Beth E. Schneider and Nancy E. Stoller (Philadelphia: Temple University Press, 1994), 215.

[112] Samantha Majic, *Sex Work Politics: From Protest to Service Provision* (Philadelphia: University of Pennsylvania Press, 2013), 2.

[113] LaShawn Harris, *Sex Workers, Psychics, and Numbers Runners: Black Women in New York City's Underground Economy* (Chicago: University of Illinois Press, 2016); Michele Tracy Berger, *Workable Sisterhood: The Political Journey of Stigmatized Women with HIV/AIDS* (New Jersey: Princeton University Press, 2004).

Additionally, historian Evelynn M. Hammonds and sociologist Cathy J. Cohen spearheaded studies on the marginalization of Black people living with HIV/AIDS, as well as the futility of colorblind approaches used by policymakers and health professionals in the early years of AIDS outreach.[114] Their contributions lay the groundwork for understanding what historian Robin D. G. Kelley calls "infrapolitics," a term used "to describe the daily confrontations, evasive actions, and stifled thoughts that often inform organized political movements."[115] As Cohen illustrates, the AIDS crisis evinced many limitations in Black politics.[116] However, her monograph focuses primarily on Black professional organizations. But as Kelley argues, "the political history of oppressed people cannot be understood *without* reference to infrapolitics, for these daily acts have a cumulative effect on power relations."[117] Indeed, as this chapter will show, CAL-PEP confronted powerful decisionmakers while maintaining its integrity and loyalty to drug dependent sex workers and other impoverished Black people lacking social services, as well as inadequate information on ways in which HIV/AIDS is transmitted and can be prevented.

In this context, this chapter intervenes both in the emerging historiography of CAL-PEP and the existing history of HIV/AIDS, particularly among poor and working-class Black people, especially sex workers. It attempts to highlight CAL-PEP's negotiations with law enforcement, professional health organizations, and low-income sex workers to show how marginalization of sex workers contributed to their disease vulnerability. As Jenness notes, groups led by sex workers argued that abuses industry women experienced—including drug dependence, violence,

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[114] Evelynn M. Hammonds, "Race, Sex, AIDS: The Construction of 'Other,'" *Radical America* 20, no. 6 (Nov-Dec 1987): 28-38; Cathy J. Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of Chicago Press, 1999).

[115] Robin D. G. Kelley, *Race Rebels: Culture, Politics, and the Black Working Class* (New York: The Free Press, 1994), 8.

[116] Cohen, *Boundaries of Blackness*, 9.

[117] Kelley, *Race Rebels*, 8.

housing insecurity—are "directly related to the prohibition of prostitution and the stigma attached to sex and especially sex work."[118] Race was central to these issues Black women experienced. By 1987, Black women were thirteen times more likely than their white counterparts to contract AIDS. This did not stop mainstream white media or Black media outlets from producing victim-blaming narratives toward AIDS patients for their sexual arrangements or "deviant" behavior like drug use and sex work.[119] This chapter explores how CAL-PEP overcame such obstacles while utilizing resources from the very institutions traditionally ridiculing industry women and becoming a staple in underrepresented Bay Area communities. Thus, it argues that despite such roadblocks, CAL-PEP effectively challenged narratives of sex workers as a vulnerable population and the subsequent hostility; centered race in an existing sex worker activist community; and later received legitimacy (though still ostracized) through establishing a 501c3 status as an official nonprofit organization and receiving donations from national philanthropic organizations.

II

Prior to creating CAL-PEP, Lockett and Alexander became members of the sex workers rights organization COYOTE (Call Off Your Old Tired Ethics), founded in 1973 by Margo St. James. Since its inception, COYOTE fought rigorously "to expose law enforcement procedures that make prostitution problematic."[120] In their quest, St. James organized annual "Hooker Balls," fundraising events, and organized panel discussions clamoring for the decriminalization

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[118] Jennes, "Sex as Work," 404.

[119] Hammonds, "Race, Sex, AIDS," 28-32.

[120] Valerie Jenness, "From Sex as Sin to Sex as Work: COYOTE and the Reorganization of Prostitution as a Social Problem," *Social Problems* 37, no. 3 (August 1990), 403.

of sex work.[121] Throughout the 1970s, many industry women, including St. James, reported being scapegoated by police officers and health professionals whenever San Francisco saw spikes in venereal diseases. In 1973, city officials quarantined active women and threatened to incarcerate them for up to 72 hours—then the appropriate time to determine if disease cultures resurfaced. To dispel this myth, St. James gathered a team of researchers who showed that nine out of ten workers had not contracted sexually transmitted diseases (STDs). Keeping the pressure on city officials, St. James decided to develop "Trix Comix," a creative magazine by and for sex workers that called out law enforcement and policymakers who abused or shunned industry women. COYOTE also established a 24-hour emergency line for women experiencing abuse in their personal relationships, mainly by police officers or by their customers.[122]

Despite their organizing skills, COYOTE failed to understand ways in which women from different ethnicities were impacted not only by police harassment, but also by the AIDS epidemic. The group's "political focus has been on decriminalization," says scholar and former CAL-PEP board member Nancy Stoller.[123] However, Black women's criminalization varied heavily from their white counterparts. Such issues isolated Lockett, who lamented that white industry avoided police harassment and jail time "mainly because they're call girls." Police, she said, "want to bust people [who are] easier for them to bust, and that's the women… on the streets."[124] For the most part, while most white women served as call girls, Black and Latinx women operated as street sex workers. Asian industry women, says Lockett, worked mostly in

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[121] Ibid., 409.

[122] "Loose Women," *Off Our Backs* 3, no. 8 (May 31, 1973): 21

[123] Nancy E. Stoller, *Lessons from the Damned: Queers, Whores, and Junkies Respond to AIDS* (New York: Routledge, 1998), 87.

[124] Ibid.

massage parlors where drugs were prohibited, and their customers were required to wear protection. “But if you’re addicted,” Lockett continued, it becomes difficult to turn down a customer requesting unprotected services. “And some of the addiction prostitutes live from day to day.”[125]

COYOTE’s relationships with local sheriffs failed to mitigate police agitation toward Black sex workers. While health professionals clamored for susceptible groups to use condoms to reduce chances of infection, when in sex workers’ possession they were registered as paraphernalia. Priscilla Alexander notes that many Black and Latina industry women had their condoms confiscated “as evidence of intent to commit prostitution, or even merely list possession of condoms on the arrest record.”[126] In some instances, police would poke holes in women’s condoms and tell them “happy hunting.” On other occasions, women were arrested and released in the middle of the night when stores closed, making it impossible to purchase condoms when returning to work. “If they need to continue working to make up for lost time,” Lockett argues, “they then have to work without condoms, which is dangerous, especially with AIDS.”[127] Lockett and Alexander’s testimonies highlight industry women’s awareness of the dangers HIV/AIDS posed to their livelihood. Being subjected to police harassment, however, skewed epidemiological reports on AIDS statistics among sex workers, thus reinforcing the importance of culturally specific approaches.

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[125] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[126] Priscilla Alexander, “Role of Prostitutes in Prevention of HIV Transmission: Education + Empowerment = AIDS Prevention,” Box 1, Folder 72, Women’s AIDS Network (WAN) Records, MSS 95-04, Archives and Special Collections, University of California, San Francisco.

[127] Gloria Lockett, “Destroying Condoms,” in *Sex Work: Writings by Women in the Sex Industry* (San Francisco: Cleis Press, 1987), 158.

Media misrepresentations and public scrutiny of industry women put some sympathizers on high alert. One person with profound distaste for such allegations was Dr. Constance Wofsy, a leading AIDS researcher at the University of California, San Francisco's AIDS Clinic. Understanding sex workers' precarity, Wofsy bemoaned the fact that San Francisco offered "no programs" for sex workers "to turn to for new skills with which they can earn a living."[128] Additionally, information was lacking on factors encouraging one to venture into the sex industry. Instead, degrading pieces were published further scrutinizing the profession, especially Black women. According to historian Elizabeth Fee, Black women were "popularly perceived as highly sexual, uninhibited, and promiscuous," especially when seen by white doctors who believed Black people were "'diseased, debilitated and debauched,' the victims of their own uncontrolled or uncontrollable sexual instincts and impulses."[129] These attitudes represent age-old American Christian values and ideals present in both conservative white and Black communities that were exacerbated during the AIDS crisis.[130] Such moralistic notions often fail to consider the intersectional dynamics of race, class and gender, thus avoiding sex work and diseases roles in broader socioeconomic problems.

Participation in what the historian LaShawn Harris calls the "urban informal economy" reflects "[B]lack women's desire to advance their own socioeconomic and private agendas, including financially providing for one's families, fulfilling sexual and personal needs, and

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[128] *San Francisco Chronicle*, January 5, 1985.

[129] Elizabeth Fee, "Sin versus Science: Venereal Disease in Twentieth-Century Baltimore," in *AIDS: The Burdens of History*, ed. Elizabeth Fee and Daniel M. Fox (Berkeley: University of California Press, 1988), 127; Alexandra Juhasz, "The Contained Threat: Women in Mainstream AIDS Documentary," *Journal of Sex Research* 27, no. 1 (February 1990): 33.

[130] Cathy J. Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of Chicago Press, 1999), 284.

achieving labor independence and flexibility."[131] In their pursuits of "economic stability and labor autonomy," says Harris, industry women are often met with "race and gender discrimination, public and family shame, arrest and imprisonment, verbal and sexual exploitation, and death." Financial hardships caused by impoverishment increases levels of stress and anxiety, thus expanding one's susceptibility to sexual and chronic diseases.[132] Also referred to as "survival sex," many women joined the profession due to the age of mass incarceration, imprisoning Black men at disproportionate rates. When one's partner was incarcerated, who also provided financial stability in a relationship in a patriarchal system, sex work became a viable option to provide for oneself and their community, including their children.[133]

Historian Robin D. G. Kelley also offers a concrete analysis of the socioeconomic issues that cross-cut race, gender and class among industry women. "Urban" displacement caused young Black people to turn many forms of play into labor, says Kelley. Sex was not exempt. Many young Black men in poor and working-class communities had the opportunity to turn their "play" into labor, including sports and various aspects of hip-hop culture, markets created by poor and working-class Black and Latinx youth.[134] Most of these working-class settings were gendered and limited young women's opportunities. "Because streets are dominated and controlled by men," says Kelley, "prostitutes often require protection; even if they are not

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[131] LaShawn Harris, *Sex Workers, Psychics, and Numbers Runners: Black Women in New York City's Underground Economy* (Chicago: University of Illinois Press, 2016), 24-25.

[132] Ibid., 29.

[133] Stephen J. Inrig, *North Carolina and the Problem of AIDS: Advocacy, Politics, and Race in the South* (Durham: The University of North Carolina Press, 2011), 24; Samantha Majic, *Sex Work Politics: From Protest to Service Provision* (Philadelphia: University of Pennsylvania Press, 2014), 17.

[134] *That's the Joint: The Hip-Hop Studies Reader*, ed. Murray Forman and Mark Anthony Neal (New York: Routledge, 2004).

assaulted, the fear of assault is constantly circulated."[135] This is not to lose sight of the fact that many women joined the profession out of financial necessity. However, unlike wage labor, sex work empowered many women to own the means of their labor, thus turning them into low-level entrepreneurs. Their worlds, Kelley explains, represent the same capitalist principles of mainstream American economics, "namely reducing labor expenditures and maximizing profit." They maintain "some control over [their] labor time," retain large sums of their fees for their services, "and often enjoy the work [they] perform."[136] The deindustrialization of the 1970s and 1980s and subsequent prison boom riddled Black families throughout the country. An expanding sex industry was a result of lack of options for adequate employment. HIV/AIDS became part of a laundry list of concerns for impoverished Black people, particularly Black women.

Many of San Francisco's AIDS researchers failed to incorporate racial and socioeconomic analyses into their studies of industry women's disease etiology. Constance Wofsy, however, saw a correlation between sex workers' drug-dependence, their financial obligations and the public scrutiny they received during the epidemic. She even started an organization, Project AWARE (Association for Women's AIDS Research and Education), primarily to combat "an allegation that AIDS was going to spread to the heterosexual population through prostitutes." Wofsy felt obligated to test and debunk this "unscientific statement."[137] Her positionality as a researcher and middle-class white woman, however, put her at a disadvantage with gaining Black sex workers' trust. According to Lockett, medical researchers had a history of exploiting industry women. Epidemiologists gained a reputation in underground economies of

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[135] Robin D. G. Kelley, *Yo Mama's Disfunktional!: Fighting the Culture Wars in Urban America* (Boston: Beacon Press, 1997), 73.

[136] Ibid., 74.

[137] Constance B. Wofsy, "Women and the Acquired Immunodeficiency Syndrome: An Interview," *Western Journal of Medicine* 149, no. 6 (December 1988), 688

"researching people, doing their studies and then walking off and leaving [industry women] holding basically nothing." She continues: "People who sat down and gave some powerful [information], don't have a thing to show for it." The information shared with medical researchers "was either sitting in a safe or sitting somewhere, but nothing useful was being done with it."[138] Industry women's skepticism was a steep hill for health professionals to overcome, but Wofsy was up for the challenge.

Wofsy wore multiple hats, including running the Center for Disease Control and Prevention's (CDC) San Francisco site.[139] This created an ideal opportunity for her to recruit low-income sex workers of color to study HIV/AIDS' presence among the population and gain their trust. In late 1984, Wofsy and the epidemiologist Judith Cohen expressed at a women's conference mutual interest in AIDS among sex workers. At one of the conference's focus groups, titled "Prostitution and AIDS," they met members of COYOTE, including Lockett. At this moment, says Wofsy, "Judith and I knew that if we were going to do any kind of work we would have to have the total, more than cooperation, combined effort, with prostitutes." After hearing a retired woman claim sex workers "would want to be tested," Wofsy and Cohen capitalized on the opportunity to create a joint program with industry women highlighting structural violence surrounding HIV/AIDS in their communities and creating solutions.[140] One of the active members of COYOTE who joined the Project AWARE and CDC coalition was Gloria Lockett, thus spearheading CAL-PEP's formation as an offshoot of COYOTE.[141]

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[138] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[139] Majic, *Sex Work Politic*, 4.

[140] Biographical—Transcript of Interview, June 14-15, 1995, Box 1, Folder 3, MSS 98-51, Constance Wofsy Papers, Archives and Special Collections, University of California, San Francisco.

[141] Majic, *Sex Work Politics*, 4.

Lockett's split with COYOTE was inevitable. In addition to COYOTE's inability to venture beyond decriminalizing sex work, their colorblind approach to the AIDS crisis rendered Black and Latinx women invisible. Moreover, race was central to the criminalization and abuse industry women faced but hardly registered with COYOTE's programs. According to Lockett, white women did not go to jail at similar rates as their Black counterparts, "mainly because they're white and call girls." Rather than being seen publicly on strolls in impoverished communities like many Black women throughout the Bay Area, many white industry women were contacted via phone and transported for their services. "People of color," Lockett says, "are the ones that are in jail most, and that's not because they commit more crimes. They're just easier to get and people can believe that they committed a crime easier than they can believe [white women] commit crimes."[142]

Lockett and CAL-PEP brought peer-to-peer contact to AIDS outreach among sex workers, which the organization saw as its strength. "The solution to the AIDS crisis," says Alexander, "is accurate and explicit education about risk reduction, as well as adequate funding for research into the causes, treatment, and prevention of the disease."[143] That means direct interactions with one's target audience explaining the modes of transmission and providing educational material to prevent new cases. As difficult as the task presented itself, given that CAL-PEP's target audience was drug-dependent sex workers, it became a hallmark of their outreach setting them apart from other service organizations. With assistance from professional health organizations and members of the medical community, CAL-PEP positioned itself to

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[142] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[143] Alexander, "Prostitutes are being Scapegoated," in *Sex Work*, 261.

incorporate long-lasting programs that benefitted additional risk groups while further humanizing industry women.

III

CAL-PEP took seriously the role education played in its name and its outreach. From members' personal experiences in the industry, as well as retired workers' encounters with active women, they found that too many drug-dependent active workers failed to comprehend the myriad forms of HIV/AIDS transmission and predisposition. As the political scientist Samantha Majic explains, "Although female prostitutes in all venues are still arrested more than their (male) clients, street prostitutes (who are more likely to be women of color and have less education) face the highest risk for abuse by pimps and law-enforcement officials."[144] Abuses include failing to provide adequate services to women who contracted the virus and, for drug-using workers, criminalizing their addiction.

The anthropologist Michele Tracy Berger labels these forms of negligence "narratives of injustice." According to Berger, seropositive industry women's "neglectful treatment ranged from receiving no or very little useful information regarding the HIV/AIDS virus to actual bias and discrimination based on their drug-using status."[145] Health professionals displayed these injustice narratives in three particular themes. There was a huge "lack of information, misinformation, or no information" from health professionals to industry women. In hospitals, clinics, and health departments, women had their status shared by physicians, nurses, interns,

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[144] Samantha Majic, *Sex Work Politics: From Protest to Service Provision* (Philadelphia: University of Pennsylvania Press, 2013), 18.

[145] Michele Tracy Berger, *Workable Sisterhood: The Political Journey of Stigmatized Women with HIV/AIDS* (New Jersey: Princeton University Press, 2004), 87.

secretaries, and any other hospital staff. Industry women also reported that hospital staff failed to assign follow-up visits after informing women they were seropositive.[146]

The second theme included focusing on death. "After learning of their HIV-positive status," says Berger, the women were "in essence, told to go home and prepare to die." In San Francisco, seropositive white men benefitted from what became known as "The San Francisco Model" of care. Professionals and volunteers—including community organizers, psychologists, psychiatrists, physicians, and other public health and mental health experts—came together to ensure AIDS patients that a positive diagnosis was not the end of their lives, while simultaneously preparing them to re-enter society.[147] Poor and working-class Black AIDS patients did not necessarily have the same luxury. The final theme was an intersectional display of judgment by physicians, nurses and hospital staff. Black, drug-dependent industry women were ridiculed because of their race, engagement in a marginalized profession, and drug use. "When they went in for an HIV/AIDS test and when information surfaced that the respondents were potential substance users," Berger continues, "comments were made that resulted in them feeling stigmatized."[148]

CAL-PEP members encountered many women who experienced some forms of Berger's injustice narratives. When Lockett began her educational outreach to women on the "stroll," a young woman notified Lockett that she was "positive" but did not know what that meant. Lockett recalls being "furious" for multiple reasons, but later realizing "people told her" of her status "but she didn't hear it." The woman "didn't want to hear it," says Lockett. "It took a lot

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[146] Ibid., 90.

[147] Thomas R. Blair, "Plague Doctors in the HIV/AIDS Epidemic: Mental Health Professionals and the 'San Francisco Model,' 1981-1990," *Bulletin of the History of Medicine* 90, no. 2 (Summer 2016): 280; James W. Dilley, "Implications for the San Francisco Model of Care," *AIDS Care* 2, no. 4 (1990): 349-352.

[148] Ibid., 91.

more than the one-shot interaction people were given at that time to understand."[149] Many epidemiologists and policymakers did the bare minimum to help low-income Black women, particularly sex workers, understand their status and overcome fear and stigma. It was CAL-PEP's understanding that health professionals already conducted enough research on drug-dependent industry women but "had been of little use in improving their work." Researchers, they believed, "had come, published their papers, then gone—leaving little of lasting value."[150] Intravenous drug use was the most reported mode of HIV/AIDS transmission among African Americans. Of injection drug users tested in a 1988 San Francisco study, 27% of African Americans tested positive, compared to 10% of Latinx and 7% of white users.[151] Despite suffering from disproportionate rates of AIDS cases from drug injection, few treatment facilities existed to assist the at-risk population. In 1981, the federal government cut funding for treatment centers and, in large cities like San Francisco, treatment programs reported "waiting lists as long as seven months."[152]

For low-income Black vulnerable populations, time was literally money. Devoting time to AIDS tests were time consuming, and impoverished African Americans had to choose between their health and their economic livelihood. Dr. Richard Chaisson, UCSF's chief epidemiologist, conducted studies of drug users in nine different programs, all of which had significant absence rates. "Nonparticipation," the study found, "was primarily attributed to lack

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[149] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[150] Gloria Lockett, Carla Dillard-Smith and Benjamin P. Bowser, "Preventing AIDS Among Injectors and Sex Workers," in *Preventing AIDS: Community-Science Collaborations*, ed. Benjamin P. Bowser et al. (New York: Routledge, 2004), 47.

[151] *Los Angeles Times*, February 24, 1988

[152] Ibid.

of time or absence from the clinic on the recruitment date."[153] Studies failed to investigate why vulnerable Black people refused to attend drug programs. Aaliyah Morgan, the medical director of Brooklyn, New York's Woodhull Clinic, posited that health professionals had preconceived notions that working-class Black people were innately unreliable for follow-up appointments. "But," she says, "the reasons poor people do not keep appointments are built into the design of the trials, including the lack of provisions for transportation to the clinics and for on-site childcare."[154] Trials failed to include such services, and in many cases, refused to reconfigure their programs to address these concerns. The Black physician Wayne Greaves had a more simplistic explanation, charging, "It is more important for a [B]lack [person] to work until [they] absolutely can't than to worry about a lymph node."[155] Even when they went in for assistance, many Black sex women relived violence in hospital settings they experienced on the streets from police, aggressive customers, and community members.

One East Bay woman, named Gloria—not to be confused with CAL-PEP's Gloria Lockett—experienced myriad forms of the socioeconomic, physical and emotional violence. After her marriage fell apart in 1969, Gloria, a self-identified "square" who never experimented with drugs or alcohol, was manipulated by a younger man who introduced her to sex work. Gloria enjoyed the "freedom" that came with reclaiming her sexuality, "even the part of going to jail."[156] However, in 1986, her entire world changed. While incarcerated in California's Institute for Women, she was diagnosed with AIDS. She lost up to forty pounds in less than a month.

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[153] Richard E. Chaisson et al., "Cocaine Use and HIV Infection in Intravenous Drug Users in San Francisco," *Journal of the American Medical Association* 261, no. 4 (January 27, 1989): 561.

[154] Rosslyn, "AIDS: We Are Not Immune," *Emerge* (November 1990): 30.

[155] *Washington Post*, October 23, 1985.

[156] Janet Cole, "Gloria: Turning a Life Around," *PWA Voice* 2, no. 1 (Winter 1989): 12.

Once released from prison, she was ostracized by her entire community. “First I got threatening phone calls,” she said. “Then I was shot at and finally I was stabbed in my back.”[157]

Her community’s response to her status culminated a process started by the clinicians who treated her conditions. According to Gloria, the prison doctors treated seropositive women with very little humanity. As her symptoms progressed, the prison hospital staff “asked her to sign a release and performed an HIV antibody test. But she was never given the results.” Matters were not much better on the outside, as upon her release, she followed up with clinicians in search of treatment for her symptoms. At Oakland’s 27th Street Clinic, a man took Gloria’s number, “disappeared for a minute, came back, and said, ‘Your test is positive. Next please.’ I said, ‘But how much time do I have?’ He said, ‘Next please. You can make an appointment and come back and talk to me later if you like.’”[158] The occurrence at the 27th Street Clinic sunk Gloria into a deep depression, but she refused to let the disease & stigma associated with it define her. Eventually, she joined CAL-PEP to help turn her life around, taking it upon herself “’to do outreach in Oakland with the prostitutes and drug addicts, since I’ve been involved with both.’”[159] Gloria’s testimony is an ideal version of women who benefitted from CAL-PEP’s programs. Bringing their educational and prevention efforts into fruition, however, were exhaustive tasks that took significant time being developed.

IV

In 1987, misinformation campaigns continued to spread that sex workers were infecting their clients with HIV/AIDS. Journalists, policymakers, and law enforcement ignored scientific studies disputing these claims, thus endangering the lives of industry women. During that year,

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[157] Ibid., 13.

[158] Ibid., 12.

[159] Ibid., 13.

The CDC conducted a study among Bay Area sex workers. The study found that of the 146 industry women tested, nine (or six percent) tested positive for AIDS. The women contracted the virus not from sexual intercourse but from injection drug use.[160] Many Bay Area health programs organized their agendas through the lens of AIDS being a "gay white male" disease, which was not uncommon in other parts of the nation. Marginalization of gay, mostly white men during the start of the epidemic led to a mobilized response from gay white communities throughout the country.

Long-term exclusion and hostility before the AIDS epidemic of gay white communities convinced them to secure "feelings of safety and familiarity" amongst one another.[161] It also made certain white gay men feel entitled to narratives of the disease and the epidemic, as well as resources. Deborah Gould, a former member of ACT-UP (AIDS Coalition to Unleash Power) evinced that the organization was racist in myriad ways, including caring primarily about AIDS patients who looked like themselves and neglecting the needs of others. Despite creating chapters throughout the nation, ACT-UP developed a reputation of alienating its nonwhite members, disregarding their concerns, and whenever they addressed the intersection of racism and AIDS, white members "usurped" leadership of such conversations.[162] Rather than dominate nonwhite AIDS activists and members of white-led groups, Bay Area organizations simply neglected the concerns of nonwhite people with AIDS (PWAs). In 1987, The city of San Francisco lost roughly "$2 million in public-private funding because of failure to involve minorities in AIDS education planning." The San Francisco AIDS Foundation (SFAF), one of the most recognized

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[160] *San Francisco Chronicle*, May 27, 1987.

[161] Cohen, *Boundaries of Blackness*, 93.

[162] Deborah Gould, "ACT UP, Racism, and the Question of How to Use History," *Quarterly Journal of Speech* 98, no. 1 (February 2012), 55.

organizations at the time, “turned down a $50,000 grant for minority education,” claiming it was not enough money to address such problems.[163] Such issues showed the importance of what scholar J. T. Roane calls “culturally specific health information” that situates “susceptibility to various conditions within their social, economic, and political contexts.”[164] Despite inconsistent support, CAL-PEP operated from this viewpoint in their harm reduction efforts among drug-dependent sex workers.

With minimal resources, CAL-PEP gained notoriety throughout the Bay Area for their creative strategies dispensing AIDS information to industry women and other impoverished high-risk groups. Health professionals paid attention to CAL-PEP’s tactics once word spread of their “Hot and Sexy Safe Sex Quiz.” The Quiz, created by Lockett and Alexander, contained over twenty graphic questions testing people’s knowledge of disease transmission.[165]

Being blunt in their communication showed they understood the language of folks whom they served, which Lockett saw as an important facet of outreach. “You cannot educate people if they don’t understand what you’re saying,” she told Nancy Stoller. “We don’t want people to have to write down the word and look it up later.”[166] As unique as the test appeared, CAL-PEP’s financial woes limited the test’s effectiveness, as active women reminded CAL-PEP the importance of time to the profession. Operating on a shoestring budget, they lacked the necessary funds it wished to provide winners who answered the most questions correctly. Instead, they fed folks who spent time with them, while also offering free condoms.[167] In the meantime, CAL-PEP

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[163] *San Francisco Chronicle*, March 3, 1987.

[164] J. T. Roane, “Black Harm Reduction Politics in the Early Philadelphia Epidemic,” *Souls* 21, no. 2-3 (2019), 150.

[165] Hot and Sexy Safe Sex Contest, CAL-PEP RFP 077-90, Box 24, Folder 19, SFH 4, San Francisco Department of Public Health AIDS Office Records, San Francisco Public Library.

[166] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[167] *San Francisco Chronicle*, April 4, 1988.

strengthened its relationship with Project AWARE while pursuing new ways to secure funding that would not only legitimize them organizationally but also compensate the marginalized risk groups they served. They explored all avenues and settled on registering as a nonprofit organization, applying the very funds from government and health organizations traditionally known for ridiculing sex work to benefit drug-dependent sex workers and other poor and working-class people of color throughout the Bay Area.

CAL-PEP's timing of crossing into the nonprofit sector could not have been better. In 1987, the year of their transition, police started to increase their austere attacks on industry women. That March, in an effort to shame sex workers, Oakland police proposed plans "to publicize the names of customers, or johns, as they are known on the streets." In collaboration with the Alameda County district attorney's office, local law enforcement fought rigorously to pass measures allowing police to arrest sex workers "on sight" who returned to areas they were previously spotted.[168] The measures emanated from community complaints, as residents became disgruntled at industry women's presence in their neighborhoods. Some were even chased off the block.[169] Many active women fought hard to adapt to new forms of marginalization and still provide for themselves. Some were aware that Tuesday and Thursday evenings were considered "vice nights—occasions when police employed decoys and conducted prostitution sweeps. To avoid harassment and arrest, women dressed in fashion unconventional for sex workers and congregated in new areas. This only frustrated law enforcement, who complained that industry women "adapt[ed] like cockroaches," making their jobs harder.[170]

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[168] *San Francisco Examiner*, March 2, 1987.

[169] Ibid.

[170] Ibid.

CAL-PEP members used their street knowledge to evade law enforcement, thereby easing the transition into becoming a nonprofit. According to Stoller, the organization's

> leadership managed the public and private funding agencies as if they were tricks (customers): they learned what the funder wanted, negotiated a good payment, warded off the law, and remained aware that their primary loyalty was to each other, not to government agencies, foundations, or any other "straight" group. They were bold about being prostitutes—renegades and educators simultaneously.[171]

One way in which they capitalized on funding efforts was ensuring industry women not only became board members but were also compensated. In such organizations, board members serve in an unpaid capacity. According to Lockett, however, women "wanted to know[,] 'Am I going to get paid to sit up there and spend [three] hours with you and do all this extra time?'" Eventually, she found creative ways to reward active industry women, which represented almost half of the organization's executive board.[172]

Despite complaints from police officers and policymakers, CAL-PEP worked diligently to shield active women from austere measures criminalizing their movement and ignoring their pain. This was a difficult process. The organization, says Samantha Majic, "[E]merged in a political-economic climate that was open to local, community-based innovation in health and social services, even though antiprostitution sentiments were amplified in the region."[173] Although they received grants from the CDC, California Department of Health Services and the National Institute of Drug Abuse by 1988, enabling them "to build their own institution and expand their HIV prevention activities," donors were reticent to dispense funds to a self-proclaimed prostitutes rights organization working with drug users. Yet, CAL-PEP stayed true to

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[171] Stoller, *Lessons from the Damned*, 89.

[172] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[172] Ibid.

[173] Majic, *Sex Work Politics*, 35.

its mission of serving and representing marginalized communities in general and particularly drug-dependent sex workers. As Priscilla Alexander stated, effective AIDS prevention among sex workers should be to protect women from HIV infection. "If the primary purpose is to protect the client," she argued, "the prostitutes will sense that their lives are deemed less valuable than those of the heterosexual men they serve." Making this a fundamental tenet of their outreach helped CAL-PEP gain the trust of many respond positively to people with whom they can identify, reaffirming CAL-PEP's intentions of making both active and retired women central to their prevention efforts.[174]

Much went into CAL-PEP's efforts to maintain its grassroots identity while also registering as a nonprofit organization. For starters, they recruited active women to serve as board members, which was an unpaid assignment. This was also a complicated process, as industry women reminded Lockett of the essential role of time in their profession. "The wanted to know[,] 'Am I going to get paid to sit up there and spend [three] hours with you and do all this extra time?'" she told Stoller. Eventually, Lockett found ways to compensate active industry women, who comprised almost half of the organization's board members.[175]

Another problem they ran into was their name. Sex work remained stigmatized in the Bay Area in the late 1980s and early 1990s, and CAL-PEP experienced the dilemma of applying for funding with "prostitute" in their name. Both the United Way and the CDC denied their grant applications, encouraging Lockett to incorporate the word "prevention" in place of "prostitute" in the organization's name.[176] Funders feared their money would help prostitutes teach other

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[174] Alexander, "Role of Prostitutes in Prevention, Women's AIDS Network Records, University of California, San Francisco.

[175] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[176] Ibid.

women how to be prostitutes.[177] In addition to mainstream scrutiny of the profession, Lockett found race and gender as intersectional elements of CAL-PEP's grant rejections. "I know people want us to mess up," she said. "Either for being Black or for being a prostitute or for being a woman, or for all three of those." Either way, she continued, "we are ex-prostitutes" who "tell everybody about it and we make them deal with it.[178] By centering industry women's humanity, Lockett put the onus on critics to confront their prejudices against sex work and sex workers. It became even more difficult to question CAL-PEP's intentions once they established mobile harm reduction services among the Bay Area's most impoverished.

V

In 1989, the Robert Wood Johnson Foundation, as well as the Northern California Grantmakers and the Alameda County Office of AIDS, accepted CAL-PEP's grant proposal to help them purchase a mobile van. The RV visited sex worker communities in Oakland, Berkeley, and San Francisco to conduct drug interventions, AIDS workshops, feed impoverished risk groups, and dispense condoms and bleach.[179] As impoverished Black and Latinx peoples' needs increased, so did CAL-PEP's services. The van later kept a nurse on hand to provide "on-site medical care," including conducting pap smears and testing for HIV/AIDS, syphilis and other sexually transmitted diseases.[180] Like their other services, CAL-PEP first needed to establish trust among drug-using sex workers, many of whom looked askance at a van funded by government organizations traversing underrepresented Bay Area neighborhoods.

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[177] Lockett, "CAL-PEP: The Struggle to Survive," in *Women Resisting AIDS*, 216.

[178] Ibid.

[179] RFP 111-91: Proposal: California Prostitutes Education Project, Box 24, Folder 61, San Francisco Department of Public Health AIDS Office Records, SFH 4, San Francisco Public Library, San Francisco, CA.

[180] Benjamin P. Bowser et al., "Preventing AIDS Among Injectors and Sex Workers," in *Preventing AIDS: Community-Science Collaborations*, ed. Benjamin P. Bowser et al. (New York: The Haworth Press, Inc, 2004), 45.

With the RV, CAL-PEP refused to wait for women to come to them. Instead, they got creative by painting the van maroon and plastered the organization's emblem on the side. Injection drug using sex workers remained their primary target population. Many of these women "would not go far from their friends and their connections." With the van, women "can look out the window and see if their connection it out there and not be so worried about missing and losing out on something."[181] Police harassment, however, made many women paranoid—assuming the van might be part of sting operations to arrest multiple industry women in one sweep. Lisa, an HIV-positive Black sex worker who battled drug dependence since the age of twelve and joined the sex industry at fourteen years of age, all but confirmed skepticism of the mobile van. While working in downtown Oakland on International Boulevard, Lisa states that active women "'were suspicious at first because they were doing drugs and were worried that CAL-PEP was part of the police.'" Undeterred, CAL-PEP members "offered food and put up a schedule of their lectures about HIV," and offered those present the opportunity to be compensated while taking the Hot and Sexy Safe Sex Quiz. This increased CAL-PEP's popularity among drug-dependent sex workers, and "'people wanted them to come every week.'"[182]

As word continued to spread, CAL-PEP decided to further their outreach by not only allowing women to spot the van, but also using the van to access women in dangerous environments who were not privy of the organization. By galvanizing those with whom women were intimate, Lockett saw it as a way to eliminate the alienation PWAs experience upon contracting the virus. "Besides," says Lockett, "it's not just her problem. It's also his problem

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[181] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[182] Majic, *Sex Work Politics*, 54.

too. They've both got to change."[183] Some women who traded sex for drugs, particularly crack cocaine, did not consider their exchange as prostitution and, therefore, did not protect themselves from infections like many active sex workers. This convinced CAL-PEP to inform crack users and dealers of the threat of AIDS, thereby showing it is not solely the woman's responsibility.[184] Additionally, they branched out to target young people who were runaways; had high juvenile hall retention rates; and dropouts considering joining the profession. To prevent them from becoming sex workers or contracting HIV/AIDS, CAL-PEP held speaking engagements in juvenile halls. They also worked with furlough programs and noticed a vicious patter: "the same people we see on the streets we see in the jail."[185] This highlights the social and environmental threat of HIV/AIDS on impoverished people with limited resources and opportunities to adequate education, employment, and housing.

Transgender sex workers were one of the most marginalized populations in the Bay Area. When their resources expanded, CAL-PEP made sure to include the transgender population in their outreach as well. Rendered invisible, Lockett noticed that trans sex workers resorted to drug use more than other groups they encountered. CAL-PEP noticed that most trans sex workers were abandoned by their families and sharing rooms at San Francisco's Ambassador Hotel. In addition to offering the organization's services, CAL-PEP also rented rooms to prevent trans workers from sleeping on the streets. When they lacked adequate funds for room rentals, "the manager of the hotel would let us use his room for workshops."[186] This was one of many examples of CAL-PEP's consistency of meeting people where they were, which was a staple of

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[183] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

[184] RFP 111-91, San Francisco Department of Public Health AIDS Office Records, San Francisco Public Library.

[185] Ibid.

[186] Ibid.

their harm reduction tactics. Documenting these stories changes the landscape of the history of HIV/AIDS and AIDS activism and sheds light on the organization's significance to understanding disease etiology and the humanity of susceptible groups.

VI

CAL-PEP's skepticism of medical and academic researchers, as well as the dehumanization of Black, drug-dependent sex workers in the age of crack cocaine and mass incarceration, has limited the number of publications about the organization. Their concerns, though legitimate, contributed to their erasure. Unsure of who would exploit their members and organization, or turn them over to law enforcement, CAL-PEP placed restrictions on who had access to their members and material.[187] This creates obstacles for scholars looking to document their stories. Retired and active members remain skeptical and require transparency before handing over material on the organization. Yet, as the history of HIV/AIDS and AIDS activism continues to expand, scholars will have a wealth of knowledge from CAL-PEP, displaying the complicated relationships between marginalized groups during the AIDS crisis and nonprofit organizations, health professionals, and law enforcement.

CAL-PEP showed the intersectional dynamics of stigma and simultaneously used it to their advantage to champion the concerns of Black sex workers. Working with the medical community and nonprofit organizations was a difficult decision for the organization. Members complained about the confusion of being funded by the same government with historical records of experimenting on Black people, while active industry women hesitated taking resources from an RV that might be working with local police.[188] CAL-PEP remained committed to its mission

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[187] Bowser et al., "Preventing AIDS Among Injectors and Sex Workers," in *Preventing AIDS: Community-Science Collaborations*, 47.

[188] Interview with Lockett, Nancy Stoller Papers, University of California, San Francisco.

of combating narratives scapegoating sex workers for infecting heterosexual men; reducing harm among an indigent population; and utilizing government resources to their advantage. Through the later part of the 1990s, as funds started to slow and members departed, the organization became less effective. However, in 2022, CAL-PEP still exists as an organization and continues to conjure new outreach strategies among the Bay Area's most marginalized populations. Although their story is far from over, CAL-PEP's insistence from its inception to have people from the target population to effect change within that group, employing culturally specific material they understand, is vital to harm reduction strategies among underrepresented groups to combat diseases. Their tactics remain important and can help contemporary researchers understand disease etiology among marginalized communities.

Chapter 3

Dr. Robert C. Scott, AIDS Project of the East Bay, and the Politics of Outreach

I

Treating Black people infected with the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) consisted of more than prescribing medicine. Few Bay Area physicians took this dilemma as seriously as the African American physician Dr. Robert C. Scott. Frustrated by the lack of services for Black people plagued by the diseases, Dr. Scott decided to launch his own clinic in 1982. Naming it the AIDS Project of the East Bay (APEB), the clinic not only offered treatment, but also sought to mitigate fear and stigma attached to the infections. The indignities behind HIV/AIDS consisted of myriad layers. Many seropositive people were abandoned by their family members. Others, particularly gay Black men and MSMs (men who had sex with men but did not necessarily identify as being gay), told their families "they got AIDS from intravenous drug use rather than risk rejection for being gay." Additionally, legitimate fear of the "dominant white system" of medicine, overwhelmingly tailored toward gay white men, resided in many African Americans.[189]

Many of Dr. Scott's patients arrived at his facility hopeless and in later stages of contracting the virus. "I have a number of patients who knew they were HIV positive and chose to do nothing because they were afraid of the treatment," he told a reporter. To gain their trust, Dr. Scott built longstanding relationships with his patients and their families, often holding HIV educational classes on ways adequate treatment offsets one's viral load, thereby extending their

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[189] Catherine Taylor, "AIDS Volunteers: Making Sense of Death and Life," *Radiance* 5, no. 4 (October 31, 1988): 41.

life after infection. "You got to be able to do more than push pills," said Dr. Scott. "You need to get to know the patients and they need to get to know you."[190] Dr. Scott's message resonated with his entire staff, requiring two weekends of intense training from employees and volunteers. These sessions taught them "to focus not on death and grief, but on helping people with AIDS and those close to them live with the disease."[191]

Dr. Scott and APEB provided a unique style of care and treatment for Black AIDS patients who previously lacked facilities in their own counties.[192] As late as 1986, APEB reportedly provided the only in-patient ward and out-patient AIDS clinic outside of San Francisco. Prior to their existence, people affected by HIV/AIDS seeking services would give fake San Francisco addresses to receive care at one of the city's facilities. The San Francisco Health Department found in 1985 that almost a quarter of patients utilizing their AIDS services lived in other counties. According to APEB's John David Dupree, "We always have 40 or 50 more patients than show up on health department figures because people lie about where they live so they can get into San Francisco General Hospital."[193]

Alameda and Contra Costa County used the inaccurate AIDS surveillance data against community organizations, notably APEB. In the last quarter of 1986, the Alameda County board of supervisors delayed funding AIDS service groups because of insufficient reporting. Despite being given over three million dollars to fight the epidemic and support victims, the county had only allotted $134,000 towards AIDS relief efforts. "They've given a variety of excuses," said

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[190] *San Francisco Chronicle*, August 16, 1997.

[191] Taylor, "AIDS Volunteers, *Radiance*, 41.

[192] According to Valerie Papaya Mann, over 85 percent of APEB's clients were African American. See Harriet A. Washington, "AIDS and the High Cost of Living," *Emerge* 8, no. 9 (August 1997): 28.

[193] *San Francisco Chronicle*, July 7, 1986.

Noreen McKeon, former APEB director. “First, they said they wanted to wait until after the elections to see if Prop 6 was going to pass,” she continued. The proposition would have lowered the salaries of state and local government employees. “Then,” said McKeon, “they said they had to look at all the health priorities in the county and not just one, so they called for studies.” The board dragged their feet over a $100,000 request from APEB—half to hire full-time staff and the other half to assist the county in monitoring AIDS cases “and see if they have shelter and other needs addressed.” Because East Bay residents often used fake San Francisco addresses, the board of supervisors used their database against funding APEB, despite the number of patients visiting their clinic. Many folks affiliated with APEB saw this as an aspect of institutional racism. Michael Symonds, former member of APEB’s advisory council, argued that Alameda and Contra Costa County hesitated “because there has never been a real gay ghetto in either county.” Instead, the East Bay had an influx in cases resulting from intravenous drug use which, according to Symonds, had “a little racism involved” because of the largely Black and Latinx populations impacted.[194]

Finding care in different counties sheltered one from the stigma of HIV/AIDS. Thus, APEB developed an empathetic approach to care that eradicated stigma and, in the process, extended patients’ lives in multiple ways. APEB helped pass a law banning discrimination “in housing, employment or business transactions” against people with HIV/AIDS.[195] The organization also fought rigorously to prohibit police departments from sharing information about seropositive patients to other officers “and medics responding to emergency calls.”[196] When not fighting racist laws, Dr. Scott and APEB members were occupied creating educational

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[194] *Bay Area Reporter*, December 11, 1986.

[195] *San Francisco Chronicle*, July 22, 1987.

[196] *Los Angeles Times*, July 17, 1991.

resources, running food banks, and offering crisis counseling to their patients. Doing "more than pushing pills," this chapter examines the nature and extent of APEB's HIV/AIDS treatment and outreach. It argues that Black people with AIDS in the Bay Area required more than drugs to mitigate their disease susceptibility, and organizations like APEB, in spite of limited funding and resources, met that need by creating a humanistic approach that instilled in its patients a new sense of living.

Before poor and working Black patients would visit APEB's clinic, they first needed to understand ways in which the epidemic affected them. In 1984, three years into the crisis and one year into APEB's existence, Black people accounted for a quarter of all AIDS cases nationally. Dr. Scott and APEB were alarmed by such figures, citing "a bastion of black leadership," rooted in homophobia and other longstanding issues like unemployment and abject poverty, to explain the lack of awareness on the disease's impact among African Americans.[197] Compounded by discrimination "rooted within white lesbian and gay institutions and spaces," Black gay men and MSMs during the early AIDS crisis experienced what Cathy J. Cohen labels secondary marginalization.[198] This process, says Cohen, "can be exercised by the more privileged members of marginal groups, as the 'management' of marginal group members is negotiated daily by those they would call their own."[199] Black people's erasure from AIDS campaigns in the Bay Area and subsequent denial of disease contraction amplified APEB's outreach obstacles. However, they became one of the most consistent organizations dispensing AIDS brochures and

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[197] *San Francisco Chronicle*, March 27, 1989.

[198] Cathy J. Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of Chicago Press, 1999), 94.

[199] Ibid., 70.

flyers in Alameda County with varying degrees of information targeting different groups, including Black youth, women, queer folks, and men—especially men engaged in same-sex sex.

APEB's reliance on flyers, however, did not mitigate the structural disparities and economic systems that limited their outreach efforts. Many low-income Black population groups dealt with multiple health issues, including but not limited to poverty, inadequate health care, diabetes, and hypertension.[200] HIV/AIDS compounded these problems, thereby making the disease invisible among Black health concerns already largely ignored by policymakers, health professionals, and media outlets. Rather than addressing the health implications of social and environmental racism, American decisionmakers instead suggested individuals become cognizant of their daily practices and ways it affects their health, thus ignoring state-sanctioned violence and blaming those victimized.

II

The historian Jennifer Brier offers a profound example of ways in which AIDS became perceived as an individual concern. In her monograph *Infectious Ideas: U. S. Political Responses to the AIDS Crisis*, Brier highlights the San Francisco AIDS Foundation (SFAF) and the Center for Disease Control and Prevention's (CDC) four-year campaign, starting in 1983, to "eroticize AIDS prevention, particularly the use of condoms, and market the strategy to gay men." The organizations favored this approach over public service announcements on the epidemic and "images of the ravages of AIDS in an attempt to scare people into changing their behavior." Despite condom manufacturers' history of appealing to heterosexuals, Les Pappas, the SFAF's campaign designer, saw targeting gay communities in the middle of the epidemic as a form of

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[200] Benjamin P. Bowser et al., "African-American Youth and AIDS High-Risk Behavior: The Social Context and Barriers to Prevention," *Youth & Society* 22, no. 1 (September 1990): 54-66; Mindy Thompson Fullilove, *Root Shock: How Tearing Up City Neighborhoods Hurts America, and What We Can Do About It* (New York: New York University Press, 2004).

gay liberation. "In effect," says Brier, "consumerism became a solution to the epidemic and simultaneously the mechanism by which difference among 'homosexually active men' disappeared." Pappas, and therefore the SFAF and CDC, approached the disease from a white gay perspective, rendering efforts to reach susceptible communities of color unsuccessful.[201]

Despite their shortcomings with communities of color, particularly poor and working Black population groups, the CDC and SFAF's ideas proliferated without their involvement. The individualistic notion of care during the crisis followed marginalized communities and AIDS organizations. This dynamic, says political scientist Lester K. Spence, "exacerbates inter- and intra-racial inequality by creating institutional and ideological apparatuses that place more and more responsibility on the backs of populations most in need of state resources."[202] By positing that one is responsible for their own health, notwithstanding health determinants such as poverty, underemployment and housing insecurity, HIV/AIDS became a politicized health issue. APEB, in many ways, succumbed to narratives deeming individuals liable for their positive status. They created an aggressive advertisement campaign targeted at Black people with messages about smarter decision making. The burden of trying to fix systemic issues exposing African Americans to infection while also dispensing material that failed to address structural racism overwhelmed APEB. That failing does not, however, dismiss their valiant efforts to provide care and community to an alienated population. Instead, it warrants a critique of neoliberal ideology adopted during the epidemic that placed "primary responsibility for combatting the disease on the populations least likely to have the capacity to do so."[203]

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[201] Jennifer Brier, *Infectious Ideas: U. S. Political Responses to the AIDS Crisis* (Chapel Hill: University of North Carolina Press, 2011), 45-47.

[202] Lester K. Spence, "Live and Let Die: Rethinking Secondary Marginalization in the 21st Century," *Souls* 21, no. 2-3 (2019): 194-195.

[203] Ibid., 193.

AIDS awareness advertising campaigns differed across racial and economic lines. Organizations embraced such strategies to confront specific social problems towards particular population groups, often to suggest adopting behavioral changes. To be successful, says the scholar Angelique Harris, social marketing campaigns "must have an understanding of the target population and of the unique issues and problems facing this population."[204] Mainstream narratives at the time of AIDS' 1981 identification wrongly described the disease as one solely affecting gay white men, colloquially calling it "gay cancer." This mobilized support for gay white communities impacted by the disease, leading to the establishment of organizations and increased popularity of gay newspapers.[205] This left poor and working Black communities alienated until many white-dominant organizations incorporated feigned diversity components for people of color. Though writing about HIV/AIDS in North Carolina, Stephen J. Inrig's analysis applies to the problem of diversity in AIDS organizations throughout the country. Inrig states,

> Dating circles largely remained segregated in Durham, and many gay [Blacks] thought white gays cared little for [Blacks] or their freedom struggle. Moreover, many [Black] gays, who enjoyed little support from the larger [Black] community, chose to hide their sexual orientation, preserving a hypermasculine public image while participating in covert male-only sexual networks. This clandestine and ambiguous sexual identity kept many [Blacks] outside mainstream gay culture and made them hard to reach by the state's largely white AIDS groups.[206]

By the time many white organizations developed minority approaches, their groups lost significant support and became increasingly hostile to people of color. *San Francisco Chronicle*

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[204] Angelique Harris, *AIDS, Sexuality, and the Black Church: Making the Wounded Whole* (New York: Peter Lang, 2010), 92.

[205] Randy Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (New York: St. Martin's Press, 1988), 107-108.

[206] Stephen J. Inrig, *North Carolina and the Problem of AIDS: Advocacy, Politics, and Race in the South* (Chapel Hill: University of North Carolina Press, 2011), 44.

journalist Randy Shilts, for example, who was one of the first reporters to cover the epidemic regularly, expressed displeasure with the AIDS Coalition to Unleash Power (ACT UP)'s decision to include African American and Latinx members and outreach efforts. According to Shilts, ACT UP's progressive approaches "was demonstrating its 'growing irrelevance' in the gay [white] community by, ostensibly, being more concerned about poor [Black people] and Hispanics with AIDS than about gay white men with AIDS." The groups' popular "SILENCE = DEATH" campaign "'was losing its grip on the gay imagination.'"[207] Shilts equated gayness with whiteness, which caused several problems with broad-based AIDS outreach. Perspectives such as his and others who thought like him erased the Black gay AIDS experience through their colorblind logic. The resentment gave communities of color more incentives to closet their sexuality and seropositive status, as many local gay white organizations also had the support of health professionals.[208] Lastly, playing identity politics influenced Black organizations like APEB to develop awareness strategies placing blame and responsibility on their target audience, therefore failing to establish a critique of structural violence that increased their outreach populations' disease susceptibility. This was the result of APEB's pamphlet campaigns directed towards local African Americans.

The first step many organizations took in distributing AIDS brochures was to get target audiences to understand their vulnerability and ways in which the disease is transmitted. This was a complex step, as neglected groups, specifically poor and working-class African Americans, were a challenging population to reach. Like many other Black organizations during

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[207] Deborah B. Gould, *Moving Politics: Emotion and ACT Up's Fight Against AIDS* (Chicago: University of Chicago Press, 2009), 282.

[208] Robert M. Wachter, "AIDS, Activism, and the Politics of Health," *New England Journal of Medicine* 326, no. 2 (January 1992), 128.

the early stages of the epidemic, APEB focused on educational activities through its volunteer initiatives. These were published in newspaper ads and in their pamphlets. This was common practice, notes Cathy Cohen, as “one of the goals of these new organizations was to provide AIDS information and education in a manner that resonated with Black Americans.” Led mostly by gay Black men, novice Black AIDS service organizations “never focused exclusively on AIDS’ impact on gay men of color.” Rather, groups like APEB employed tactics that would benefit all marginalized communities but centering the needs of African Americans.[209] Despite being stigmatized and alienated, organizations run by gay Black men highlighted ways in which all Black people were affected, thus showing the importance of collective work. Nonetheless, as mentioned earlier, many—specifically APEB—also succumbed to narratives placing both blame and responsibility almost solely on the victims in their outreach efforts. One Black subpopulation facing an uphill battle through which APEB reached them was gay Black men. The struggles, however, did not discourage Dr. Scott and APEB from creating an aggressive and visible campaign targeting the subcommunity.

There are several reasons local health professionals and grassroots organizers struggled to reach Black gay and MSM populations. Part of the problem was their closeted sexuality, which many men refused to acknowledge or hesitated to share out of fear of abandonment. In the United States, Black masculinity and sexuality has been objectified since slavery. Twentieth-century analyses of Black families by white scholars pathologizing Black culture caused extra pressures convincing non-heterosexual men to shield their sexuality—keeping it on the “down low,” as it is known in many Black communities. Down low narratives, says scholar C. Riley Snorton, were created “by certain pressures exerted under advanced capitalism and the disjointed

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[209] Cohen, *Boundaries of Blackness*, 98-99.

and deeply ambivalent sensibilities that characterize representations of [Black] (masculine) sexuality as hypermasculine (and perhaps, consequentially, as burdened and overly determined by hyperheterosexuality) and sexually deviant."[210] Dr. Scott, a self-identifying gay Black men, understood why alienated Black men would protect their sexuality from public scrutiny. This led to the creation of a support group through APEB. The support group, officially established in 1986, met every Monday to provide "emotional support and advocacy," as well as for people to discuss personal issues, "health and safer sex information, drug-related issues, and topics of interest to the participants."[211]

The support group was only one of many efforts led by APEB prioritizing the health of Black gay men experiencing abandonment and sheltering their sexuality. Adjusting with the times, Dr. Scott made frequent requests for volunteers and opened paid positions for individuals taking the matter seriously. In the 1990s, for example, APEB created three new positions for AIDS health educators. One of their many tasks included facilitating "group risk reduction sessions to African American gay/bisexual men in Alameda County." To vet potential candidates, APEB required applicants to "have HIV educational outreach experience and legitimate knowledge of African American gay/bisexual culture."[212] One of their earliest and most known actions were their drop-in support groups. The drop-in sessions started in the mid-1980s, the same time the organization started to lose funding and volunteers. These sessions were sponsored in newspaper ads, with such messages as "No fees, donations requested, no one

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[210] C. Riley Snorton, *Nobody is Supposed to Know: Black Sexuality on the Down Low* (Minneapolis: University of Minnesota Press, 2014), 49.

[211] *Bay Area Reporter*, June 4, 1987.

[212] *Whazzup!* Magazine 1, no. 6 (October 1996), 28.

turned away for lack of funds."[213] This implicit message addressed concerns many recent seropositive patients had, while simultaneously highlighting the economic disparities created through health care inequalities.

APEB's educational department staff also became foot soldiers canvassing neighborhoods to raise awareness among Black gay men and MSMs. Their "Street Outreach Program" component, for instance, offered "education and information regarding HIV transmission and risk reduction to men who have sex with men but do not self-identify as gay/bisexual." Additionally, the outreach workers provided training "around all aspects of HIV infection," including "epidemiology, virology, infection control, legal issues, and more."[214] The organization engaged with Alameda County residents on a community level, as Dr. Scott led by example for what he envisioned from others. The *San Francisco Chronicle* claimed that he ran his clinic and private practice like "door-to-door milk deliveries." He grew a reputation to "chase down patients with HIV," or contact patients' family members or their pastors to remind patients of appointments or share with them new AIDS information.[215] This approach changed, however, with the organization's brochure campaign to market AIDS awareness to various Black subpopulations throughout the Bay Area.

III

Local gay men experienced multiple forms of subjugation well before the AIDS crisis. In the 1970s, the Black Panther Party identified gay and women's liberation movements as oppressed groups. This encouraged the BPP to mobilize such marginalized communities into voting blocs to address their somatic and material concerns. According to historian Donna Jean

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[213] *San Francisco Bay Times* 10, no. 8 (May 1989), 36.

[214] *San Francisco Bay Times* 11, no. 5 (February 1990), 2.

[215] *San Francisco Chronicle*, February 16, 2001.

Murch, in 1973, BPP representatives "advocated new legislation to ban police brutality and discrimination based on gender and sexual orientation in jobs and housing, adoption and child custody, taxation, and inheritance laws."[216] Dr. Scott himself experienced multiple forms of discrimination in the East Bay. In the 1970s, while teaching anatomy, physiology and microbiology at Oakland's Laney College and serving as secretary of the Bay Area Physicians for Human Rights (BAPHR), he was often ignored and dismissed upon entering East Bay medical clinics while inquiring about medical concerns. "No one took time to explain anything," he recalled, "and particularly being a teacher who took time with concepts and explaining to people, ultimately that was the thing that started making me think about going to medical school."[217] The harsh experiences not only led to him becoming a physician, but also became central to his outreach approaches among Black vulnerable populations during the AIDS crisis.

It is difficult to assess how effective Black organizations were at marketing AIDS awareness and prevention toward vulnerable Black subgroups. As historian Stephen J. Inrig illustrates, "Challenges on several different levels—structural, institutional, cultural, and organizational—all conspired to hamper outreach efforts while contributing to the spread of the virus in vulnerable minority communities."[218] As the disease became both a growing health and political issue and racialized minority AIDS organizations individualized their approaches to place the onus on those at risk, outreach efforts turned toward a neoliberal form of what political scientist Lester K. Spence calls "health promotion." Health promotion strategies, he says, "are increasingly adopted in order to incentivize individuals to take responsibility for their own

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[216] Donna Jean Murch, *Living for the City: Migration, Education, and the Rise of the Black Panther Party in Oakland, California* (Chapel Hill, University of North Carolina Press, 2010), 211.

[217] *San Francisco Chronicle*, February 16, 2001.

[218] Inrig, *North Carolina and the Problem of AIDS*, 58.

health.” These approaches offered information related to one’s individual health status, how to maintain one’s health, and individual approaches practically to avoid hospitalization. They included “advertising campaigns that warned individuals of the morbidity risks posed by certain practices and behaviors, warn individuals of the problems associated with various diseases/ailments, give individuals data as to various morbidity rates, or some combination of the above.”[219] To reiterate, while highlighting this phase of the Black AIDS experience, I argue that APEB yielded to the dominant strategies of mainstream, largely white AIDS activism that failed to develop a critique of state-sanctioned violence that placed their targeted audiences at increased risk. Instead, Black organizations like APEB, operating on a shoestring budget, put together herculean efforts to alleviate AIDS among poor and working-class Black risk groups. Rather than allowing their inability to secure state funding and support to discourage them, their individualistic approach highlights larger problems of ways medical and political decisionmakers failed to take seriously the threat of AIDS among African Americans.

Alameda County supervisors conjured many excuses to delay AIDS funding for people of color. In late 1984, organizers clamored for the creation of an AIDS ward similar to the San Francisco Model of care, which prepared seropositive patients to reintegrate into society; included social workers, community organizers, psychiatrists, nurses and physicians at patients’ disposal; and offered basic services to patients too sick to care for themselves.[220] This model was almost exclusively for gay white men, as AIDS surveillance statistics myopically described the crisis as one of gay white men. Thus, the majority of available resources went to gay white

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[219] Spence, “Live and Let Die,” 195.

[220] *Bay Area Reporter*, January 29, 1987; J. W. Dilley, “Implications for the San Francisco Model of Care,” *AIDS Care* 2, no. 4 (349-352); Thomas R. Blair, “Plague Doctors in the HIV/AIDS Epidemic: Mental Health Professionals and the ‘San Francisco Model,’ 1981-1990,” *Bulletin of the History of Medicine* 90, no. 2 (Summer 2016): 279-311.

organizers, many of whom worked closely with local white physicians. Failing or refusing to think beyond identity politics with an intersectional analysis of the epidemic, local decisionmakers perpetuated the idea that care should emanate from the community affected. According to psychiatrist James Dilley, "gay men and lesbians provide much of the care to gay men [read white], ex-intravenous drug users and other recovering individuals provide much of the AIDS education to the substance abuse community, people of [color] agencies provide service in communities of [color], and retired sex industry workers can be found once again 'working the streets.'"[221]

Matters were not as simple as Dilley and others perceived among vulnerable populations. In late 1984, East Bay organizers fought exhaustively with local policymakers to secure an AIDS ward in Alameda County. Records show that as early as May 1983, officials considered the virus a serious threat, leading to a public forum, hosted by grassroots organizers, on June 1st of the year to discuss the political ramifications of funding disparities in AIDS care.[222] The forum did not create immediate actions. By February of 1984, county officials continued to delay dispensing resources addressing the growing epidemic to communities in need. A collection of organizations maintained that policy inaction emanated from misconceptions of AIDS being a gay white disease concentrated in San Francisco. Community representatives disputed elected officials' claims, highlighting that over 40% of national cases were among non-white population groups.[223] This fight lasted for years. Rather than waiting for government support, APEB strengthened its campaign to spread awareness on the disease through advertisement campaigns

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[221] Dilley, "Implications," 349-350.

[222] *Bay Area Reporter*, May 26, 1983.

[223] *Bay Area Reporter*, February 2, 1984.

to multiple vulnerable populations, gay Black men and MSMs being one of their primary audiences.

APEB devised many creative tactics to spread AIDS awareness and prevention material to Black vulnerable subpopulations. They expressed genuine concern for Black youth, given that by 1986 African Americans accounted for a quarter of all cases nationally.[224] The emergence of crack cocaine exacerbated African Americans' disease susceptibility. One study involving 222 Black young people between the ages of 15 and 19 in Oakland and San Francisco revealed that less than 60% of the teenagers used condoms during sexual intercourse, and only 20% of them used protection during their most recent intercourse. Many young women in the study from the Oakland group confessed "going door-to-door offering sex in order to support their crack habits." The local Black youth engaging in drug use and frequent unprotected sex ran "extraordinarily high risks of acquiring AIDS."[225] To mitigate this problem, Black sexual health and drug dependence scholars suggested AIDS prevention messages come from the communities in which they serve—a difficult task in neighborhoods where drug distribution was the main source of employment and access to social mobility. "The danger would not become apparent until friends began to die from AIDS," said Bowser et al.[226]

APEB did not wait for AIDS statistics among Black young people to increase for them to develop outreach campaigns targeted at the group. Instead, in 1986, the organization introduced its "Safer Sex Kits."[227] The kits consisted of multiple condoms, a bottle of lubrication, a rubber

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[224] *San Francisco Sentinel*, December 12, 1986.

[225] Benjamin P. Bowser et al., "African-American Youth and AIDS High-Risk Behavior: The Social Context and Barriers to Prevention," *Youth & Society* 22, no. 1 (September 1990), 57-58.

[226] Ibid., 64.

[227] *San Francisco Sentinel*, July 18, 1986.

dam, and “a brochure which includes an extensive list of healthy sexual activities including hugging, feeling, wrestling, toys, masturbation, kissing and various methods of having intercourse without exchanging semen.” Despite trying to highlight the epidemic as a community problem, APEB in the same vein resorted to individualistic rhetoric with the kits. “The idea behind the kit,” the organization quoted in a newspaper advertisement, “is to give people enough information and some tools to help them assess their own risks and encourage them to make their own decisions on the kinds of risks they feel safe in taking.”[228] Such health promotion statements reinforced individual responsibility, placing the burden on the populations most at risk.[229]

Black organizations throughout the country found explicit, culturally specific content as an effective way to transmit AIDS information among African American populations. In Philadelphia, for instance, the group BEBASHI (Blacks Educating Blacks About Sexual Health Issues) employed this approach “in response to the conditions of stigma, shame, and ignorance perpetuated by the City’s limited allocation of resources to address the growing epidemic in its pernicious effects on poor Black communities across the city.”[230] The same could be said about Alameda County in general and particularly Oakland. The inadequate responses from policymakers led to APEB partnering with local school boards and cable show host Gail Sanchez to show a film explicitly discussing AIDS prevention. The film aired on local cable stations and taught teenagers “about AIDS, advocate masturbation as an alternative to intercourse and demonstrate—using fingers—how to use condoms.” The show, titled “Let’s Talk About Sex and Loving,” aired three times per week, and aired throughout the East Bay. Some parents inveighed

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[228] *San Francisco Sentinel*, August 15, 1986.

[229] Spence, “Live and Let Die,” 196.

[230] J. T. Roane, “Black Harm Reduction Politics in the Early Philadelphia Epidemic,” *Souls* 21, no. 2-3 (April 2020), 147.

that the program did a poor job expressing abstinence as a preventive measure, while others refused to allow their children to watch. One segment featured APEB member John David Dupree who, on air, "show[ed] how to use condoms by placing one over two of Sanchez's fingers." Like the Safer Sex Kits, Dupree also noted alternatives to intercourse, such as hugging, cuddling, and kissing. The program also featured a panel of local teenagers between the ages of thirteen and seventeen, who asked Dupree and Sanchez unfiltered questions about AIDS transmission and prevalence among Black and Latino youth.[231]

The following month, APEB hosted a forum titled "Children, Youth, and AIDS," designed to reiterate the significance of AIDS education among young vulnerable populations. Along with the Bay Area Urban League, APEB compiled statistics to show how young people were at risk of infection. The organizations found that a quarter of teenagers had at least four sexual partners, and half had intercourse by the age of sixteen. With the summer approaching and the dearth of youth employment opportunities, APEB understood that the allure of drugs and sexual intercourse would entice African American youth, thereby increasing their disease susceptibility. Thus, APEB and the Urban League warned parents, teenagers, teachers, and community members that sexually active youth needed to be informed "of how to protect themselves from AIDS."[232]

As time progressed, APEB's AIDS outreach efforts toward young people continued to gain attention, leading to educators and school administrators asking for their expertise at reaching the youth. By the early 1990s, the organization offered counseling, educational and home services to over 500 AIDS patients. School board members, teachers and administrators

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[231] *San Jose Mercury News*, May 13, 1987.

[232] *Bay Area Reporter*, June 4, 1987.

were cognizant of APEB’s previous work creating Safer Sex Kits and their frequent public forums for Bay Area youth. Their work encouraged educators to consult the organization to help produce “a more comprehensive AIDS program for schools.” Roger Gooden, founder of the educator’s collective “Educators and Friends Who Care,” saw APEB’s inclusive approach as a template, as Gooden anticipated backlash from conservative and religious groups.[233] As a Black gay man, Dr. Robert C. Scott played a pivotal role in confronting stigma from Black churches towards AIDS patients. Dr. Scott served as an usher at Oakland’s Allen Temple Baptist Church. He also pressured the pastor into addressing the disease’s significance among African Americans, including members of his church, which culminated in the establishment of an Allen Temple AIDS Ministry.[234] One patient said he and Dr. Scott had “a Christian relationship” based on trust and when he “was at death’s door,” Dr. Scott “got in touch with our pastor” to alleviate the pastor’s misconceptions about AIDS, homosexuality, and drug use.[235] Official members of APEB and volunteers each underwent a day-and-a-half workshop teaching “the basics of home care for people with AIDS,” showing local educators the level of seriousness to which Dr. Scott and APEB took the epidemic.[236] Their positive reputation with young people further increased their profile, as their marketing campaign continued to thrive as the organization expanded.

IV

Few people were more prepared than Dr. Scott to produce structurally competent material for African Americans in the Bay Area, and simultaneously train volunteers for similar roles. Since its 1977 inception, Dr. Scott served as a founding member of the Bay Area Physicians for

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[233] *San Francisco Chronicle*, June 28, 1993.

[234] *Oakland Post*, August 17, 2011.

[235] *San Francisco Chronicle*, February 16, 2001.

[236] *San Francisco Sentinel*, April 10, 1987.

Human Rights (BAPHR). On July 24, 1977, seventeen people attended a meeting to address "the need among the gay community to be assured adequate health care, and a need on a professional level to provide a foundation for addressing gay health education and the topic of homosexuality in medical training programs and among our colleagues." At the gathering, they discussed the purpose of the organization, essentially agreeing to four key functions:

> (1) to support adequate education on homosexuality in medical school programs, (2) to serve in a consciousness-raising effort for health professionals regarding homosexuality, (3) to organize a physician referral service for gay patients, and (4) to become involved in the political activity of the gay community as needed.[237]

As the majority-white organization's secretary, Dr. Scott gained empirical evidence of the San Francisco Model's form of care for primarily white HIV/AIDS patients and brought it to the East Bay, along with his compassionate treatment and humanistic approach. This method was crucial for Black men who feared abandonment from their communities if revealed they were both gay and seropositive, as stories abound of the alienation Black gay and MSMs experienced. In North Carolina, for instance, one Black gay man slit his wrists and throat before allowing his family to abandon him because of his sexuality.[238] Many religious leaders and politicians viewed AIDS as a disease for certain people who got what they "deserved." Thus, Blackness coupled with HIV/AIDS and homosexuality became, according to the theorist C. Riley Snorton, "an additional proof of an already stigmatized (read: blackened) body."[239]

Dr. Scott went above and beyond to prevent additional stress and depression among his patients. One client, for example, lauded Dr. Scott for following him "during the past two years of chronic illness," becoming not only the patient's physician but also his friend. While

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[237] "BAPHR – The First 18 Months," *Bay Area Physicians for Human Rights Official Newsletter* 1, no. 1 (January 1, 1979): 1.

[238] Inrig, *North Carolina and the Problem of AIDS*, 26.

[239] Snorton, *Nobody is Supposed to Know*, 66.

experiencing depression from his AIDS symptoms, the patient claimed that Dr. Scott communicated with him on a weekly basis. "If he did not hear from me for a week or 10 days he would call to ask how I was feeling and what was happening in my work up," said the patient. Dr. Scott even offered his personal home phone number for inopportune times that one might need to talk. "It is very reassuring to patients to know that they can be in direct contact with you in an emergency," Dr. Scott's patient concluded.[240]

Treating hopelessness was as important as treating HIV/AIDS infections. Many of his discouraged patients also expressed their frustration with the information disparities around treatment. "I have a number of patients who knew they were HIV positive and chose to do nothing because they were afraid of the treatment," Dr. Scott told the *San Francisco Chronicle*. Protease inhibitors, for example, required patients to "follow a rigid schedule." Missed applications of the drug made the disease resistant to treatment. Knowing that his patients "want[ed] to live," Dr. Scott worked through lunch breaks to translate accurate knowledge on AIDS treatments, ways the disease attacks white blood cells, and the list of opportunistic infections.[241] Utilizing the resources he created and helped manage through APEB, Dr. Scott knew the organization would have to transmit information effectively to at-risk groups skeptical of medical treatment, modes of infection, and fearing abandonment.

Many African Americans expressed discontent with color-blind approaches to AIDS outreach that prioritized the needs of white communities and underdeveloped methods to support Black people. Thus, APEB employed culturally specific material to Black men susceptible to infection or living with HIV/AIDS, especially Black gay men and MSMs. As Marlon Bailey

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[240] "Letter to the Editor," *Bay Area Physicians for Human Rights Official Newsletter* 5, no. 3 (March 1983): 3.

[241] *San Francisco Chronicle*, August 16, 1997.

notes, "HIV/AIDS prevention and sexual health paradigms developed by public health have neither worked to reduce HIV nor improved the sexual health and well-being of Black communities, let along Black gay men." To this end, AIDS awareness and prevention strategies needed to address the aspects of structural racism—including but not limited to poverty, unemployment, incarceration, and health and health care disparities—as well as intersectional stigma, homophobia, and the alienation many Black gay men experienced upon their communities learning of their health status and sexuality.[242]

With a public health department resistant to funding the organization, APEB was forced to look inward and emphasize implicitly that Black people would have to save themselves. Generally speaking, health promotion strategies "incentivize[d] individuals to take responsibility for their own health." Alameda County, however, refused to fund APEB for its AIDS outreach efforts.[243] Thus, APEB's flyer and brochure campaign shared educational facts about HIV/AIDS transmission to Black men in ways they understood. That included offering emotional support, which the organization emphasized at its extensive workshops for volunteers. For instance, one flyer features two Black men hugging, with the message, "If your lover becomes HIV positive, he may need a shoulder to lean on." The flyer also reveals that AIDS was the number one killer among Black men between ages 24-44. With the emboldened words "use a latex condom every time," the flyer also reinforces APEB's declaration of emotional support, stating, "Don't let your fear of HIV break up your relationship. Protect yourself. Protect your lover."[244]

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[242] Marlon M. Bailey, "Black Gay Men's Sexual Health and the Means of Pleasure in the Age of AIDS," in *AIDS and the Distribution of Crises*, ed. Jih-Fei Cheng et al. (Durham: Duke University Press, 2020): 219-220.

[243] *San Francisco Sentinel*, May 13, 1988.

[244] "AIDS Project of the East Bay Flyers circa 1990s," Box 9, Folder 7, African American Museum & Library at Oakland Vertical File Collection, MS 179, African American Museum & Library at Oakland, Oakland Public Library. Oakland, California.

Systemic racism created the conditions in which Black gay men experienced abandonment. Their marginal status was reflective of dominant American society's hostility toward gay communities. As Cathy J. Cohen evinces, the alienation and distance experienced by marginalized groups "result not from a one-time, or single-domain, experience of marginalization, but instead are rooted in a historical experience of exclusion across domains."[245] Such powerlessness created depression among those abandoned whose serostatus were interpreted by their communities as inevitable death.[246] As a preventive measure, APEB shared facts about transmission to alleviate stigma that rendered people living with HIV/AIDS invisible. The organization ensured that their support groups were "open to any person involved in the physical, medical, spiritual or emotional care of people with AIDS, their families and friends."[247] Their flyers were more explicit. One, featuring four Black men, was titled "Don't let HIV/AIDS break up your circle of friends." With messages like "Together we stand, divided we fall" and "Don't let HIV break up your friendship," the flyer also called for unity and stressed the importance of support for those infected. Lastly, the brochure also stressed the importance of knowing one's status and using latex condoms. The document asks, "In your circle of friends, do you know who is positive? If one of your boys tested HIV positive would he still be in your circle of friends?"[248] These questions reinforce the importance of knowing one's status, while simultaneously accentuating the significance of moral support for people living with HIV/AIDS.

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[245] Cohen, *Boundaries of Blackness*, 49-50.

[246] Nelson Varas-Diaz et al., "AIDS-Related Stigma and Social Interaction: Puerto Ricans Living with HIV/AIDS," *Qualitative Health Research* 15, no. 2 (February 2005): 177.

[247] *San Francisco Sentinel*, April 11, 1986.

[248] "AIDS Project of the East Bay Flyers circa 1990s," Box 9, Folder 7, African American Museum & Library at Oakland Vertical File Collection, MS 179, African American Museum & Library at Oakland, Oakland Public Library. Oakland, California.

Unprotected sex in safe spaces were common for some Black gay men and MSMs. Some, during the height of the epidemic in the late 1980s, operated in underground economies to continue to engage in “raw sex” and evade the stigma associated with unprotected intercourse. These practices, says Marlon M. Bailey, “allow [Black gay men] to claim and enact sexual autonomy during this HIV crisis that disproportionately impacts them.”[249] For some, intimacy, satisfaction, and sexual pleasure were more important than fear of infection.[250] This created a quandary for groups like APEB hoping to prevent new cases and simultaneously offer support for those seropositive. One of their best attempts in their flyer campaign included an image of a Black man sitting on a stool, fully clothed, holding a hat with both hands around his pelvic area. The message underneath the image reads: “I was feeling good but I wanted to feel fabulous. So, I started doing brothers without protection.” Tying it back to the startling statistics of infection and mortality rates among Black men, the flyer later reads, “I met this really fine brother and we got into something… Now, I’m thinking maybe I made the wrong choice, because AIDS is the number one killer of Black men between the ages 24-44.” The flyer does not judge, nor does it state whether or not the individual pictured contracted the virus. The following message, however, reinforced community support and health promotion for susceptible populations, asking, “Sound familiar? You’re not alone if it does. Safer sex is not always an easy choice, but you can make the change.”[251]

A more explicit version targeting Black gay men and MSMs who favor intimacy over protection featured two Black men, hugging closely, with one whispering in the other’s ear. Directly below the photograph are the words, “Say it… Show it… Do it.,” all capitalized and in

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[249] Bailey, “Black Gay Men’s Sexual Health,” 218.

[250] Ibid., 225-226.

[251] “AIDS Project of the East Bay Flyers circa 1990s, Box 9, Folder 7, Oakland Public Library. Oakland, California.

bold print. Below the bold print features the sentence: “When I’m out on the town, I want to have a good time!” The following sentences reinstate the importance of safe sex and the message of AIDS killing Black men at greater rates than anything else in the country. “So, when whispering that special fantasy,” the flyer continues, “don’t forget to tell and show him just what you want. Forget the smooth lines. Always have safer sex.”[252] As Angelique Harris argues, framing AIDS as a social problem and dispensing information to communities in ways that complement their construction of AIDS is a technique of meeting people on their levels.[253] These were culturally specific attempts to disseminate AIDS information that resonated with Black gay men and MSMs.

APEB’s flyer campaign, in spite of its well intentions, had several limitations. The organization failed to critique structural violence that increased African Americans’ disease susceptibility. In doing so, APEB reinforced neoliberal forms of AIDS outreach that avoided stigma, underemployment, housing discrimination, and medical racism—all of which placed Black people at greater risk to infection. Failing to contextualize their target populations’ material reality with the epidemic made AIDS an issue “of people simply not making the proper choices about their own bodies. People become consumers,” says political scientist Lester K. Spence, “and consumption is tied to ‘healthy choices.’”[254] Their Safer Sex Kits, which were discussed earlier, are a prime example of how well-intentioned outreach reproduces victim-blaming. “The idea behind the kit,” stated in one of the organization’s newspaper advertisements,

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[252] Ibid.

[253] Harris, *AIDS, Sexuality, and the Black Church*, 92.

[254] Spence, “Live and Let Die,” 202.

"is to give people enough information and some tools to help them assess their own risks and encourage them to make their own decisions on the kinds of risks they feel safe in taking."[255]

Additionally, the organization's brochures echoed respectability politics among African Americans. One flyer featured an image of a Black child, with the words above the child's photograph: "Dreams… Do Come True. Be Here for Her Future." Below, the image is the daunting fact that the majority of women and children infected with the virus were African American. The historian Evelynn M. Hammonds highlights that by 1987, Black women were thirteen times more likely than white women to contract AIDS, and that 91% of infected infants were children of color.[256] Before advocating the use of latex condoms, the brochure mentions believing in children's futures with the hopes that one day there will be a cure for the virus. "Until that day," it concludes, "it's going to take all of us working together. Each child is a precious gift. So, let's make each day special."[257] This narrative dichotomizes "innocent victims" versus those guilty. "Children," says historian Dan Royles, "as a powerful cultural symbol of innocence, had to be protected from those guilty others: the man 'stepping out' on his wife and kids, the woman who contracted HIV through sex work or shared needles, or the predatory homosexual."[258] The organization's inability to develop a critique of structural racism in its outreach efforts placed them in the arena of neoliberal forms of health promotion that blamed victims of the disease for their status. Understanding the state's role in minimizing APEB's efforts is critical to the organization's story.

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[255] *San Francisco Sentinel*, August 15, 1986.

[256] Evelynn M. Hammonds, "Race, Sex, AIDS: The Construction of 'Other,'" *Radical America* 20, no. 6 (Nov-Dec 1987): 28.

[257] "AIDS Project of the East Bay Flyers circa 1990s, Box 9, Folder 7, Oakland Public Library. Oakland, California.

[258] Dan Royles, *To Make the Wounded Whole: The African American Struggle against AIDS* (Chapel Hill: The "University of North Carolina Press, 2020), 39.

V

Many health departments throughout the country did not contextualize HIV/AIDS with other ongoing health crises experienced by poor and working-class African Americans. This oversight increased skepticism and frustration with the health care system among Black people, especially those with other pressing needs. In addition to HIV/AIDS, many low-income Black communities battled such issues as drug and alcohol use, infant mortality and cancer, in addition to working service sector jobs that did not provide health insurance. Black AIDS organizers repeatedly highlighted these structural failures mounted frustration among their target populations, as AIDS was not a primary concern of many of their patients. With people struggling to balance "single parenting, unemployment or working two or three jobs, dealing with substandard education, lack of money, teenage pregnancy and homelessness," AIDS was seen as an afterthought.[259] The medical anthropologist Merrill C. Singer uses the term "syndemic" to describe such situations. "In syndemics," says Singer, "the interaction of diseases or other health problems (e.g., malnutrition) commonly arises because of adverse social conditions (e.g., poverty, stigmatization, oppressive social relationships) that put socially devalued groups at heightened risk."[260] Against this backdrop, APEB fought extensively to secure adequate funds towards their AIDS outreach programs but were met with hostility from the Alameda County Department of Public Health, which delayed funding and, along with APEB's parent organization, the Pacific Center, eventually took over the organization.

APEB's shortcomings exemplify ways systemic racism hindered AIDS organizations' ability to alleviate suffering among stigmatized populations. The Alameda County health

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[259] Rosslyn, "AIDS: We Are Not Immune," *Emerge* Magazine 2, no. 2 (November 1990): 30.

[260] Merrill C. Singer et al., "Syndemics, sex and the city: Understanding sexually transmitted diseases in social and cultural context," *Social Science & Medicine* 63, no. 8 (2006): 2011.

department was a dominant institution that limited resources and defined ways organic organizations would utilize the county's funds. Noting APEB's construction of culturally specific outreach illuminates how hierarchies confine access to its resources, "thus further [marginalizing] the most vulnerable of the community, increasing the potential harm of crises such as AIDS."[261] As early as 1986, the organization clamored for financial support to continue services for the county's AIDS population. The health department, however, delayed voting on the measure into the next year, giving "a variety of excuses."[262] Funding finally came after two white men, Jack Hanna and J. C. Keller, chained themselves to the Alameda County Administration Building for three weeks demanding that the county allocate funds towards HIV/AIDS organizations, including APEB. This created a $50,000 pool for APEB to develop "Shanti-like volunteers," as local health professionals hoped that APEB would replicate majority-white San Francisco organizations like Shanti Project.[263]

Suggesting they mimic Shanti Project frustrated many APEB members, as the comment assumed APEB lacked its own volunteer services, which were running for five years by the time the county offered financial support. One member of APEB wrote to the *Bay Area Reporter* and Alameda County officials expressing their displeasure, as the comments implicitly suggested San Francisco's model was superior to their own.[264] This was no anomaly, as East Bay groups continued to get overshadowed by San Francisco's more popular services and expressed their frustration with such sentiments. One APEB client even penned an op-ed. David M. Rolland called out The North Face company for throwing "so much effort towards San Francisco when

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[261] Cohen, *Boundaries of Blackness*, 25.

[262] *Bay Area Reporter*, December 11, 1986.

[263] *Bay Area Reporter*, January 29, 1987.

[264] *Bay Area Reporter*, February 19, 1987.

they are based in the East Bay." This type of invisibility contributed to funding disparities, as those with influence overlooked HIV/AIDS cases and grassroots organizations in predominately Black communities like Alameda County. "We do not have the staff or the budget to solicit help from the community in general, Rolland continued, "but this does not excuse ignorance of our existence, or ignorance of our needs, and our community needs."[265]

At the time, Alameda County had the fourth highest number of AIDS cases per county in the nation, trailing only Los Angeles, San Francisco, and San Diego.[266] Thus, calling our corporations like The North Face for their negligence proved to be an effective strategy to bring awareness and resources to the East Bay. In 1988, The North Face hosted an AIDS benefit event where a fifth of its proceeds went to the San Francisco AIDS Foundation and APEB. They also led a canned food drive for the organizations.[267] Charity, however, did not mitigate systemic failures that reinforced health and health care disparities and regulated the nature and extent of APEB's outreach by controlling its budget through neglect. Instead, it illuminated the organization's clamor for help and simultaneously publicized its internal woes that resulted from a lack of funds.

By the second quarter of 1988, APEB suspended its direct services for AIDS patients due to inadequate funds. The state, however, framed the organization's shortcomings on financial mismanagement.[268] APEB relied heavily on financial donations and volunteer services, largely because they did not receive government funding. This forced them to devise creative strategies to raise money. One constant strategy was an annual Bike-A-Thon where, in 1988, they raised

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[265] *Bay Area Reporter*, March 19, 1987.

[266] *San Francisco Sentinel*, May 13, 1988.

[267] *San Francisco Sentinel*, March 4, 1988.

[268] *Bay Area Reporter*, April 28, 1988.

over $11,000 towards AIDS services. They also held classical music concerts featuring artists like Elizabeth Blumenstock and Lisa Grodin, who showcased the works of artists such as Mozart and Johann Sebastian Bach.[269] This did not, however, encourage the state to support APEB financially, but to allow them to continue to sink, in spite of their programs, than for the state to intervene.

Despite a strained relationship with county officials and the prospect of unpaid labor, many continued to work for APEB to offer services to people living with HIV/AIDS. Framing the Pacific Center and Alameda County's takeover through a framework of financial mismanagement obscured the significance of APEB's services, which prioritized the needs of their clients. As patients' needs expanded, APEB dug into its emergency fund to offer support. This included accessing their food bank, which provided "nutritionally balanced, easily accessed groceries for PWAs too impoverished or ill to adequately provide for themselves and their dependent loved ones." They also provided free transportation for their clients to and from medical appointments and the organization's support meetings. Additionally, the emergency fund helped clients meet "rent, utility, and other essential payments, and miscellaneous client emergency needs, including massage therapy and hot meal deliveries."[270] County officials and members of the Pacific Center failed to comprehend ways in which precarity functioned as needs for AIDS patients whose treatment required more than antiretroviral drugs. Rather than lambasting and penalizing the organization for meeting client demands, the health department could have benefitted from APEB's culturally competent model of care that highlighted structural violence as a public health issue rendering their patients susceptible to infection.

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[269] *San Francisco Sentinel*, May 6, 1988.

[270] *San Francisco Sentinel*, March 25, 1988.

Failing to do so reinforced colorblind approaches to AIDS activism and organizing that focused exclusively on drugs as the cure, thus letting systemic racism off the hook. While APEB, in its own right, fell victim to individual forms of health promotion, they did so as a result of inadequate support, utilizing the tools at their disposal to help communities affected by the epidemic.

VI

The AIDS Project of the East has a unique and extensive story that deserves to be told. Without institutionalized archive collections related to the organization or its founder, Dr. Robert C. Scott, it is difficult compiling material that helps paint a more complete picture of the nature and extent of their outreach. This chapter utilized public sources to highlight the successes and pitfalls Dr. Scott and the organization experienced. That included Dr. Scott wearing many hats, including serving as a founding member of the Bay Area Physicians for Human Rights and his role as an usher at Oakland's historic Allen Temple Baptist Church. Reverend Dr. J. Alfred Smith, Sr. and his son lauded Dr. Scott for his "powerful presence, not only as a physician with a large case load of people living with AIDS, but also as a community advocate, a board member of AIDS organizations, and an AIDS educator."[271] Documenting Dr. Scott's relationship with Allen Temple's AIDS Ministry would illuminate similar trends of doing more than prescribing medicine to people living with HIV/AIDS, as he showcased with APEB.

This chapter focused primarily on Dr. Scott's engagement with the politics of APEB's volunteer campaign. APEB members' willingness to continue working with their patients, in spite of their organization being usurped by the county, highlights their humanity and dedication

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[271] "Memorandum from J. Alfred Smith Jr. to J. Alfred Smith Sr. re: Status Report of AIDS Ministry Activities 1992-10-21," Box 14, Folder 4, African American Museum & Library at Oakland Vertical File Collection, MS 179, African American Museum & Library at Oakland, Oakland Public Library. Oakland, California.

to healing their patients. It also shows Alameda County health officials' myopic understanding of AIDS etiology and perspective of effective treatment. Rather than ostracizing the organization for using its funds to provide basic services for its patients, local decisionmakers should have applauded APEB for how its work elucidated larger systemic problems that rendered marginalized populations vulnerable to infection. Instead, policymakers and media outlets continued to cover the epidemic through the lens of a gay white disease. Local newspapers and television networks called coverage of Black and other ethnic groups affected "a delicate balancing act." Frank McCullough, the executive director of the *San Francisco Examiner*, a gay publication run by and focusing almost exclusively on white men, doubled down on his statements, claiming, "I'm really troubled about dividing AIDS up into colors" and pledged that eventually the disease's impact on communities of color was "a story we'll get on."[272]

This is the context in which APEB's individualized health promotion campaign, which was its most present, should be understood. While some chapters of the national organization ACT-UP (AIDS Coalition to Unleash Power) embraced identity politics in which they hoarded resources for their demographic, APEB was forced to rely on themselves with messages in their pamphlets echoing that Black people would have to save themselves.[273] The local health department showed their unwillingness to fund the organization, justifying APEB's position that prevention would be the best form of treatment, as they saw no end in sight to structural violence. That does not, however, exonerate APEB from criticism. Instead, it offers a broader perspective of the organization's challenges in the midst of trying to help abandoned Black subpopulations. Flaws and all, Dr. Scott and APEB created a format that humanized its patients,

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[272] *Santa Cruz Sentinel*, November 3, 1988.

[273] Deborah B. Gould, "ACT UP, Racism, and the Question of How to Use History," *The Quarterly Journal of Speech* 98, no. 1 (February 2012): 54-62.

extended their lives, and assured them that a positive diagnosis neither defined them or signaled an end to their lives. Navigating hostile territory that tolerated and reinforced structural violence limited APEB's outreach, but its members' focus on the patients illuminates the significance of a culturally specific approach to AIDS outreach.

Chapter 4

Radical Inclusion: Bishop Yvette Flunder and Black Church Responses to the AIDS Epidemic, 1982-1996.

I

How HIV/AIDS is framed for marginalized communities is equally as important as the ways in which those communities understand and confront the epidemic. That was true for Black churches from 1981—when AIDS (the acquired immune deficiency syndrome) was first identified—through the early 1990s, when Black churches were recognized nationally for taking what observers viewed as aggressive approaches to raise awareness among their churchgoers. Originally falsely described as the "gay related immune deficiency syndrome," or GRIDS, media attention, public policy and medical and scientific research and resources were directed mostly towards gay communities, especially white men, men having same-sex sex were hit disproportionately in the Center for Disease Control and Prevention's (CDC) early epidemiological reports.[274] Little was done to mitigate national dialogue of AIDS being a so-called gay white disease and, later, a gay disease. This convinced many Black churches to interpret the epidemic as such, which limited many churches' attempts to develop effective outreach programs.

Black churches also lacked the sovereignty to define AIDS on their terms its effects on their communities, which many scholars warned against in the framing of HIV/AIDS. According to the medical historian Charles Rosenberg, American medicine's practical aspects, particularly

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[274] Kevin M. Moseby, "Two regimes of HIV/AIDS: The *MMWR* and the socio-political construction of HIV/AIDS as a 'black disease,'" *Sociology of Health & Illness* 39, no. 7 (2017): 1072-1074.

those overlapping racial, class, and gender concerns, are formed through specific communities' relationships with scientists and physicians. Differences, says Rosenberg, "can all play a role in the process through which physicians formulate and agree upon definitions of disease—in terms of both concept formation and ultimate application in practice. Health professionals framing disease definitions, and the consequences of such definitions, explain in part the limited responses to HIV/AIDS in Black communities roughly during the first decade of the epidemic.[275]

In addition to AIDS being framed as a white disease, other consequences included insufficient data and information on ways in which African Americans were impacted. The scholar Angelique Harris notes that HIV/AIDS discourse has historically emphasized "the importance of presenting HIV/AIDS education and information in a culturally appropriate manner" to facilitate awareness and reduce stigma.[276] The inability—or refusal—to produce culturally specific medical information hindered African American communities in general and particularly Black churches. As the governing body of Black communities, Black churches have the influence to steer African American communities in either direction. As homophobia and stigma towards drug users and sex workers occurred nationally, it was also reflected in many Black churches. The sociologist Cathy J. Cohen calls this process secondary marginalization—whereby leaders of already-marginalized groups police the conduct of those on the fringes to maintain respectability in dominant white society.[277]

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[275] Charles E. Rosenberg, "Framing Disease: Illness, Society, and History," in *Framing Disease: Studies in Cultural History*, ed. Charles E. Rosenberg and Janet Golden (New Brunswick: Rutgers University Press,1992), xiv-xvi.

[276] Angelique Harris, "Framing AIDS Facts: An AIDS Education and Prevention Strategy," *Black Theology* 11, no. 3 (2013): 306.

[277] Cathy J. Cohen, *Boundaries of Blackness: AIDS and the Breakdown of Black Politics* Chicago: University of Chicago Press, 1999), 70-73.

This chapter builds upon the work of scholars such as Harris, Cohen, and Kevin M. Moseby, among others, who have highlighted ways in which framing of the early HIV/AIDS epidemic did a disservice to Black communities. Particularly interested in Black churches in the Bay Area, this chapter illuminates that disparate framing notwithstanding, many Black churches still created holistic approaches confronting HIV/AIDS in the first fifteen years of the epidemic—before it was recognized nationally that African American churches were now taking the epidemic seriously.[278] From 1983 through the 1990s, many local Black churches were on the frontlines of AIDS campaigns in their communities, practicing what the Black lesbian Bishop Yvette Flunder calls "radical inclusion." Flunder witnessed stigma, homophobia, and systemic problems such as inadequate access to health care and poverty, subjecting people to HIV/AIDS, particularly Black trans folks and people in same-sex relationships. In church settings, Black gay men played prominent roles but were denigrated behind closed doors and in some sermons, as many ministers viewed same-sex sex as sin. The abandonment and shame experienced by Black people in nonnormative sexual relationships had direct effects on their health, convincing some to use drugs to cope with their marginality and others to avoid seeking treatment out of fear of further disrespect. These people, says Flunder, were "church burned," a term she used to describe ways churches failed their congregants. "We sing their songs and shout and get happy off their music, but condemn them privately," she said.[279]

As a solution, Flunder and other Black church leaders employed radical inclusion to center the experiences of African Americans subjected to secondary marginalization, hoping to eradicate stigma and increase awareness and prevention regarding their vulnerability. Radical

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[278] Harris, "Framing AIDS Facts," 309-311.

[279] *USA Today*, October 31, 1994.

inclusion binds together justice, theology, and health issues because in Black communities, Flunder saw empirically the “detrimental” experiences “in our community to live this dichotomy of being told by people that you are promiscuous and substandard and evil and everything for being gay.” HIV/AIDS added another element of stigma for trans folks, drug users, and people in same-sex relationships.[280] Thus, radical inclusion confronts the “insidious attempt” in church communities and beyond “to separate those persons who should receive compassion in the epidemic from those who should not.” The hatred bestowed upon secondary-marginalized African Americans are, in Flunder’s words, “systemic in American society” and “employs a god of vengeance in the form of AIDS.”[281]

Against this backdrop, this chapter argues that despite the national framing of AIDS as a “gay white disease” placing Black churches at a disadvantage, many Bay Area leaders employed radical inclusion to address HIV/AIDS among marginalized groups—including but not limited to people in same-sex relationships, trans folks, drug users, and sex workers. In the process, ministers constructed their own approaches of radical inclusion, focusing on matters varying from homophobia to so-called illicit drug use and housing insecurity. Tackling sensitive subjects in Black communities such as same-sex relationships limited many churches’ outcomes due to homophobia and stigma by their focus groups. That does not, however, discredit their willingness to address these issues in traditional sacred spaces and in neighborhoods ravaged conditions such as deindustrialization, chronic joblessness, drug use, and inadequate access to health care that increased their target populations’ exposure. By addressing HIV/AIDS as early

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[280] “Oral History Interview: Yvette Flunder,” Interviewed by Monique Moultrie, April 28, 2011, https://lgbtqreligiousarchives.org/media/oral-history/yvette-flunder/YFlunder.pdf.

[281] Yvette A. Flunder, *Where the Edges Gather: Building a Community of Radical Inclusion* (Cleveland: The Pilgrim Press, 2005), 34.

as 1983, their efforts invert claims of stagnation on part of Black churches during the first decade of the AIDS epidemic, causing a rethinking of ways in which scholars have approached narratives on AIDS and Black churches.[282]

II

Black churches have historically been spaces for collective action in Black communities. The 1787 founding of the African Methodist Episcopal (AME) church by Richard Allen and Absalom Jones, amid northern enslavement in Philadelphia, established Black churches as agents of change addressing racial and health inequities. During the year of the AME's founding, a yellow fever epidemic swept Philadelphia. Physician and abolitionist Benjamin Rush believed African Americans were immune to yellow fever, thus petitioning Allen and Jones to volunteer Black people to "stem the tide of the virus" through acts of caregiving, grave digging, housekeeping, and collecting trash. Allen saw this as an attempt to prove African Americans' humanity and, thus, eradicate slavery and white people's assumptions of Black inferiority and biological determinism. Instead, people like the publisher Mathew Carey accused African Americans of looting white people's homes. Allen countered Carey's claim by pointing out Carey fled the city during the epidemic, and others turned their backs on the sick. In Allen's estimation, "two thirds of the persons, who rendered [nursing, gravedigging, and other] services, were people of color, who, on the application of the elders of the African church… were liberated, on condition of their doing the duty of nurses at the hospital."[283] By administering

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[282] Cohen, *Boundaries of Blackness*, 277-286; [282] William L. Jeffries IV et al., "On the Battlefield: The Black Church, Public Health, and the Fight against HIV among African American Gay and Bisexual Men," *Journal of Urban Health* 94, no. 3 (June 2017): 385.

[283] Richard Allen and Absalom Jones, *Narratives of the Proceedings of the Black People During the Late Awful Calamity in Philadelphia, in the year 1793: and a Refutation of Some Censures, Thrown Upon Them in Some Late Publications* (Philadelphia: William W. Woodard, 1794), 5-8; Deirdre Cooper Owens, "Medical Racism has Shaped U.S. Policies for Centuries," *Black Perspectives*, March 22, 2021, accessed February 5, 2022, https://www.aaihs.org/medical-racism-has-shaped-u-s-policies-for-centuries/.

services to both Black and white people, free and enslaved, Jones and Allen showed the roots of Black churches' community outreach whose services impacted and ameliorated more than just marginalized African Americans.

These efforts continued throughout enslavement and into the twentieth century, involving more than the church's dominant male leadership. During the "nadir" period from the end of Reconstruction through the Progressive Era, Black Baptist and AME denominations continued to develop social and economic programs addressing the plight poor and working-class African Americans.[284] According to historian Evelyn Brooks Higginbotham, from the late nineteenth to the early twentieth century, as Jim Crow segregation restricted African American progress throughout the country, Black churches prioritized "both the spiritual and the social condition of their people" by creating "schools, health clinics, publishing houses, libraries, recreation centers, and innumerable other organizations." In 1907, the Nineteenth Street Baptist Church in Washington, D.C. had more than 2,000 members and created a health clinic for the indigent with care provided by "a dozen physicians, pharmacists, trained nurses and dentists."[285]

Black Baptist women were pivotal in church outreach campaigns for poor and working-class African Americans. Inspired by Jane Addams' work with Chicago immigrants, Black women during the first quarter of the twentieth century spearheaded efforts to eradicate sickness, poverty, and diseases in Black communities. The social reformer Nannie Helen Burroughs encouraged Black women to specialize in social reform material, advising her peers to publish literature on Black social conditions to avoid white misrepresentation. By 1920, many African

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[284] Rayford W. Logan, *The Negro in American Life and Thought: The Nadir, 1877-1901* (New York: Dial Press, 1954); Pero G. Dagbovie, "Reflections on Conventional Portrayals of the African American Experience during the Progressive Era or "the Nadir," *The Journal of the Gilded Age and Progressive Era* 13, no. 1 (2014): 9.

[285] Evelyn Brooks Higginbotham, *Righteous Discontent: The Women's Movement in the Black Baptist Church, 1880-1920* (Cambridge: Harvard University Press, 1994): 172-174.

American Baptist women created a report on “vital statistics” that situated poor Black health as social diseases exacerbated by structural racism. Specifically, they made “correlations between life expectancy and overcrowded housing and assessed the nutritional benefits of foods commonly found in the diets of [Black people].” Clamoring for adequate knowledge of reproductive health and venereal diseases, Black church women advocated for sexual education that departed from acceptable public conversations on sexually transmitted infections.[286] This is the tradition in which Flunder and other African American clergy immersed in AIDS activism were raised, using the church to illuminate adverse problems in Black communities, including health concerns. The process was far from easy, as approaches to AIDS outreach and understandings of responsibilities to one’s community varied.

In November 1991, Flunder held church service in the living room of her and her partner Shirley Moore’s home, consisting of marginalized African Americans—including but not limited to Black gay, lesbian, trans, drug users, and sex workers. As part of her mission to create an environment celebrating what she terms same gender loving (SGL) people with a focus on justice through biblical principles, Bishop Flunder developed radical inclusion to combat alienation, homophobia, sexism, and marginalization in fights for equality. The timing of the November 1991 service intentionally aligned with her crusades against the spread of HIV/AIDS in Black communities. Previously a leader in Oakland’s historic Love Center Church for almost a decade after leaving the Black church altogether for the previous six years, Bishop Flunder felt a duty to galvanize and center the experiences of the most marginalized groups around her. “I felt called to plant a church, and I shared it with my pastor and told him what I felt God was saying to me, and that what I felt called to do was very much connected to a liberation for same

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[286] Ibid., 178-180.

gender loving people," Flunder said in an interview. Love Center had several gay and lesbian church members. However, Flunder was determined to create a space for SGLs to be celebrated, not simply tolerated, as Love Center was best known for their choir, which she participated in during the group's ascension to national recognition. Still, Flunder "wanted to create an environment where we could be very focused on justice issues as our primary concern."[287]

Prior to starting her own church, Flunder had to overcome depression from the impact of HIV/AIDS on her friends and family. Her former husband and father of her daughter was her closest encounter with epidemic. The two married out of fear of alienation and ostracism from their family members, as both identified as SGLs. "I guess we figured that we would cancel each other out in some way," Flunder said. After three years, they had a daughter and her partner later died from AIDS complications. Despite the difficulties and emotional toll of those years, Flunder saw it as a "sort of the precursor to my work in HIV, but it was a very difficult time." One of the psychological problems that stuck with her was how she avoided seroconversion, despite her former partner being diagnosed with the virus. "I have no idea… why I'm not HIV positive," she said, suggesting a level of survivor's remorse.[288]

The AIDS epidemic reminded Flunder of war, referring to the early 1980s as the "dying year" and suffering from "multiple loss syndrome." Friends and colleagues throughout the country died from AIDS. At one point, she estimated attending "two or three funerals a week." The pace at which her peers died from AIDS complications prevented her from grieving and healing after their transitions. The scholar Dagmawi Woubshet describes what Flunder

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[287] "Oral History Interview: Yvette Flunder," Interviewed by Monique Moultrie, April 28, 2011, https://lgbtqreligiousarchives.org/media/oral-history/yvette-flunder/YFlunder.pdf.

[288] Terri Wilder, "Bishop Yvette Flunder Has Spent Decades Challenging People's Theology around HIV," *The Body: The HIV/AIDS Resource*, March 30, 2020, accessed November 19, 2021, https://www.thebody.com/article/bishop-yvette-flunder-decades-challenging-peoples-theology-hiv.

experienced as “a poetics of compounding loss.” Mourning narratives during the AIDS epidemic, particularly for Black queer folks,

> do not recount, respond to, and reflect upon singular events of mourning, but instead explicitly underscore—and are in some ways almost deliriously obsessed with and full of rage over—the serial and repetitive nature of the losses they confront. These mourners deal with the deaths of lovers and friends one after another in rapid succession and in devastatingly contracted spans of time. This is such a central element of the collective trauma of queer life in the 1980s and ‘90s that a trope of inventory taking surfaces time and again as a haunting leitmotif in this body of mourning.[289]

Before organizing against HIV/AIDS, Flunder drowned her sorrows in bottles of bourbon as a coping mechanism. One evening, though, while sitting alone with her thoughts in the dark and a cup of whiskey, she had an epiphany to help overcome her “multiple grief realities and issues.” With Donny Hathaway’s song, “Giving Up is Hard to Do” playing in the background, Flunder realized that she needed to fight harder than ever to combat the spread of HIV/AIDS among her peers and other marginalized communities. “And it dawned on me,” she remembered, “we’re going to have to fight back. And that was really the beginning of the journey of working to end AIDS.”[290]

Flunder’s practical approach to radical inclusion centers marginalized communities—including but not limited to trans people, drug users, sex workers, and same-gender loving people—while acknowledging and confronting ways in which Black churches contribute to the stigma these communities experience. “The reality of homophobia, homohatred, and heterosexism in the church, whether internalized or externalized, has been especially oppressive to those living and dying with AIDS,” says Flunder. Flunder’s approach directly confronted secondary marginalization by challenging fellow church leaders to eradicate the stigma they

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[289] Dagmawi Woubshet, *The Calendar of Loss: Race, Sexuality, and Mourning in the Early Era of AIDS* (Baltimore: Johns Hopkins University Press, 2015), 3.

[290] Wilder, “Bishop Yvette Flunder.”

place on those most adversely affected by social and environmental racism. The most marginalized, says Cohen, who adhere to nonnormative practices such as their sexuality and drug use, “are defined as standing outside the norms and behavior agreed upon by the community.” As such, the neglected are forced to choose between conforming to said agreements or experience abandonment, even from family members.[291]

Victims of secondary marginalization found a new home with Flunder’s aptly titled City of Refuge United Church of Christ (COR). For example, COR member, colloquially referred to as Larry the Christian Queen, saw his family’s support wane the more he expressed his desire for other men and was deserted upon a positive AIDS diagnosis. Many family members saw his seroconversion as “punishment for his disobedience” and used his AIDS status as an excuse not to visit him in the hospital. Not until his final days did his father pay him a visit, only to complain about funeral expenses because “’some young people bring these things [AIDS] on themselves by making the wrong decisions.’”[292] While COR provided a home for SGL and other marginalized people looking for a church home, they could not on their own eradicate heteronormativity, homophobia, sexism, and patriarchy.

Some Black churches were more progressive than others in addressing HIV/AIDS. For example, as stated earlier, Oakland’s Love Center Church was not known for its outreach programs on HIV/AIDS. That does not, however, mitigate their services to poor and working-class African Americans, including providing Flunder a home to develop her approaches to HIV/AIDS activism. The Hawkins Family, led by pastor and choir director Walter Hawkins and his brother Edwin were groomed in Berkeley’s Ephesian Church of God in Christ under the

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[291] Cohen, *The Boundaries of Blackness*, 75.

[292] Yvette A. Flunder, *Where the Edges Gather: Building a Community of Radical Inclusion* (Cleveland: The Pilgrim Press, 2005), 36-37.

tutelage of the prominent Pastor E. E. Cleveland. According to historian Claudrena N. Harold, Cleveland gained reputations for his “fiery sermons” and “unwavering support of young people,” culminating in hosting the April 1968 funeral of seventeen-year-old Black Panther Party member Bobby Hutton, who was murdered by Oakland police.[293]

After years of mentorship from Cleveland, Walter Hawkins was ordained as a minister in 1972, shortly thereafter creating the Love Center. Immediately, the Love Center opened its doors to all, including “heterosexuals, gays, and lesbians,” and a variety of “Christians seeking a stronger relationship with God, fellowship, and a sense of belonging.”[294] Around 1981, Flunder joined the Love Center, ending her six-year hiatus from church. The Love Center refined the theology with which Flunder identified, reminding her that one’s relationship with God and salvation “is not fragile and you don’t lose it and have to get it back every time you make a mistake in life.”[295] Flunder was not alone, as marginalized African Americans continued to migrate to the Love Center.

III

One person attracted by the Love Center was the famous disco singer Sylvester, who died of AIDS complications in 1988. Raised in the Black church, Sylvester was known for his unique performance style, setting up a rather “portable ministry” during concerts. While on the road, Sylvester “prayed before shows, by himself in a quiet spot, and sang hymns as warm-ups with other singers, many of whom grew up in the Church of God in Christ or a similar tradition.” In 1982, Sylvester was introduced to the Love Center by a friend and couldn’t stop returning. That

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[293] Claudrena N. Harold, *When Sunday Comes: Gospel Music in the Soul and Hip-Hop Eras* (Chicago: University of Illinois Press, 2020), 89-92.

[294] Ibid., 96.

[295] Oral History Interview, Yvette Flunder.

same year, he performed at a benefit concert for the church's scholarship fund. Being a Black gay-identifying man did not discourage Sylvester from church and assumed homophobia like previous congregations. Rather, he immediately clicked with Flunder and Hawkins, as all three were raised in the tradition of the Church of God in Christ (COGIC). Individually, all three left the COGIC because of its strict tradition. Hawkins, however, saw Love Center as an opportunity to reunite "all those young people who I knew could not survive in a traditional church setting." Instead of "passing by" drug users, sex workers, and people like Sylvester in same-sex relationships, Bishop Hawkins embraced their "strangeness," which made Sylvester feel at home.[296]

Radical inclusion subverts what Flunder calls "oppressive theology," which accommodates "those who fit a normative definition of the dominant culture while excluding those who do not."[297] This style of preaching hurt Sylvester, who was forced out of his childhood church because of his sexuality. "He was angry at the way he had been handled by the church," says Flunder, who became one of Sylvester's closest friends from 1982 until he died from AIDS complications in 1988. Guilt and shame from his childhood followed Sylvester into his twenties, especially "for being as flamboyant a gay man and a Christian as he was." Sylvester turned his culpability into a marketing tool through disco culture with hopes of preventing others from experiencing similar tribulations. Those who followed him claim gospel was a central theme throughout his life, including in his music.[298] Others who knew him were not surprised, as he identified as same gender loving at the age of eight through interactions with another church

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[296] Joshua Gamson, *The Fabulous Sylvester: The Legend, the Music, the Seventies in San Francisco* (New York: Picador, 2005), 225-226.

[297] Flunder, *Where the Edges Gather*, 7.

[298] *San Francisco Chronicle*, December 17, 1988.

member. Few were aware, however, of his sexuality until around the time he turned thirteen, when he became "too flamboyant to be on the down-low," a colloquial term used for Black men engaged in same-sex sex who conceal their sexuality.[299]

Black male sexuality has been misrepresented in many ways. The scholar Darius Bost notes that scholarship and dialogue in fields ranging from social psychology and Black liberation psychiatry each view nonconformist sexual preferences as "pathological symptoms of the psychic damage accrued from racism." Failing—or refusing—to humanize Black gay men, scholars, journalists, policymakers and others overlook Black gay men's personhood while making general claims against their sovereignty and ways in which racial capitalism and anti-Black racism contributes to their subjectivity. Relegating Black gay men "being," rather than "doing," as Bost suggests, one neglects the state-sanctioned violence wrought onto Black men in same-sex relationships. "Black gay being," as Bost explains and Sylvester lived, "attends not only to the forms of structural violence that usher [B]lack bodies to corporeal death but also to the foundational violence that renders the ontological status of [B]lack gay men as imperiled."[300] As such, Sylvester's positionality as a Black gay-identifying man expressing his sexuality freely inverted ways American society has perceived not only Black gay men but Black male sexuality. His seroconversion, moreover, highlighted more than his sexuality increasing his vulnerability. It also illuminated ways in which local AIDS infrastructure failed Black people living with HIV/AIDS, thus reinforcing the importance of Flunder's "radical inclusion" theory applied to all AIDS activists, people perceived as at increased risk for infection, and those living with HIV/AIDS.

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[299] Gamson, *The Fabulous Sylvester*, 24.

[300] Darius Bost, *Evidence of Being: The Black Gay Cultural Renaissaince and the Politics of Violence* (Chicago: University of Chicago Press, 2019), 11-3.

Sylvester conducted his final interview in November 1988 with *PWA Voice*, a local newsletter by and for PLWHA. Published in early 1989, Sylvester highlighted—both implicitly and explicitly—Black men's marginality in local and national AIDS activism and care infrastructures, as well as how religion kept him hopeful through an exhaustive and painful AIDS experience. Few knew of Sylvester's serostatus until June 1988, when he publicized it at the San Francisco Gay Pride Parade. He used the parade to express his frustration with national and local distribution of AIDS services, which omitted African Americans. "White, gay boys would not give the services to the [B]lack queens," said Sylvester. "All the services were going to the white community." White "queens," he believed, hoarded "all the money, all the resources," and treated "[B]lack men like slaves. You give us what's left over." He saw similarities in inequitable resource distribution from San Francisco to the nation's capital, challenging local and federal policymakers to ensure that Black communities benefitted from AIDS funding and programs.[301]

Sylvester's initial AIDS diagnosis came with news that he had also contracted pneumocystis *carinii* pneumonia (PCP), an opportunistic lung infection that weakens the immune system. Otherwise-healthy human beings carry roughly 1,200 CD4 cells—also referred to as white blood cells—that help one's body fight infections. PCP is activated when one's CD4 count hovers around 200. This shows that Sylvester was diagnosed at a late stage of seroconversion, which is common among Black men engaged in same-sex sex who cite medical and systemic racism, perceived stigma, inadequate access to health care, and lack of trust for

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[301] *San Francisco Chronicle*, December 17, 1988; Mark Grossfeld, "Moments with Sylvester," *PWA Voice* 2, no. 1 (Winter 1989): 8-9

health care providers as reasons they receive AIDS tests at later stages.[302] He was so weak physically that he showed up to the Pride Parade in a wheelchair, being pushed by his personal manager Tim McKenna. However, putting himself on display and speaking unabashedly about ways racism within AIDS resource allocation were more important to Sylvester. More than anything, he hoped he would help other African Americans in ways they dealt with, and understood, HIV/AIDS. Black people were "at the bottom of the line" receiving AIDS information, "even when we've been so hard hit by this disease," he told the *Los Angeles Times*. "I'd like to think that by going public myself with this, I can give other people courage to face it."[303]

Sylvester's version of radical inclusion helped some embrace their sexuality and simultaneously encouraged churches confront their denial and homophobia. According to McKenna, "There are people who came out of the closet to Sylvester's music," a revelation that Sylvester downplayed but embraced the fact that he "never believed in lying or denying what I am to anyone." Sylvester's integrity resulted in him turning down a record label contract that asked he shield his sexuality.[304] Reverend Walter Hawkins believed that the dignity and vulnerability Sylvester shared publicly was "freeing people." His flamboyance, coupled with his overt religiosity, "made a statement that there is a love in God that embraces anybody who wants to come."[305]

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[302] Grossfeld, "Moments with Sylvester," 9; Sharon B. Mannheimer et al., "Infrequent HIV Testing and Late HIV Diagnosis Are Common Among a Cohort of Black Men Who Have Sex with Men in 6 US Cities," *Journal of Acquired Immune Deficiency Syndromes* 67, no. 4 (2014): 440-443; Centers for Disease Control and Prevention, "Late HIV testing—34 states, 1996-2005, *Morbidity and Mortality Weekly Report* 58, no. 1 (2009): 661-665.

[303] *Los Angeles Times*, September 10, 1988.

[304] Ibid.

[305] Gamson, *The Fabulous Sylvester*, 227.

Bishop Flunder visited Sylvester in the hospital until his last day. During one of her visits, Sylvester confessed that through all his dangerous situations, "God has been good to me," and accepting death by putting his life "in God's hands" with no regrets. "When he says I'm ready to go, then it's time to go." At his funeral, Reverend Hawkins immediately denounced preconceptions by attendees that AIDS was a form of retribution. "AIDS is *not* God's punishment," said Hawkins. "Be yourself and do what you do on Sundays," he told the crowd—something he believed Sylvester wanted to leave them with.[306] In his analysis of Black lesbian feminist and activist Barbara Smith's eulogy of James Baldwin, scholar Darius Bost argues that funerals served as spaces contesting and refashioning the intersections of blackness and homosexuality. By refuting the silence cast upon nonnormative sexuality, Black gay men's funerals went from serving mourning purposes to militancy, acting as "a refusal of the discourses of respectability and the disciplinary mechanisms of shame and silence necessary to the production of [B]lack/gay liberalism."[307] The support Flunder and Hawkins offered Sylvester exemplified the radical components of radical inclusion by spitting back at Black respectability politics and homophobia emanating from many Black churches during the first decade of the epidemic.

IV

Despite the impact Flunder, Hawkins and other pastors had with their AIDS ministries, homophobia remained an obstacle in several Black churches. In a study comprising over fifty Black clergy members, Mindy Thompson Fullilove and Robert Fullilove found that stigma remained a problem for Black church mobility regarding AIDS programs. Homosexuality,

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[306] Ibid., 265-271.

[307] Bost, *Evidence of Being*, 88-93.

viewed as the "greatest stumbling block" of them all, was seen by the clergy subjects as "the worst of all sins, thus making the denunciation of homosexuality an important part of many religious services." Some well-intentioned pastors only worsened matters during their services by describing the AIDS epidemic as the "enemy," suggesting that nonnormative sexual practices—described as "immoral behavior"—presented new challenges to ministers and their followers. Black teenagers espoused similar sentiments, seeing men engaged in same-sex sex as a threat to their perceptions of Black masculinity.[308] As such, radical inclusion meant not only centering marginalized African Americans and their AIDS experiences, but also helping members of religious communities advance their interpretations of HIV/AIDS.

These were some of the responsibilities with which Dr. Robert C. Scott was tasked. Dr. Scott was a Black gay-identifying physician who, in 1982, founded the AIDS Project of the East Bay, which was the first AIDS service organization in the Bay Area outside of San Francisco, as discussed in chapter three.[309] Dr. Scott also worked as an usher at Oakland's historic Allen Temple Baptist Church where his main task was helping people find their seats.[310] Eventually, Dr. Scott became frustrated by the silence from the church's pastor, Reverend Dr. J. Alfred Smith, Sr., who refused to address the epidemic, despite it impacting members of his church. Eventually, Pastor Smith listened and took Dr. Scott's advice, culminating in the creation of an Allen Temple AIDS ministry that offered services and referrals to people living with HIV/AIDS in and around East Oakland.[311]

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[308] Mindy Thompson Fullilove and Robert E. Fullilove, III, "Stigma as an Obstacle to AIDS Action: The Case of the African American Community," *American Behavioral Scientist* 42, no. 7 (April 1999): 117-123.

[309] Catherine Taylor, "AIDS Volunteers: Making Sense of Death and Life," *Radiance* 5, no. 4 (October 31, 1988): 41.

[310] *East Bay Times*, October 15, 2009.

[311] *Sun Reporter*, October 15, 2009.

The establishment of the AIDS ministry was only the start of Dr. Scott bringing radical inclusion to Allen Temple. Records show that Pastor Smith's initial AIDS analysis reinforced victim-blaming and the bifurcated innocent-guilty framework of the epidemic. For example, in a 1987 interview, Pastor Smith blamed Black male drug users for infecting their sexual partners, particularly Black women. "We must also go back to the moral basics and teach an ethical morality that many people (think) is passe," said Pastor Smith. "Monogamy is what the Good Book teaches. We have to emphasize the high ethical code that many people in modern society have thrown away." Pastor Smith's comments were consistent with ways in which Black church leadership faltered after the 1960s and 1970s' iteration of the Black freedom movement, overlooking sociopolitical problems such as poverty and the impact of drug epidemics and instead focusing on abstinence, marital status, and family relationships. Whereas Black churches were once the authority for addressing problems facing Black youth, most Black churches failed or refused to develop appropriate programs addressing substance use, health-related services, and sexuality programs.[312] Dr. Scott took umbrage with Pastor Smith's outlook, but eventually convinced Pastor Smith not only to create sufficient programs but also to change his perspectives on AIDS vulnerability.

In a memorandum to Pastor Smith from his son, James Smith, Jr., the two acknowledged Dr. Scott's influence in Allen Temple's AIDS outreach. The junior applauded Dr. Scott's "powerful presence" managing "a large case load of people living with AIDS," serving as "a board member of AIDS organizations, and an AIDS educator." Dr. Scott made strides in eradicating the influence of secondary marginalization within Allen Temple. By 1992, the

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[312] Cohen, *Boundaries of Blackness*, 278-279; C. Eric Lincoln and Lawrence H. Mamiya, *The Black Church in the African American Experience* (Durham: Duke University Press, 1990).

Smiths offered pastoral care “to patients and families,” including during hospitalization from AIDS related complications “and subsequent death.” Moreover, Smith, Jr. noted the church “carefully and prayerfully” preparing eulogies for families “who may have brought theological questions about these deaths.” For Black people in nonnormative sexual relationships, funerals were rather silent, as many Black families struggled confronting their homophobia, while others abandoned family members engaged in same-sex sex. Allowing and embracing—as opposed to tolerating—queer mourning at funerals offered another tenet of radical inclusion, as Dr. Scott partnered Allen Temple’s AIDS ministry with Flunder’s City of Refuge as another attempt to eradicate AIDS stigma.[313] Queer mourning, says the scholar Dagmawi Woubshet, “broke not only the public silence around AIDS but also the silent funerals and obituaries that effaced the lives of gay men from the record.”[314]

There were still many obstacles to reducing new AIDS cases, eradicating homophobia, and disseminating accurate information to African Americans throughout the Bay Area. In late 1987, Allen Temple held AIDS conferences addressing these cross-cutting issues. Their formats included mixed panels with physicians, ministers, and Black PLWAH to share their experiences. Arguably their most known session consisted of Pastor Smith, Dr. Scott and a Black woman named Gloria who learned of her serostatus in prison. Despite their efforts, the conference was poorly attended, much to the chagrin of Pastor Smith who anticipated Black youth being heavily represented in the audience. One of the main takeaways from the November 1987 meeting was Black churches “not doing their Christian duty towards the Black community as far as educating about AIDS.” Education needed to be dispensed in a culturally appropriate manner, they

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[313] *Oakland Tribune*, October 15, 2009.

[314] Woubshet, *Calendar of Loss*, 84.

contended. For over four hours, they stressed that Black churches had a responsibility to educate all African Americans "on how to prevent the transfer," Black queer and trans folks, drug users, and sex workers.[315] This was an urgent plea, as numbers continued to rise among African Americans throughout the Bay Area.

In 1989, a report indicated an eighty-seven percent rise in AIDS cases over the last twelve months among African Americans in Alameda County. Given their historical role as leaders in Black communities, Black ministers received heavy criticism and were scapegoated for the sudden increase. One of the earliest responses to the statistic was a march throughout Oakland, organized by the group Black & White Men Together (BWMT). Only two ministers, however, joined the march, including Pastor Smith and Reverend Cecil Williams of San Francisco's Glide Memorial Church. Lewis Ashley, a member of BWMT, claimed one minister said they refused to join the march "because it would support sodomy." Reverend Williams was equally frustrated with the absence of fellow Black ministers and their continued denial to adopt AIDS ministries. "I was here last year holding a workshop teaching [B]lack ministers about AIDS. There was 50 there," Williams said. At the end of his tutorial with fellow ministers, Reverend Williams asked how many would start AIDS education programs "and only eight ministers raised their hands." He saw homophobia as the main issue continuing to plague Black churches, despite the presence and influence of people in same-sex relationships in most Black churches. "What we have to do is stop pretending that we don't have gays in our churches," he said. "I'm glad that a third of my congregation is gay or lesbian. I am proud to announce it and I want them to be proud of themselves also."[316]

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[315] *Bay Area Reporter*, November 12, 1987.

[316] *Bay Area Reporter*, April 6, 1989.

Flunder saw Black clergy's silence and disrespect of churchgoers in same-sex relationships as a glaring contradiction with biological implications. "The same bible that calls homosexuality an abomination kept slavery and kept women barefoot and pregnant," she said.[317] The abandonment and shame felt by Black SGL churchgoers have often resulted in those living with HIV/AIDS to avoid medical treatment. Flunder labels this process as being "church burned," blaming the church for Black PLWHA's reluctance to seek treatment or express their sexuality freely.[318] The corporeal implications of homophobia added another dimension to radical inclusive outreach, as drug use from the introduction of crack cocaine and persistence of heroin, compounded by homophobia and poverty, created an HIV/AIDS syndemic testing Black churches' leadership, particularly how they confronted homophobia within their congregations, and developed effective awareness and prevention strategies for cross-cutting issues.

V

Unemployment, coupled with substandard living conditions, created an outlet for diseases to proliferate in poor and working-class African American communities. As suburbs were created around the East Bay, allowing white Oakland residents to relocate, the city's Black population increased as work simultaneously disappeared. From 1959 to 1969, Black unemployment rose from 23% to 34%. So-called urban renewal—or what the radical theorist James Baldwin calls "negro removal"—also occurred with the construction of Interstate 880 and the Bay Area Rapid Transit, or BART, in what were predominantly Black neighborhoods.[319] To

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[317] *San Francisco Chronicle*, August 5, 1993.

[318] *USA Today*, October 31, 1994.

[319] Benjamin P. Bowser and Barbara Hill, "Rapid Assessment in Oakland: HIV, Race, Class, and Bureaucracy," in *When Communities Assess their AIDS Epidemics: Results of Rapid Assessment of HIV/AIDS in Eleven U.S. Cities*, ed. Benjamin P. Bowser et al. (New York: Lexington Books, 2007), 130-132; Chris Rhomberg, *No There There: Race, Class, and Political Community in Oakland* (Berkeley: University of California Press, 2004), 121; Brandi T.

little surprise, the displacement and underemployment of Black residents resulted in an increase in violent crimes, especially from drug wars. Crack and heroin, after years of state-sanctioned displacement, created the conditions for HIV/AIDS to spread among poor and working-class African Americans living in clustered Bay Area communities. Government inaction only worsened matters, especially for church outreach programs. In San Francisco, Reverend Cecil Williams of Glide, blamed the Reagan administration for the city's rising unhoused population, which simultaneously increased the number of meals Glide provided to families in need. In 1983, they fed roughly 350 people per day during their free meal programs. By 1984, that number doubled to an average of 700. "You remember Ronald Reagan's safety net, don't you," asked Williams. "Well, it's a fantasy. The poor suffer, and we do what we can."[320]

One group suffering disproportionately in the Tenderloin neighborhood of San Francisco was the trans community, especially trans sex workers. According to Gloria Lockett—founder of the Bay Area-based sex worker organization CAL-PEP (California Prostitutes Education Project) discussed in chapter two—the trans community's marginality rendered them invisible. Plagued by homelessness and anti-trans racism, many resorted to drug use to cope with their circumstances, while others engaged in "survival sex" where they exchanged sexual favors for basic needs such as temporary housing, food, and money. Lockett noticed that most Tenderloin trans folks could be found at the Ambassador Hotel in the area. To this end, CAL-PEP worked with the hotel manager to rent rooms for trans folks and occasionally use his office for workshops on ways in which the AIDS epidemic impacted the trans community.[321] Flunder was

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Summers, "Untimely Futures," *Places* (November 2021), accessed January 29, 2022, https://placesjournal.org/article/black-homelessness-in-oakland/?cn-reloaded=1&cn-reloaded=1&cn-reloaded=1.

[320] *New York Times*, November 25, 1984.

[321] Interview with Gloria Lockett, Nancy Stoller Papers, Box 5, Folder 35, MSS 2000-6, Archives and Special Collections, University of California, San Francisco, San Francisco, California.

also familiar with Tenderloin district, citing the area's prevalence of drug trafficking, sex work, unhoused people, and folks with disability. But the trans community, says Flunder, "makes us tell the truth about the blurred gender lines that have always existed in our community."[322]

To celebrate trans people within her church walls, Flunder created a support group—Transcending Transgender Ministries—and created leadership roles for trans folks at City of Refuge. One of the most popular trans members of COR was Reverend BobbieJean Baker, who joined COR shortly after moving to San Francisco in 1992. Baker grew up in a church that rejected her for her sexuality. Baker was raised with the understanding that Black churches operated as mutual aid societies that welcomed people in "God's house" irrespective of their problems. Not until she met Flunder did Baker restore faith in Black churches that practiced liberating theology. Flunder trained Baker to undertake health counseling, "specializing in HIV/AIDS risk assessment and intimate partner violence." In the early 2000s, they also co-founded TransSaints, a national faith-based organization of trans and gender nonconforming people.[323] "Inclusion in the life of the church is as essential to transgendered persons as it is to SGL persons," says Flunder. A radical inclusion that genuinely reaches out to "to the outer edges of society" shows the church's true intentions. "Whoever will, let them come."[324]

Waiting for people to join was not always the case for Flunder. Her team devised creative awareness and prevention strategies that addressed social and environmental factors' roles in disease vulnerability. For instance, many of their congregants were living with HIV/AIDS, while others faced hunger and housing insecurity. "It's hard to talk to a man about Jesus when he's

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[322] Flunder, *Where the Edge Gathers*, 26-27.

[323] Elizabeth Perez, "'You Were Gonna Leave Them Out?': Locating Black Women in a Transfeminist Anthropology of Religion," *Feminist Anthropology* 2, no. 1 (May 2021): 95-101.

[324] Flunder, *Where the Edge Gathers*, 29-31.

hungry, homeless and sick," said Flunder's partner Shirley Miller. These problems led to the creation of the Ark House, a two-story shelter home created by Flunder and Reverend Walter Hawkins in1990 that offered food and shelter to PLWHA. Of the Love Center's roughly 1,100-member congregation, almost a third wrestled with a form of drug dependence. They also had over twenty church members waitlisted for housing assistance at the Ark. Flunder saw the church's AIDS programs as upholding its core values. Besides, if a Black church "is not dealing with AIDS, crack cocaine, and homelessness, they might as well shut down, because they are no more than a social club," said Flunder.[325]

In the following year, the Ark House became the Ark of Refuge, an official organization started by Flunder with three houses catering to the overlapping issues of HIV/AIDS, homelessness, and drug dependence. In 1992, Flunder opened the Hazard-Ashley house in Oakland. This location provided medical care and social services for PLWHA. In 1993, she established Restoration House in San Francisco, which was described as "a long-term housing program for African-American women with HIV," also offering treatment to people battling drug dependence. Back in Oakland, the third house was opened in the following year. Flunder named it the Walker House, which provided permanent housing for unhoused PLWHA, as well as those with disabilities because of their serostatus. "The turnover is a result of some people dying," said Flunder.[326] By 2015, Flunder officiated 149 funerals, by her count, for people who died from AIDS complications. As her congregation became more diverse, so did her outreach, later creating a City of Refuge chapter in Tijuana, Mexico.[327] Expanding her outreach was true to the vision of radical inclusion. Embracing the most marginalized communities during the early

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[325] *San Francisco Chronicle*, August 27, 1990.

[326] *Bay Area Reporter*, November 28, 1996.

[327] *Washington Post*, March 20, 2015.

AIDS crisis showed them that seroconversion did not signal an end to their lives. Situating AIDS within a syndemic model of drug use, homelessness, and inadequate health care highlighted problems beyond the scope of the Black church and they should thus be applauded for their efforts.

VI

Despite its significance as the first known shelter run by a Black church for PLWHA in the country, little is written about the Ark of Refuge. This speaks to the misconceptions of African American churches in the early AIDS epidemic, as archival silences are mistaken for inaction. Flunder, Hawkins, and others, however, have shown an active, thought-provoking approach to the early AIDS epidemic that has centered marginalized African Americans. Their ability to contextualize it with larger social issues highlight deeper problems in American society with which Black churches were tasked. Rather than use the federal government's inaction and the medical community's poor initial framing of HIV/AIDS as an excuse, Black churches developed active responses to the epidemic that were on par with traditional roles embraced by Black churches since its founding.

African Americans remain disproportionately affected by HIV/AIDS. In 2020, the Kaiser Family Foundation reported that African Americans account for 43% of new diagnoses, 42% of PLWH, and deaths among Black Americans are 44% higher than any other racialized group in the country. Of the 1.1 million Americans with HIV/AIDS, almost half are Black, despite representing only twelve percent of the nation's population.[328] A 2017 CDC report estimated that

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[328] "Black Americans and HIV/AIDS: The Basics," *Kaiser Family Foundation*, February 7, 2020, accessed February 21, 2022, https://www.kff.org/hivaids/fact-sheet/black-americans-and-hivaids-the-basics/; Sydney Rogers, "Black Trans Women and Femmes Speak Out About Lack of Inclusion in HIV Cure Research," *The Body*, June 3, 2021, accessed February 26, 2022, https://www.thebody.com/article/black-trans-women-femmes-lack-of-inclusion-hiv-cure-research.

"if current rates continue, one in two African-American gay and bisexual men will be infected with the virus," compared to one in eleven among their white counterparts and one in 99 among all Americans. 62% of Black trans women are living with HIV.[329] Despite their efforts, Black churches are ill-equipped to fix systemic problems that have plagued African Americans for centuries. As such, radical inclusion had a limited reach due to the dehumanization of African Americans when AIDS was first identified. Moreover, disease susceptibility continues to be described as an inherent problem when structures are designed that make groups vulnerable. Practicing radical inclusion on a national level would help eradicate stigma and increase health equity, which Flunder, Hawkins, and other Black Bay Area clergy exemplified in many forms. The erasure of their contributions highlights entrenched problems that, when uprooted, offer new perspectives into ways Black churches confronted the AIDS epidemic and when.

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[329] Linda Villarosa, "America's Hidden H.I.V. Epidemic," *New York Times Magazine*, June 11, 2017.

Conclusion

> "Let me be clear, the Black and brown communities that were first on the list of who died cannot be last on the list of who receives the vaccine, period. We cannot and we will not let that happen. The Reverend Dr. King who spoke in this magnificent church said of all the forms of inequality, injustice in health is the most shocking and the most inhumane because it often results in physical death. COVID proved Dr. King right. We need to make special efforts with the vaccine to reach the underserved Black, brown and poor communities. The private market alone will not do it. We need to enlist community trusts to distribute the vaccine. We need medical teams and outreach teams going into public housing projects and low-income communities."
>
> - New York Governor Andrew M. Cuomo at Riverside Church, New York City, November 15, 2020.[330]

On March 11, 2020, the World Health Organization declared SARS-CoV-2—commonly referred to as coronavirus and the virus that causes COVID-19—an international pandemic. It did not take long for the new disease to disproportionately affect African Americans, as the social and environmental issues that placed low-income African Americans at risk were exacerbated through structural inequalities. One of the first public health measures emphasized social distancing, which people living in condensed environments saw as problematic. Law enforcement agencies throughout the country used this as an opportunity to weaponize the pandemic and enforce disparate measures for majority-white and majority-Black communities. New York, for instance, saw police distributing masks to unmasked white citizens and simultaneously beating and arresting African Americans for being unmasked in public spaces. In

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[330] "Video, Audio, Photos & Rush Transcript: Governor Cuomo Delivers Remarks on Trump Administration's Vaccination Distribution Plan," November 15, 2020, Accessed March 13, 2022, https://www.governor.ny.gov/news/video-audio-photos-rush-transcript-governor-cuomo-delivers-remarks-trump-administrations.

terms of infection, Black Americans have also experienced the most hospitalization from COVID-19, in addition to the highest mortality rates.[331]

Many of the same structural and medical problems African Americans experienced during the 1980s and 1990s' iteration of the AIDS epidemic still exists with the coronavirus pandemic, including insufficient responses from policymakers. As the epigraph shows, New York Governor Cuomo made no mention of eradicating the systemic problems that leave poor and working-class Black and Latinx folks susceptible to disease infection. Rather, the governor leaned into a biomedical response, relying exclusively on medical technologies in "public housing projects and low-income communities" to mitigate health inequities in substandard living environments. As the first chapter shows, building upon sociologist Celeste Watkins-Hayes's "traditional approaches to care" concept, relying heavily on biomedical interventions cause concern among grassroots activists and patients, fearing that their only interactions with health professionals involve seroconversion—from HIV/AIDS to COVID-19.[332] Instead, rather than relying on one method, African American activists, clinicians, and clergy exemplified a need for tighter biomedical, behavioral, and structural interventions to mitigate Black vulnerability to premature death.

Stronger collaboration between all three interventions would show effort in mitigating African American's skepticism of the medical community. In 1991, an *American Journal of Public Health* report highlighted Black Americans' mistrust of health professionals. While the

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[331] Elie Mystal, "Covid Is About to Become the Newest Excuse for Police Brutality," *The Nation*, May 5, 2020, accessed March 12, 2022, https://www.thenation.com/article/society/coronavirus-police-brutality/; "Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity," Centers for Disease Control and Prevention, last updated March 10, 2022, accessed March 15, 2022, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[332] Celeste Watkins-Hayes, *Remaking a Life: How Women Living with HIV/AIDS Confront Inequality* (Oakland: University of California Press, 2019), 185-187.

American medical community has a history of experimenting on African Americans since enslavement, recent skepticism stemmed from the 1972 revelations of the United States Public Health Service's syphilis experiment at Tuskegee. The syphilis experiment consisted of over 400 Black men with syphilis being monitored for the disease's progression. This information contributed to the Black collective imagination surmising medical experimentation, and some suggesting AIDS as a government conspiracy to kill African Americans. "The continuing legacy of the Tuskegee Syphilis Study," read the *American Journal of Public Health* report, "has contributed to Blacks' belief that genocide is possible and that public health authorities cannot be trusted." Little has been done since this report to eradicate African Americans' fear and theories of state-sanctioned genocide. As a potential solution, the reports' authors suggested honest conversations with African Americans, conversations and feelings "justified by the history of the Tuskegee study."[333]

Policymakers and the medical community have made few attempts to mitigate African Americans' skepticism of health professionals, as recommended in the 1991 article. In the age of COVID-19, this has contributed to Black Americans' vaccine hesitancy. Coronavirus infection, moreover, has caused psychological problems. The higher mortality rates among African Americans are exacerbated by grief, as it is "accompanied by disproportionately many economic, health-related and other stressors which further increase African American's potentially adverse psychological secondary COVID response."[334] Like HIV/AIDS, marginalized groups'

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[333] Stephen B. Thomas and Sandra Crouse Quinn, "The Tuskegee Syphilis Study, 1932-1972: Implications for HIV Education and AIDS Risk Education Programs in the Black Community," *American Journal of Public Health* 81, no. 11 (November 1991): 1500-1504.

[334] Lonnie R. Snowden and Jonathan M. Snowden, "Coronavirus Trauma and African Americans' Mental Health: Seizing Opportunities for Transformational Change," *International Journal of Environmental Research and Public Health* 18, no. 7 (March 2021): 3-5.

vulnerability caused compounding loss in need of structural, biomedical, and behavioral interventions. As Dr. Scott and the AIDS Project of the East Bay, as well as Bishop Yvette Flunder and the Ark of Refuge, showed, diseases have social and environmental implications and deserve complex responses that confront cross-cutting issues.

Relying on biomedical tactics leave in place the systemic problems that existed before new disease epidemics and pandemics. As retired NFL player Marshawn Lynch said in a conversation with Dr. Anthony Fauci, we have "bigger problems" than the disease alone. Decades of structural violence, said Dr. Fauci, created higher incidence of diabetes, hypertension, obesity, kidney disease, and chronic lung disease for Black Americans than white Americans. The "type of shit in our community" that "we have access to" and "at our disposal," responded Lynch, put poor and working-class African Americans at disadvantages that a vaccine alone will not help. But returning to "normal," said Lynch, allows us to ignore "the problems that make us susceptible to dying."[335] Lynch was born and raised in Oakland, California. His comments to Dr. Fauci illustrate ways in which Black activists—who confronted HIV/AIDS and continue to confront COVID-19—believe in doing more than pushing pills. Normal for most is abnormal to the health of many Black Americans. AIDS is very much still with us today, as are the underlying conditions mentioned by Dr. Fauci. Any intervention that does not address the structural problems that create poor health outcomes is insufficient. Black activists in the Bay Area offered many examples that have radical potential for American public health today. Placing the onus to create change on those with the least capabilities to do so, however, are

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[335] Marshawn Lynch, "Sitting Down with Dr. Anthony Fauci," Marshawn Lynch Beast Mode Productions, April 16, 2021, YouTube video, 6:25-16:15, https://youtu.be/ODHkJ1hI2Js.

inadequate attempts that leave in place systemic problems, which will only be amplified during the next cross-cutting health crisis.

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