THE OHIO AIDS MOVEMENT:
COMPETITION AND COOPERATION BETWEEN GRASSROOTS
ACTIVISTS AND PROFESSIONALLY SPONSORED ORGANIZATIONS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
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* * * * *

The Ohio State University
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DEDICATION

to my son Keegan Kelly McCormick
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CHAPTER I

INTRODUCTION

In 1984 Casper G. Schmidt, a psychohistorian, proposed a theory of the origins of the AIDS epidemic in the United States.

Against the grain of monoetiological thinking and unconsciously held Cartesian dualism, I posit that AIDS is a bio-psycho-social disorder. I argue that a sequence of group psychological events in the U.S. has shamed-and mercilessly so-the homosexuals and drug addicts, giving rise to an epidemic of shame-induced depression.¹

Schmidt's hypothesizing is confined to the question of the origins of AIDS and does not attempt to speculate, as will this research, on the social responses generated by the HIV epidemic. In 1992, with the viral origins of the Human Immunodeficiency Virus (HIV) generally accepted among both popular and scholarly audiences, Schmidt's assertions concerning a psychological basis for the phenomena of AIDS appear unsophisticated and ill informed, but should not be dismissed out of hand.²


² Human Immunodeficiency Virus produces an infection that results in a breakdown of the body's immune system, and consequently the ability to defend oneself from a myriad of common and exotic infections and cancers. The most often fatal end stage of HIV disease is called Acquired Immune Deficiency Syndrome (AIDS). In 1984 the viral source of AIDS was reported by Robert C. Gallo of the federal Centers for Diseases and Luc Montagnier of the Pasteur Institute in Paris, France. Even though various authors, most notably Peter Duesberg (1988), continue the debate on the etiology of AIDS, virtually all subsequent
In the context of this project, it should be noted that psychological explanations for collective behavior do have a place in the history of the development of social movement theory. Classical or "irrationalist" perspectives (LeBon 1960), were dominant in western the period 1890 through the 1920's. These theoretical perspectives are not unlike Schmidt's (1984) hypothesis, as they characterized social movement actors as "emotional and irrational" and under the influence of a "collective mind". Though more rational-calculation approaches have come into theoretical dominance for the study of social movements, Schmidt (1984) reminds us that psychoanalytic explanations of collective behavior continue to proliferate.

Notions of "social contagion" relative to AIDS persist, though it is misinformation rather than HIV disease that is spread by this mechanism. After almost a decade of education directed to the general public a significant segment of the population continues to fear causal transmission of (Centers for Disease Control 1989).

This study looks beyond explanations of the origins of AIDS, or even the implications of social science research for HIV education, disease prevention or patient care initiatives (Kaplan et al:1987). Rather it seeks to describe and analyze the socio-cultural response to AIDS that nationally has birthed a multi-billion dollar AIDS social movement industry (SMI). Specifically, I will examine the response to the AIDS crisis in Ohio a low HIV prevalence state.  

research on the disease has been based on the premise that HIV is the cause of AIDS (Evans 1989; Johnson and Viera 1987).
The dissertation focuses on interorganizational relations with an explicit acknowledgement of the regional socio-political environment out of which the Ohio AIDS SMI emerged. SMOs at both nascent and later stages of development are examined to determine how sociopolitical conditions and social control agents augmented or detracted from the development of SMOs within the larger AIDS social movement industry.

In a recent review of research in the field of social movements, McAdam, McCarthy, Zald (1988) advanced two hypotheses regarding the expansion and specialization of SMOs faced with increased demand. The two specific questions raised were 1) do the number of organizations within a focused social movement expand when increased demands are placed on a social movement? and 2) if that expansion occurs, do organizations "product differentiate" in an effort to ensure a specific "niche" for their group within the movement? McAdam et al (1988) suggest that systematic study of social movement may reveal under precisely what conditions competing organizations can be expected to cooperate. I use this case study of the Ohio AIDS social movements to explore these questions. The specific objective of the study is to document the Ohio AIDS SMI, and delineate how conflict and cooperation between organizations within the social movement industry was characterized by struggles to assert organizational identities and control resources.

3 HIV (human immunodeficiency virus) is the viral origin of the end stage illness called AIDS (Acquired Immunodeficiency Syndrome). I will rank all U.S. states and territories with reported AIDS case totals below ten thousand as "low HIV prevalence."
SIGNIFICANCE OF PROBLEM

During the decade of the eighties the HIV/AIDS crisis moved from a vague reference in an obscure federal health agency publication to a multi-billion dollar global industry (Shilts 1987; Panem 1988; Sabatier 1988). As of February 29, 1992, there were 213,641 individuals officially recorded by the Centers for Disease Control (CDC 1992) as AIDS cases, sixty-four percent of whom are already dead. Recent federal projections estimate that between 1 and 1.5 million men, women and children in the United States are infected with HIV. The World Health Organization (United Nations and WHO 1991) estimates that 8-10 million are infected worldwide.

The estimated cost of the medical care for persons living with HIV/AIDS in the United States alone is 4.5 billion dollars for 1991 (Hellinger 1988). Publically funded responses to AIDS include Federal programs (i.e. the AIDS Drug reimbursement program, block grants, veteran's benefits, and medicaid) and state/local programs (i.e. indigent care programs, catastrophic health insurance programs, high-risk insurance pools, and drug programs) (National Health Law Program 1991). Medical advances including the anti-viral drug zidovudine (AZT) will lower overall costs while enhancing the quality of life for some, but no "cure" or HIV vaccine is predicted for public distribution within this decade (Johnston and Hopkins 1990)

* The initial mention in the U.S. medical literature of what was later identified as AIDS came in the Centers for Disease Control (CDC) publication the Morbidity and Mortality Weekly Report (MMWR) (June 5, 1981, p.250-2) and detailed "Pneumocystis Pneumonia - Los Angeles" in "active homosexuals."
In Spring 1983, the AIDS epidemic was "symbolically declared" the United States' number one health priority by Dr. Edward N. Brandt, Jr., the Assistant Secretary for Health (Shilts 1987; Panem 1988). A massive and diversified social movement industry (SMI) has sprung up to meet the medical, social, psychological, spiritual and material needs of HIV infected individuals and their friends, lovers and families. As the epidemiology of the HIV epidemic shifts within the United States ever larger segments of the population, particularly men of color, injection drug users, and women and their children, the AIDS SMI expands (Peterman, Drotman, Curran 1985; Adler and Piot 1988; Berkelman, Heyward, Stehr-Green, Curran 1989; Selik, Castro, Pappaioanoo, Buehler 1989).

A major segment of the health and human services infrastructure has been co-opted and drawn into the battle against AIDS (Perrow and Guillen 1990). Additionally, non-constituency institutions including hospitals, nursing homes and hospices as well as local and state public health agencies, community based organizations and other direct service providers work alongside AIDS specific organizations (National Academy of Science 1986). The major focus of this case study is Ohio's AIDS specific social movement. Organ AIDS specific organizations are established most often at a grassroots level directly in response to unmet needs demonstrated within a particular locale (Arno 1986; Rounds 1988; Shaw 1988).
THEORETICAL CONSIDERATIONS

Three major approaches to the study of social movements are currently utilized by scholars in the field. The classical approach to social movements sets the study of movements in the context of "collective behavior" (Miller 1985; Taylor and Whittier 1992). This perspective places heavy emphasis on the emergent phase of collective behavior, and was first systematized by Blumer (1946; 1954). This work was continued and elaborated on by Turner and Killian (1972). Neil Smelser (1963) also working in the collective behavior tradition further expanded the scope of the classical approach by shifting its focus and examining social movements as a response to social structural strain (McAdam et al 1988).

Social movements are the largest-scale phenomena studied in the collective behavior tradition (Miller 1985). Other behavior studied within the collective behavior field includes crowds, riots, fads, cults and fashions (Miller 1985; Perry and Pugh 1978). These various types of social interaction were originally grouped together because of scholars assumptions that they were all a consequence of irrational and unpredictable social action. Later scholars, including Berk (1974) as well as Turner and Killian (1972) switch emphasis and framed their studies of social movement participation in terms of rational decision-making and the characteristics of organizations (Morris and Herring 1984).
Resource mobilization (RM) theory emerged in the 1970's, and became the dominant force in the study of social movements for the next two decades (Taylor and Whittier 1992). RM theory was originally formulated using studies of social movement activism from the 1960's and 1970's including analyses of the women's movement, the civil rights movement, environmental movement and other social justice causes (Freeman 1979; Morris 1984; McAdam 1982; Jenkins 1983). Resource mobilization theory has been most precisely and consistently articulated by a John D. McCarthy and Mayer N. Zald in their series of articles and texts. McCarthy and Zald (1977; 1973) stress the importance of favorable opportunity structures' and the role of pre-existing organizing of aggrieved groups (Taylor and Whittier 1992).

Resource mobilization theory dismisses the role of generalized beliefs and ideology (McCarthy and Zald 1977; Freeman 1979 and Jenkins 1983). Instead RM theory makes its central contribution with its focus on social movement organizations as the primary unit of analysis (McAdam 1982; McCarthy and Zald 1973; Zald and Ash 1966). Further, RM theory conceptualizes an understanding of politics which emphasizes collective action played out in the arena of the state (Tilly and Gurin 1990). Taylor and Whittier (1992) suggest that this emphasis produces a narrow definition of collective action which scholars have criticized because of a gender bias which can serve to exclude the experience of women (Tilly and Gurin 1990).
The new social movement approach highlights the discontinuity between movements of the 1960's and 1970's, and the abolitionist, suffrage, peace and worker's socialist movements of late 19th and earlier 20th century eras (Taylor 1988). New social movement theorists attributed social action to structural changes in western industrialized societies, and to the appearance of new sets of grievances (Klandermas and Tarrow 1988). Klandermas and Tarrow go further in their review of new social movements characterizing the central theme as emphasizing a shift in values, action forms and constituency between "old movements" (i.e. the labor movement) and newer movements such as the peace, environmental or women's movements.

The values expressed by the new social movements are anti-modernistic, and typically challenge state authorities in the name of populations with little formal power (Tilly 1988). The action forms utilized by new social movements involve unconventional strategies, and organizations are de-centralized, small scale and anti-hierarchical (Klandermas and Tarrow 1988). Klandermas and Tarrow (1988) further suggest that the constituencies of new social movements are individuals who either "pay the price" related to the social problems caused by modernization, and/or are particularly sensitive to the inequities of modern life.

Other scholars contributing to the new social movements' scholarship attribute emerging activism to new aspirations spawn from expanded opportunities for self-actualization in post-war Europe (see Klandermas
and Tarrow 1998 for review of European contributions). Still other authors view new social movements as a response to increased state intervention into the everyday life of citizens (Melucci 1981). Melucci's insight emphasizes a process of collective identity formation that represents a political strategy for responding to the social problems associated with modernization (Melucci 1981; Klandermas and Tarrow 1988).

Following Zald and McCarthy (1980), and resource mobilization theory, I will utilize the concepts of a social movement organization (SMO), social movement industry (SMI) and social movement sector (SMS). Social movement organizations are complex formal organizations, actively pursuing the goals of a particular social change agenda (see also Zald and Ash 1966). SMOs may attempt to fulfill the goals of either social movements or countermovements (Zald and McCarthy 1980). A social movement industry, like the one under examination in this study, consists of all the social movement organizations which are focused on a specific issue set and are pursuing relatively similar goals. A social movement sector, in contrast, contains all the SMIs within a society with no regard to their connections with a particular social movement (McAdam et al. 1988; Garner and Zald 1985).

This research project examines one segment of the emergent AIDS SMI in the United States and will describe and analyze the AIDS SMI in Ohio. As of March 31, 1992, The Ohio Department of Health reports 3157 AIDS cases using the Centers for Disease Control's conservative case
definition (ODH 1992; ACTUP/NY 1990). In Ohio reported cases are overwhelmingly among men who have sex with other men. Gay related transmission accounts for 80% of the total cases (ODH 1992). Ohio's three largest metropolitan counties—Franklin, Cuyahoga and Hamilton—account for 56% of Ohio's reported AIDS cases. Mid-sized cities in Ohio—Toledo, Dayton, Akron, Canton, and Youngstown—are slowly being drawn into the mainstream of the HIV epidemic as they begin to experience client case loads large enough to make impractical the management of HIV/AIDS in a case by case crisis mode. Counties where the mid-size cities are located account for 20% of Ohio's total cases (ODH 1992).

McAdam et al (1988) note that at a macro sociological level the rapid emergence of a new social movements industry, like the AIDS SMI, depends on activists exploiting the opportunities for social movement activity presented by changing political, economic and/or demographic conditions. The efforts of Ohio's public health and Gay/Lesbian activists in mobilizing the state's AIDS SMO's confirm this hypothesis. It should be noted that Lesbian participation in the AIDS movement is not without controversy (Lockwood 1989; Winnows 1989). Some Lesbian activists decry the failure of the earlier Gay movement to prioritize women's issues while others suggest that the hostility and right-wing backlash generated by AIDS has lead to greater unity and the return of

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5 Considerable criticism of the AIDS surveillance system exists and many believe that doctors who have been overwhelmed and demoralized by the problem are failing to be complete in their reporting practices. A revision of the AIDS case definition was scheduled for early 1992 and has been delayed. This change will allow for individuals with very low CD4 cell counts, but who have not experienced a qualifying illness or condition, to be counted as an official AIDS case.
radical Lesbians to the Gay civil rights cause (Cavin 1990).

The focus of the dissertation is on three substantive areas for developing social movement theory. First, a typology is constructed that delineates variation within the Ohio AIDS SMI relative to questions of organizational origins and goals. Lofland's (1981) typology of SMOs is used to present a typology of AIDS SMOs in Ohio.

Second, following Zald and McCarthy (1980), and using a resource mobilization perspective, I examined SMO competition and cooperation in the Ohio AIDS SMI. Third, my work analyzes the constraints facing SMOs from a variety of social control agents (Barkan 1984). This section also documents the strategic choices made by SMO leadership in reaction to those constraints. The relationship between state government and the Ohio AIDS SMI is examined for the role played by the Department of Health as both an agent of social control and a major resource for movement activity.

SUBSTANTIVE CONSIDERATIONS

Substantively the AIDS epidemic has been, and will continue to be, a catalyst for significant challenge of mainstream organizations (Perrow and Guillen 1990). For example, both daily operations and organizational policies in nonconstituency institutions, including law enforcement agencies, hospitals, and blood banking centers, have been influenced by the potential presence of HIV infection (Freeman 1983). This challenge, which has gone largely unmet, extends also to organizations within racial and ethnic communities (see DiClemente, de la Cancela 1989; Mays and Cochran 1988; Amaro 1988; Johnson 1986; Dalton 1989), as well as to the hard hit Gay male community (Perrow and Guillen 1990; Shilts 1987; Kramer 1989; Altman 1986; Patton 1985). The politicization and subsequent failure of the federal government to adequately address the scale and severity of the AIDS epidemic in the United States is both well-documented and beyond the scope of the current discussion (Panem 1988; Shilts 1987; Perrow and Guillen 1990; Kramer 1989).

The response to the HIV epidemic by the federal bureaucracy has been slow. Early in the AIDS crisis the Federal government was ineffective in its attempts to coordinate the exchange of information about the emerging epidemic. For example, the Centers for Disease Controls' failure to utilize formal channels and officially notify the American Association of Blood Banks concerning the risks of HIV transmission through blood transfusion allowed HIV contaminated blood and blood products to be used (Panem 1988; Shilts 1987; Perrow and Guillen 1990 and Kramer 1989).
James Curran, who headed up the early CDC AIDS effort, noted:

(A) tendency among fellow scientists either to discount or
to deny the seriousness of the disease ... (according to
Curran) scientists avoid issues that relate to sex and had
little understanding of homosexuality.6

The AIDS epidemic consistently failed to attract the attention and
efforts of those best positioned to make a difference.

Perrow and Guillen (1990) argue that in the example of New York
state - a high HIV prevalence region - societal hostility to the urban
poor in combination with the ideological and economic policies of the
Reagan administration and the homophobic concerns of legislators and
organizations contributed to what they define as a "failure to
respond."7 Even in low HIV prevalence areas social and public health
policy makers are increasingly required to account for HIV/AIDS needs
in their overall planning efforts (Columbus AIDS Community Advisory
Coalition 1989).

AIDS related expenditures for both the private and public sector are
extraordinary. Johnston and Hopkin's (1990) worst case projections for
the year 2002 estimate total AIDS costs at $78.3 billion. The demands
are increasing at an exponential rate. Hospitals, the cornerstone of
the health care industry in the U.S., have been overwhelmed in high HIV
prevalence areas (Lloyd 1988; Moseley 1989). AIDS patients typically


7 As of February 29, 1992, New York state ranked first in AIDS cases in
the United States with 43,707 reported. California is second with
39,807 cases. Florida, Texas and New Jersey are the other states
with case loads over twelve thousand. Puerto Rico, Illinois, Penn-
sylvania and Georgia create a third tier with case loads ranging from
6849 to 5873. Ohio ranks 14th with 3157 reported AIDS cases.
incur higher fees and stay in the hospital longer than other patients (Lloyd 1988). Researchers estimate daily hospital expenses for AIDS patients between $683 and $1003 per day (Bloom and Carliner 1988).


The insurance industry, in an effort to minimize loss exposures, has developed rigorous HIV testing and client screening protocols that make almost all HIV infected persons ineligible for adequate individual health or life insurance coverage. The insurance industry's policies have served to shift an ever increasing portion of the financial burden for AIDS patient care onto the public sector (Johnston and Hopkins 1990). Though often overlooked, an analysis of the macroeconomic effects of AIDS must also include cost estimates measuring the loss of workers through illness and premature death (Johnston and Hopkins 1990).

The successes of AIDS activists in influencing legislative and public health policy at a national level has initiated fierce debates over how funding priorities are being set. Segments of both the general
public and the U.S. Senate have challenged the appropriateness of providing even bare bones support for AIDS research, prevention and patient care (Shilts 1987; Panem 1988; ACTUP/NY 1990). Those advocating limited and tightly controlled federal spending for AIDS tend to identify AIDS appropriations as subject to cooptation by "Gay rights organizations" whose agendas are in fundamental contradiction to traditional "family" values.

One of the leaders of the anti-Gay AIDS backlash, and a sounding board for the rhetoric of the AIDS countermovement, ultra-conservative Senator Jesse Helms of North Carolina has led numerous actions aimed at blocking and/or reducing federal funding of AIDS related efforts. Senator Helms has been particularly effective in connecting anti-Gay rhetoric to his AIDS bashing initiatives (Plummer 1988; Weeks 1988). In response to his counter movement activities, the AIDS social movement nationwide has targeted Helms as its arch-villain (Crimp 1987; Turner and Killian 1976).

Substantively the AIDS crisis will continue to act as a catalyst for re-shaping the public health agenda into the 21st century. The AIDS issue generates intense political wrangling from both the right and left wings of the political spectrum and is likely to remain a lightening rod generating hot political and public debate.
SOCIAL SCIENCE APPROACHES TO HIV/AIDS

Since the onset of the AIDS crisis, a wave of scholarly work has appeared, producing helpful insights into the workings of the epidemic. Initially, almost all social scientific scholarship related to HIV/AIDS was behaviorally based though more recent contributions have moved beyond these limitations (Huber and Schneider 1992; Gamson 1989; Gilder 1989; and Weitz 1991). Kaplan et al (1987), reviewing the AIDS literature, conclude that researchers have produced an abundance of socio-psychological analyses of issues related to disease transmission and progression. This emergent body of scholarly work is overwhelmingly focused at a micro level using the individual as the unit of analysis. Kaplan et al (1987) divide the social science literature on AIDS into two categories. The first attempts to understand the social influences on HIV exposure, while the second aims at understanding the social links to HIV disease progression. The second category is primarily linked to sociology through the medical sociology tradition (Weitz 1991).

Because HIV is neither causally nor randomly transmitted it is important to understand the social influences on HIV exposure. Among the most important topics that came under early social scientific study were sexual behavior patterns (Winkelstein et al 1987; Feucht et al 1990; de la Vega 1990; Randolph 1988; Martin 1987; McRusic et al 1985; Redfield et al 1985), injection drug use practices (Centers for Disease Control 1990; Hahn American Public Health Association 1989), and blood products usage protocols (Kitchen et al 1984). These emerging litera-
tures were broadly informed by previous research dealing with the social etiology of sexual behavior and drug use patterns.*

Kaplan et al (1987) also note the contributions made by social scientists regarding the study of the natural history of HIV infection for people living with the virus. This again ties to medical sociological research. Specifically, a pre-existing literature related to patients reactions to the stress of illness informed later study of the unique stresses associated with HIV disease (Tyhurst 1951; Parke 1971; Batchlor 1984; Tross 1985; Cassens 1985). It should be noted that the fear, anxiety, and stigmatization facing most people living with known or suspected HIV infection are very significant (Weitz 1991; Kelly and St. Lawrence 1988). Correspondingly higher rates of suicide have been noted among HIV infected persons (Perry et al 1990).

An additional focus for medical social scientific studies has been social influences on human immune system functioning. Harkening back to Schmidt's (1984) thesis concerning the "bio-psycho-social" origins of AIDS, the 1980's saw numerous research projects that documented the relationship of stress to physical illness, and more specifically, to immunodeficiency (Dorian et al 1982; Jemmott and Locke 1984). Other socioculturally influenced behavior patterns, described in the AIDS

* Earlier studies of heterosexual patterns (see Kinsey, Pomeroy, Martin 1948; Kinsey, Pomeroy, Martin Gebhard 1953), continue to be the best source of data. In the era prior to AIDS, researchers explored same sex sexuality in studies by Gagnon and Simon (1973) Bell, Weinberg, Hammersmith (1981); and Bell and Weinberg (1978). As the availability of drug treatment increased in the 1970's and early eighties so too did research on drug use for examples see Agar (1973) and Kandel (1980).
literature as "co-factors", have been hypothesized to affect immune function. Included among these are poor nutrition, cigarette smoking, alcohol consumption, sleep deprivation and illicit drug use, such as marijuana smoking or the inhalation of amyl, butyl or isobutyl nitrate. The potential long-term influence of the AIDS epidemic on almost every sector of U.S. society is enormous. Assessing the social, psychological and economic implications of the HIV/AIDS crisis is one role for social scientists (Turner et al 1989; Academy of Science).

The sociologist Gagnon (1988) joins Turner et al (1989) in noting the serious inadequacies of existing knowledge concerning human sexuality. He warns of the consequences of those weaknesses for HIV/AIDS education and prevention efforts. Relative to AIDS, the inadequacies of our understandings of sexual behavior are glaring. For example, no reliable estimate of the numbers of males in the U.S. who engage in same sex sexual behaviors is available. Without insight into the rate of acquisition of new sexual partners among Gay men, projections for spread of HIV become invalid.9

The availability of funding for AIDS and related topics has stimulated an emergi that studies sexuality in the context of disease (Feucht et al 1990; Mays and Cochran 1988; Coxon 1988; Ekstrand and Coates 1990; CDC 1990; Golombok, Sketchley, Rust 1989; Sonenstein, Pleck, Ku 1989; Hays et al 1985; Levy and Albrecht 1989).10 The cur-

9 See Coxon (1988) for an attempt to compute such an estimate.

10 See also the January 1992 Footnotes, a publication of the American Sociological Association, for their "Action Alert" calling sociologists to protest to Congress regarding Bush administration attempts
rent connection of the issues of sexual behavior, disease, and death may have long-term consequences for the theoretical directions taken by sexual research (Gagnon 1988). Funders of research on sexuality are in short supply. Those sources of research dollars that do exist in both the private foundation and public grantsmaking sectors are increasingly focused on sexuality issues tied to AIDS.\(^\text{11}\) The AIDS epidemic has illustrated the limits of the current scientific knowledge base concerning sexuality. No baseline data documenting American sexual behaviors and attitudes exists, and the studies now being done often fail to acknowledge the broad frameworks that shape the role sexuality plays in the individual lives of members of various racial and ethnic communities (Gagnon 1988; Levy and

The application of a disease model to sexuality research has created a paradigm vulnerable to cooptation by the AIDS countermovement. Linking sex to death promotes the "sex negative" agendas of right wing political countermovement organizations (Dworkin 1983; Viguerie 1981). The goals of countermovement organizations include limiting women's access to abortion services and blocking the availability of sex educa-

\[^{11}\] The American Foundation for AIDS Research (AMFAR) and the Robert Wood Johnson Foundation are two of the major private foundations that have begun funding AIDS-related sexuality studies. In the public funding sector, the United States Conference of Mayors (1989) has also allocated significant resources to examining sexuality issues in the context of AIDS. Additional federal dollars come from the National Institute of Drug Abuse (NIDA), the National Institutes of Health (NIH), and the Centers for Disease Control (CDC) (The U.S. Conference of Mayors 1988; Lingle and Wood 1988).
tion in public schools (Conover and Gray 1983; Luker 1984). Gagnon (1988) reminds us that research that focuses on "sexuality from the perspective of AIDS rather than AIDS from the perspective of sexuality" may be short sighted and, can as a result, introduce new bias into a field already riddled with conceptual and methodological limitations (Johnston and Hopkins 1999).

In summary, social scientific approaches to HIV/AIDS serve to enrich the general AIDS literature. Initially focused on behavioral questions, this literature has now begun to shift to more theoretical questions involving the long-term influence of AIDS on the social structure. However, sociology as a discipline has been very slow to respond to the emergence of the AIDS crisis. Throughout the 1980's, with the exception of work presented at sociology meetings and conferences, sociologists remained largely silent on the epidemic (Huber and Schneider 1992).

SOCIAL MOVEMENT APPROACHES TO HIV/AIDS

The social movement literature related to the nascent AIDS movement is underdeveloped without an overarching theoretical structure. Initial efforts to examine local communities' responses to the AIDS crisis have focused on New York City and San Francisco, California, the two major epi-centers of HIV seropositivity where the largest numbers of AIDS cases have been diagnosed and reported (Perrow and Guillen 1990; Arno 1986; Gamson 1989). There are few attempts in the current literature to examine AIDS organizing outside of the context of large metropolitan
east and west coast locations. A major contribution of this dissertation will be to examine AIDS SMOs outside of the epicenters of HIV disease. This case study of an AIDS SMI in a low HIV prevalence region seeks to bridge the gap created by the bi-coastal focus of existing AIDS specific social movement research in the emerging literature.

An emerging scholarly literature has begun to explore AIDS activism and social movement activity in the context of existing theoretical frameworks (Gamson 1989; Plummer 1988; Shaw 1988; Arno 1986; Rounds 1988; Weitz 1991; Perrow and Guillen 1990; Cavin 1990). Not all of these explanations have occurred in the context of social movement theory. Public health administrators (Arno 1986; Panem 1988), social workers (Rounds 1988) and specialists in the sociology of organizations (Perrow and Guillen 1990), political scientists (Altman 1986) and journalists (Shilts 1987) have all addressed issues of organizational response to the AIDS epidemic.

Gamson (1989) applies new social movements theory to examine a San Francisco based group - the AIDS Coalition to Unleash Power (ACTUP). He considers the consequences of ACTUP's strategical tactics, and concludes that ACTUP/SF has a strategy of confronting cultural definitions and images related to the AIDS crisis and the societal response. He did his participant observing with ACTUP/SF in a city where there is a reported AIDS case load which is 97% men who have sex with other men.

Gamson's (1989) critique of "new social movements" theory views ACTUP/SF in a larger context of identity politics which originates out
of an established historical past. Gamson's analysis identifies both the traditional political targets of ACTUP/SF strategic choices and the consequences for cultural and expressive mechanisms embodied in this form of AIDS activism. ACTUP serves as the AIDS movement's "radical flank" (Haines 1984).

The cultural messages produced by AIDS activists and educators through their work in the AIDS social movement have also come under study. Crimp (1988) comments on the development of linguistic, social and personal understandings of AIDS and analyzes their consequences. Considerable work regarding the AIDS movement has focused on issues of cultural imagery, symbolism and discourse (Crimp 1988; Treichler 1988; Sontag 1978; Plummer 1988; Gamson 1989). Because the AIDS crisis taps such a deep reservoir of cultural taboo (Patton 1985), it has been a ripe topic for scholars interested in shifting cultural definitions. This line of research is connected to earlier studies of illness and its social control (Sontag 1978; Brandt 1985).

Arno (1986) examines the role of community based organizations (CBOs) in mounting San Francisco's response to the AIDS epidemic. Arno (1986) concludes that community based organizations, while requiring significant financial support from government and private sources, can serve to help control public health care costs. Further, Arno advocates for increased support for local AIDS social movement organizations whose goals include provision of services. He suggests that such allocation of resources is sound public health policy.
Rounds (1988) specifically examines community organizing in rural settings. She notes the barriers to such efforts and presents a strategy for creating a grassroots AIDS social movement organization. Her formula for the establishment of rural AIDS SMOs serves as a blueprint for emergent organizing that is initiated outside of the context of Gay community.

Shaw (1988) and Schneider (1992) scrutinizes the role of community organizing in the prevention of HIV infection among women. Noting the success of Gay and Lesbian community AIDS organizing efforts, these authors advocate greater funding from both public and private sources to support direct action AIDS-focused organizing targeting women. These scholars suggestions are timely because they directly acknowledge the growing support for an AIDS agenda which is responsive to issues of gender parity.

Perrow and Guillen (1990) document the inadequate response to the AIDS epidemic made by organizations in New York state and throughout the nation. Noting the failures of both governmental and private groups, Perrow and Guillen (1990) detail the pattern of denial and avoidance of the AIDS crisis demonstrated within organizations. These authors conclude that a unique set of issues related to homophobia and disdain for poor, injection drug users and members of ethnic and racial communities combined with the current socio-political context to create a stigma powerful enough to account for the massive organizational failure.
Weitz (1991) acknowledges the "narrow focus" of AIDS related social scientific research that emphasized strategies for developing public health policy rather than models for understanding AIDS and its socio-political contexts. Weitz (1991) is particularly critical of the failure she describes of sociologists to go beyond the study of individual behavior to analyze the social context out of which "HIV risk" behaviors occur.

In sum, sociologists have only begun to examine the full scope of the socio-cultural context that surrounds the AIDS crisis. Individual sociologists working in this field have too often found their research driven instead by the agendas of funding agencies (Gagnon 1988). Considerable gaps exist in the present literature, and I will be attempting to close one of those gaps by focusing on questions of social movement industry development and inter-organizational cooperation and competition.

OUTLINE OF CHAPTERS

This dissertation analyzes the AIDS SMI in Ohio by describing the structure, goals and strategic choices of member social movement organizations while concentrating on an analysis of how organizational emergence predicts later development. I begin with a review of the relevant social movements and AIDS-related literatures. In Chapter Two the methodological approaches used in this case study are detailed, and the data sources and data analysis strategies are presented.
Chapter Three traces the historical and sociopolitical context out of which the AIDS movement emerged. Further, this chapter examines the role that a hostile socio-political climate played in discouraging AIDS movement activism. The pre-existence of both a right wing dominant elite with its conservative agenda, and Gay and Lesbian community networks, with their civil rights agendas, have significant consequences relative to AIDS mobilization. Additionally, Chapter Three reviews the historical development of Gay and Lesbian civil rights activism in the U.S. and places that struggle in its relationship to later AIDS movement activities.

Chapter Four examines the cooperative and competitive linkages which exist within the AIDS social movement in Ohio. The forces of cooperation and competition will be considered at both intra-organizational and inter-organizational levels. Also noted here will be the social control activities of authorities. Chapter Five describes the emergence of the Ohio AIDS social movement industry, its ideological frameworks and organizational goals. Furthermore, this chapter reviews the state wide political environment and the socio-political regional context. The concepts of the "de-homosexualization process" and the "principle of inclusiveness" are introduced, and utilized to set the context for an examination of Ohio AIDS social movement organizations and their evolution.

Chapter Six looks more specifically at the two pathways for social movement emergence which exist in Ohio. The shifting ideological base
is examined relative to questions of movement leadership and membership. The role of incentives in mobilizing movement participants is also considered. Included here is an analysis of the consequences of professional movement leadership for the Ohio AIDS social movement. Chapter Seven provides a descriptive overview and a recounting of the theoretical implications raised by this research's review of classical social movement and resource mobilization theory.
CHAPTER II
METHODOLOGY

The dissertation uses the case study method, since it facilitates the discovery of richly descriptive exploratory accounts (Jorgensen 1989; Lofland 1971). The Ohio AIDS social movement industry is the unit of analysis (Jorgensen 1989; Lofland 1971). I use field methods to generated three types of data - participant observation, intensive interviews and documentary analysis. In addition, each of these three methods will be examined for their respective strengths and weaknesses. In this chapter, I describe the data sources utilized for the project.

While I was engaged in this study, I was employed as a consultant to the Ohio Department of Health’s AIDS Activities Unit. I was able to use this position to create opportunities for entree into the netw AIDS activists in Ohio and to recruit key informants for intensive interviewing (Dexter 1970; Shaffir et al 1980). As part of my responsibilities, I traveled and lectured extensively throughout t Attending conferences and meetings, I was able to establish rapport with key participants in AIDS organizing. This allowed access to both individuals and organizational documents. As an active participant in the AIDS movement in Ohio, I observed the emergence, growth and occasional decline of various AIDS organizations. The rapid emergence of this
social movement, its challenge to the status quo, and its ability to access established power structures created an unique opportunity for case study of a social movement industry.

DATA SOURCES

Participant Observation
From Winter 1987 to Fall of 1988 I served as a volunteer for the Columbus AIDS Task Force, a local "full service" AIDS specific social movement organization. This group is a dominant player in the local AIDS arena. It provides educational services to the general community, conducts targeted HIV prevention activities and offers a variety of emotional, financial and practical support services for a large client base. Its funding sources include state and local grants from government, private foundation funding as well as private donations.

Initially, I volunteered my time as an "AIDS Hotline" operator and was required to complete an HIV/AIDS training workshop provided by the agency. This opportunity, in conjunction with coursework I took at the Ohio State University prepared me to accept paid employment in the Ohio AIDS industry. In October of 1988 I became an independent consultant to the Ohio Department of Health's AIDS Activities Unit to work with issues related to women and AIDS. My specific areas of responsibility included HIV education, prevention, and HIV testing family planning settings as well as heterosexual safer sex programming.
I also participated in a variety of AIDS Unit activities - attending AIDS Advisory and Educational Materials Review Committee meetings, coordinating the statewide observance of "National Condom Week" '90, as well as representing the Ohio Department of Health in negotiations with local AIDS social movement organizations and non-constituency institutions. Additionally, I served as a workshop presenter for numerous local "Women and AIDS" speaker events during the Ohio Department of Health's Women's Health 1989, 1990, and 1991. All of these opportunities facilitated my ability to interact with AIDS SMOs around the state. I maintained my employment full-time with the AIDS Unit from 1988 to early 1991. Beginning in February 1991 I worked part-time with the Ohio Department of Health until December of 1991. Since November of 1991 I have taken on new responsibilities within the social movement sector, and am currently serving as the Executive Director of Stonewall Union, central Ohio's leading Gay and Lesbian civil rights organization.

The most valuable result of my participant observer role is the degree of entree I obtained to organizations and individuals (Douglas 1976; Jorgensen 1989; Schatzman and Strauss 1973). As a member of the AIDS Activities Unit, I had access to a wide variety of AIDS specific materials, including journals, computerized "AIDS Daily Summaries," and governmental reports. This allowed me to monitor developments within the field of HIV/AIDS and maintain a substantial level of expertise.
My participant observation opportunities provided me both with insight into the workings of AIDS social movement organizations and the functions of the state public health agency. Because I participated in AIDS Activities Unit sponsored training meetings as well as statewide conferences that attract local AIDS activists, I developed ongoing relationships with a diverse set of Ohio AIDS activist community members. In most cases I was able to involve key informants in my project by building upon already established relationships and utilizing my professional network of contacts in the movement (Douglas 1876; Schatzman and Strauss 1973; Lofland and Lofland 1984).

Perrow and Guillen (1990) note that their efforts to interview AIDS SMO representatives met with an "unprecedented degree of resistance". They judge a full one quarter of their sixty-five interviews to be "hostile or uncooperative". In contrast, I had overwhelming successes recruiting key informants. It should also be noted that key informants, with a guarantee of confidentiality, were exceptionally frank and open in their discussions of the organizations they represented.

Only one individual out of 34 repeatedly canceled his scheduled interview and was eventually eliminated from the sample. This single reluctant informant holds multiple professional and movement responsibilities, and the interview process was blocked because of difficulties with scheduling, not because of any unwillingness to participate. I attribute this success in obtaining the cooperation of informants to my rapport with participants and my credibility as a member of the AIDS
Activities Unit staff. Primary and secondary documentary sources were also used to serve as a check on the validity of interview data.

Reliability problems are recurrent in qualitative research (Douglas 1976; Kirk and Miller 1986; Jorgensen 1989). When possible I made use of multiple informants representing the same organization or geographical region within the state. Multiple confirmations of data using diverse data sources minimize reliability problems inherent in field research (Kirk and Miller 1986).

**Intensive Interviews with Key Informants**

I conducted thirty intensive interviews involving thirty-four individuals (Dexter 1970). These interviews were open-ended, semi-structured, tape recorded and transcribed. The interviewing process began June 1990 and extended through January 1991. Each interview session lasted on average between forty-five minutes and one and one-half hours with a range from thirty minutes to more than three hours.

Most interviews (27 of 30) were conducted in person. When scheduling and travel difficulties presented obstacles I interviewed via the telephone, for three of the thirty interviews. With the exception of the telephone interviews, I traveled to meet most key informants and nearly all interviews were conducted at the group's place of business. In cases where the group did not have their own physical locations, we made use of available space at other supportive organizations.

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12 The names location and other identifiers connected to the project's informants may be altered to protect the individual's confidentiality.
Nonprobability sampling techniques were used to select key informants (Glaser and Strauss 1967; Cook and Campbell 1979). I selected key informants from major social movement organizations in Ohio utilizing the snowball effect. My informants where chosen from a sample of all Ohio AIDS organizations. Individuals involved in the AIDS movement on a statewide level and/or who had long standing participation in the AIDS movement were interviewed first and then were asked to identify other key players (see Schatzman and Strauss (1973) for a discussion of snowball sampling procedures).

Three criterion were used to select informants. First, I choose key informants based on their involvement at either statewide or local levels within the AIDS SMI. Second, I wanted participation to represent all types of organizations, including both large complex organizations and less formal or emergent groups. Third, I wanted the sample to be representative of the diversity found among SMO participants relative to issues of race, gender, sexual orientation, and geographic region (Dalton 1989; Miller 1989; De La Cancela 1989).

In Ohio, AIDS remains a controversial topic. Individuals who choose to participate in AIDS organizations can face disapproval or suspicion from family, friends, neighbors or employers. The stigma and discrimination that people living with the HIV virus experience can, and sometimes does, extend to care givers and social service providers. Studies have documented that even professionals involved with AIDS organizations professional reputations jeopardized by association with
AIDS activism (Rounds 1988; Batchelor 1984; Cassens 1985). In order to protect the confidentiality of key informants no real names, city and/or agency identifiers will be used. Anonymity is intended to protect informants from being compromised in their positions in the movement by disclosure of information concerning their organizations, its resources and/or strategic choices.

Mirroring the principle of inclusiveness that informs the AIDS movement, which values the participation of diverse populations effected by HIV disease, I have sought an informant pool that is purposively balanced with regards to sexual orientation, race and gender (Dalton 1989). The key informant sample was 47% (n=16) female and 53% (n=18) male. Seventy-six percent (n=26) of the key informants are white, 18% (n=6) are African American and 6% (n=2) Latino/a. Information about sexual orientation data is somewhat less accessible, but all but two of the respondents disclosed their sexual orientation to me either during or prior to the interview. I am open about my own identity as a Lesbian, which I believe facilitated informants' sharing information concerning their sexual identity. Forty-one percent (n=14) of the sample are Gay men, and an additional nine percent (n=3) are Lesbian. Heterosexual females contributed thirty-five percent (n=12), while heterosexual males are nine percent (n=3) of those interviewed. The sexual identity of six percent (n=2) was unknown.

Geographic representation was also a factor considered when selecting key informants for participation in this study. Unlike New York or
Illinois, Ohio is not dominated politically or geographically by any one metropolitan area. Instead, a variety of cities with competing local interests come together to define statewide political agendas. Because each of Ohio's urban centers makes its own unique contribution to statewide politics, the failure to include any one of Ohio's multiple urban areas could produce a flawed analysis.

Ohio has three major metropolitan centers: Columbus, Cincinnati and Cleveland. Fifty-three percent (n=18) of key informants live in these three cities. Additionally, Ohio has five smaller cities: Akron, Canton, Youngstown, Toledo and Dayton. Individuals from each of these regions are included in the study for a collective total of twenty-six percent (or n=14 individuals). Representatives from Ohio's rural and college town communities were also included (21% or n=7 individuals).

Seventy percent (n=24) of key informants are paid and/or full-time staff members of the organizations they represent. Another eighteen percent (n=6) are working for either public health, family planning or in health education positions. Only 12% (n=3) of the sample are not employed in the AIDS or health arenas. The significance of the predominance of paid employess in the sample will be considered later when I explore the consequences of an increasingly professional leadership for the movement.

The interview guide used was open ended and semi-structured (See Appendix One). Each informant was questioned concerning how they began their own involvement in AIDS work and about the origins of the organi-
zation(s) they represented. The additional substantive areas explored were: 1) organizational leadership; 2) current and long-term organizational goals; 3) organizational access to resources; 4) problems or constraints blocking organizational success and; 5) the relationships between AIDS social movement organizations; and the relationship between the AIDS movement and the local government.

Key informants were chosen for participation based on the extent of their knowledge regarding AIDS organizing activities in their particular geographic region. This assessment was made as a result of my own knowledge of key players around the state and was confirmed through snowball sampling of other key informants.

A wealth of data was generated through the interviews. A triangulation strategy using secondary data generated from both primary and secondary sources, as described below, was used to verify information gathered from key informants (Webb et al. 1986; Plummer 1983). When possible, multiple representatives from single organizations were utilized as additional checks of the reliability of presented data (Kirk and Miller 1986; Jorgensen 1989; Douglas 1976).

Secondary Analysis
Documentary analysis can be used both to enhance the internal validity of qualitative studies, and as a major data source (Kirk and Miller 1986; Plummer 1983). When used in combination with intensive interviewing strategies the weaknesses of one method is mitigated by the relative strengths of nonreactive and unobtrusive measures (Webb et al.
1986). For this research I analyzed both primary and secondary sources of documentary data. Primary data sources collected from AIDS SMOs included organizational newsletters, fund raising mailings, educational pamphlets, the organization's "Articles of Incorporation" and other IRS records available to the public. An attempt was made to gather the documents listed above systematically, but they were not available for all of the SMOs under study.

Secondary sources that present journalistic (Shilts 1986; Kramer 1989) and scholarly case history accounts (Perrow and Guillen 1990) of the AIDS SMO nationally or in the coastal epi-center cities were also reviewed. Local secondary sources of data were gathered from the Ohio Department of Health's (ODH) AIDS Activities Unit and include the AIDS Health Care Resource Directory, other governmental records such as AIDS surveillance data, and budget and grant records from the ODH Office of Grants Management.

Two additional sources of secondary data are the National AIDS Information Clearinghouse (NAIC), a depository of AIDS information with a national scope, Stonewall Union's (a local Gay organization) The Ohio Gay Guide 1990, Lavender Listings 1991, and the Directory of Homosexual Organizations. I obtained a computerized listing from NAIC for all AIDS-related organizations in Ohio's eight major cities. The documentary sources were sorted relative to geographic location and used to augment information gathered through the interviewing process.
DATA ANALYSIS

Transcribed interview data was analyzed using computer-assisted techniques. Computer assistance speeds the data analysis process by reducing the tedious task of data sorting. Furthermore, computer based technologies allow for an almost unlimited capacity to code/recode and sort/resort data files into analytical classifications. For data analysis, I used The Ethnograph, a software designed to assist in the production of qualitative research and the manipulation of interview data. The Ethnograph is a set of interactive, menu-driven computer programs designed to assist in the mechanical aspects of data analysis.

All interviews were transcribed verbatim and then coded line by line (Strauss and Corbin 1990). I read each interview twice for coding purposes and to increase coding reliability. This repetitive coding strategy increases the consistent use of coding categories (Jorgensen 1989). I also briefly reviewed the coding concepts list before beginning any interview coding session (see Appendix Two for a code word list).

The coding of interviews utilized the process of developing categories described by Glaser and Strauss (1967) and Strauss and Corbin (1990). Some categories were suggested "in vivo" by informants themselves (Strauss 1987). Other categories were named as logical references to the data requested and others as operational measures of the social movement concepts employed (Strauss and Corbin 1990). As data

For further discussion of the innovations brought to qualitative analysis by the availability of computer technology see Becker et al (1984), and Conrad and Reinharz (1984).
analysis progressed, the coding process became increasingly refined.

In sum, this work focuses on the AIDS SMI in Ohio, a large midwestern state with a low HIV prevalence and an urban population fairly evenly distributed in eight cities. The findings of this research are exploratory and generalizable only to regions within the United States that may be similarly described. The analysis I offer of the Ohio AIDS SMI is intentionally descriptive, particularistic, and comprehensive in its scope. As a result, efforts to generalize the findings beyond the scope of the study may produce inaccuracies. A deliberate effort was made to collect data from a diverse set of key informants, while continuing to acknowledge the limitations of the chosen methods relative to questions of generalizability.

The dissertation, because of its heavy reliance on field research, is vulnerable to the classic criticisms of the approach (Jorgensen 1989; Kirk and Miller 1986). The strengths of field research lie in the flexibility of its strategies and the richness and depth of the data it generates (Lofland 1971; Strauss 1987). A common criticism of field methods stems from the supposed "subjective" quality of qualitative analysis and its significant reliance on the interpretations of the researcher (Kirk and Miller 1986).

Reinharz (1979) asserts the importance of acknowledging the value of the researcher's experience in the production of sociological analyses. She calls on researchers to admit the influence of "subjectivity" in the inquiry process. This perspective argues the case for increased rather than diminished reliability in studies using field work methods.
The weaknesses of intensive field research lie, however, in the extreme demands it places on a researcher's time and budget.

Critics note that qualitative approaches risk a loss of reliability due to the difficulty of producing consistent and repetitive confirmed findings (Jorgensen 1989). Field research rarely offers precise descriptions of large populations, and conclusions drawn using this approach are often suggestive rather than definitive (Kirk and Miller 1986). Compared to survey approaches, intensive interviewing and the use of documentary analysis offers meaningful insights into the understandings of data rather than rigorous hypothesis testing (Reinharz 1979; Shaffir et al. 1980; Dexter 1970). These insights and illustrations serve to reinforce the validity of data produced using field research methods (Kirk and Miller 1986; Jorgensen 1989).
CHAPTER III
THE POLITICAL AND SOCIAL CONTEXT OF AIDS ACTIVISM

Many early social movement theorists were preoccupied with the emergent phase of collective action (Blumer 1946; Turner and Killian 1972; Smelser 1963; Gurr 1970). These theorists focused greater attention to the features of the pre-movement period that gave rise to activism rather than to the movements themselves (McAdam et al 1988). Newer theoretical perspectives such as resource mobilization theory and the political process model, have shifted theoretical foci from micro to macro levels of sociological analysis, while maintaining theoretical interest in socio-political contexts.

With its emphasis on internal movement dynamics, resource mobilization theory evaluates the larger political environment within which movement activism occurs in terms of an invariant set of external institutional constraints that determine "resource availability" (McCarthy and Zald 1977; Schock 1990). More explicitly, political process theory emphasizes the influence of the larger political environment on the emergence, development, and long range outcome of social movements (Tilly 1978). Within the political process perspective, political opportunity structures are viewed as the external institutional constraints which frame activism within a particular historical
and socio-political era. I will utilize this definition of political opportunity structure in the following discussions. It is with consideration of these scholarly understandings that I analyze the historical and sociopolitical contexts from which the AIDS social movement industry emerged.

This chapter is organized into two major sections. The first section examines the political opportunity structure out of which AIDS activism emerged. Within this discussion, both institutional structures and power configurations are examined. The second section highlights a unique component of political opportunity structure by examining the role of the Gay and Lesbian movement as a pre-existing network that facilitated AIDS organizing.

POLITICAL OPPORTUNITY STRUCTURES
Following McAdam (1982) and Jenkins (1985), I will focus on the political context that existed as the AIDS movement emerged in the early nineteen eighties. Tarrow's (1988) comparative analysis of Western European and U.S. collective action demonstrates the significance of political opportunity structure, political alignments, and the presence of outside groups that support the movement in the rise of collective action. Kriesi (1990) also introduces power configurations as an aspect of political opportunity structure. I will use Kriesi's concept to better define the role of the state government and other political actors in determining opportunity in the AIDS SM.
The political opportunity structure in the U.S. that existed at the onset of the AIDS epidemic was dominated by large scale social processes that can best be characterized through an examination of the domestic political priorities of the era. The rising tide of conservatism brought with it a "pro-family" agenda that resulted in an ever-increasing erosion of abortion rights, a decline in enforcement of anti-discrimination legislation, and a deterioration of affirmative action gains (Crawford 1980; Ryan forthcoming Staggenborg 1991).

Economic and marketplace realities reflected a period of increasing unemployment, poverty, and homelessness, in part a consequence of de-industrialization and the expansion of the low paying service sector (Ryan Forthcoming). Additionally, cuts in federal funding for social services, school meal programs, and housing typified domestic policy prioritization (Ryan Forthcoming). This era was not a period ripe for progressive social policy. An explanation is necessary for how the AIDS social movement industry could emerge in such a seemingly inhospitable socio-political environment. To do that, it is essential to review the institutional structures and political power configuration of the period.

Institutional Structures
Certain dimensions of a political opportunity structure that characterize a given society tend to be stable over time (Schock 1990). The United States has a democratic, polyarchic political structure dominated by a strong party system. The regime openness that characterizes
the American political system has produced an institutional structure that minimizes the potential for revolutionary movements and tends to effectively institutionalize conflict (Gelb 1987; Kitschelt 1986). Within the U.S., the government possesses considerable state strength and the ability to institutionalize conflict by addressing the demands of its citizens.

Smelser (1963) described a given society's ability to accommodate social change as "structural conduciveness." Both Smelser and Gamson (1975) evaluate the U.S. political institutional structure as highly differentiated. Highly differentiated societies are vulnerable to norm-oriented social movements that confront specific institutions within the society.

Regime capacity (Tarrow 1988) is measured by the ability of a government to control its economy and to efficiently implement policy. In the U.S., the government exercises substantial control over the economy through legislative initiatives, the activities of the Federal Reserve, and regulation of the banking industry. Overall, and relative to countries throughout the world, the U.S. possesses considerable regime capacity.

Uncharacteristically, state control of the health care system and the political economy of medicine is weak (Garner and Zald 1985). This is documented by the inability of government to respond to the progressive failure of the U.S. medical system to adequately meet the health care needs of an increasing sector of American people (Hopkins and
Johnson 1990; Starr 1982). These failures facilitate a broad range of public interest and social movement campaigns including calls for the reform of the mental health system, national health insurance, increased accessibility to chemical dependency treatment, and the prioritization women's health concerns. The U.S. medical establishment is politically dominated by the American Medical Association (AMA), which is a powerful interest group in its own right (Starr 1982). Health care issues including access to care and insurance increasingly dominated the larger national debate throughout the early 1980's and early 1990's.

At both national and local levels diminished state control of the medical economy makes this arena particularly vulnerable to greater levels of social activism. To understand the origins of the AIDS movement requires a more specific focus on efficiency of the public health sector and the state's role in maintaining a viable and functioning system of accessible health care. One example of how the AIDS crisis is taxing the health care system of epi-center urban areas can be seen when public hospitals, stretched beyond their resources, refuse care to the indigent (Perrow and Guillen 1990; Johnston and Hopkins 1990).

Medical specialties, like the study of infectious diseases, finds those already in practice overburdened with skyrocketing case loads while the discipline has difficulty recruiting new residents (Johnston and Hopkins 1990). Johnson and Hopkin's (1990) report on a 1984 survey of nurses where two-fifths stated they would request a transfer if they
were required to care for HIV infected patients on a regular basis. The reluctance of health care workers to care for AIDS patients may ultimately mean additional costs as hospitals are forced to actively recruit the needed professionals.

The domestic policies of President Ronald Reagan created a federal aversion to increased spending for human services (Perrow and Guillen 1990; Shilts 1987; Panem 1988). Early in the AIDS epidemic, federal health agencies were encouraged to "cannibalize" existing programs to fund AIDS research and surveillance efforts. In 1981 early efforts at the Centers for Disease Control (CDC) included the establishment of the Kaposi's Sarcoma and Opportunistic Infections (KOSI) Task Force. The KOSI Task Force pulled staff off of various CDC projects including specialists in immunology, veneralogy, virology, cancer epidemiology, toxicology and sociology (Shilts 1987). At a time when the AIDS crisis required a massive influx of new dollars, federal purse strings were pulled tightly closed to all new spending initiatives with the exception of military funding (Perrow and Guillen 1990; Shilts 1987; Panem 1988).

In sum, the U.S. has institutionalized structures that generally support reform-oriented activism. This structural configuration creates a system that tends towards the institutionalization of conflict. Though the state possesses the capacity to implement its policies in many arenas, the public health arena represents, however, an institutional segment under escalating strain. The state's control is
increasingly undermined by rising medical costs and shrinking access to health care (Johnston and Hopkins 1990).

The socio-political climate in which the AIDS epidemic emerged shaped the response of the state of Ohio to the crisis (Shilts 1987; Panem 1988; Altman 1986; Johnston and Hopkins 1990). Numerous writers have, from the onset of the epidemic, acknowledged the intensely political nature of responses to AIDS (Patton 1985; Altman 1986; Shilts 1987; Adam 1987; Kramer 1989; Perrow and Guillen 1990). For example, Perrow and Guillen (1990) consider "organizational failure," along with Reagan administration budget cutting, and the influence of the "Moral Majority," as potential explanations of the federal failure in responding to the AIDS epidemic. They find that all these factors in combination provide the best understanding of why and how the response to AIDS has been so politicized. I now turn to a discussion of the political power configuration that served to shape both public and private sector reactions to issues raised by the HIV crisis.

**Power Configurations**

According to a polity model (Tilly 1978), changes in political power configurations lead to greater opportunities for "challengers" in a system dominated by contenders who are "members" with routine access to the resources of the state (Schock 1990). From 1969 to the present, the configuration of political power in the U.S. has been mixed though it generally marked the declining influence of the political Left (Kriesi 1990). One marker of that shift is the political dominance of
the Republican party, demonstrated by its ability to maintain almost complete control of the U.S. presidency from 1968 to the present.¹⁴ During the past two decades, shifting political alignments have also resulted in substantial changes in the federal judiciary. The current Supreme Court is the most ideologically conservative body to serve since the mid-20th century (Baum 1992).

Changes within the power configurations outside of government can also produce opportunities for challengers. Challengers can join in coalitions with other challenging groups to increase their political power. It is necessary to note however, that such coalescing groups do not necessarily gain greater access to the system. Rather, when a challenging group is able to associate its issues with governmental agencies sympathetic to its cause, often access to political power can be improved (Tarrow 1988).

The early governmental response to AIDS was spearheaded by congressional members representing constituencies hardest hit by the epidemic, including Ted Weiss (D- New York) and Henry Waxman (D- California). In 1983 Congress called for hearings to investigate the federal response to the emerging crisis (Panem 1988). These hearings began the ongoing effort to increase federal funding of AIDS prevention, surveillance and patient care activities.

Public health professionals at federal, state and local levels were also important allies for AIDS organizers, even though their efforts were often judged as inadequate by critics within the AIDS activist community (Kramer 1989; Shilts 1987). Dr. Edward Brandt, then Assistant Secretary for Health at the Public Health Service, labeled AIDS the "number one priority" for public health in 1983 (Panem 1988). Within social movement scholarship, political alignments shifts are typically viewed as creating opportunities for social movements, and have tended to contribute to mobilization when there is movement from conservative to more liberal political alignments (Jenkins 1985; Jenkins 1987). Any evaluation of the relative success or failure of the AIDS movement at the national level must acknowledge that mobilization occurred in a period when major societal political alignments were, with the exceptions noted above, explicitly unsupportive of mobilization opportunities.

Any discussion of the influence of power configurations and political alignments in the U.S. in the 1980's and 1990's as they relate to the rise of the AIDS movement would be incomplete without reference to countermovement activity occurring within this time frame (Mottl 1980; Useem 1984). More specifically, what must be noted is the rise in political influence of the New Right coalition dominated by politically activist Christian fundamentalists and evangelicals (Liebman and Wuthnow 1983). The New Right emerged as the dominant domestic political force at precisely the time when spread of HIV became epidemic.
The New Right's domestic political agenda includes a wide range of single issue campaigns. It is pro-military, anti-taxes, "pro-life", anti-gun control, "pro-family", anti-pornography, anti-school busing, and strongly anti-Gay rights. Though individual members of the new right coalition may differ on any of these issues, the rejection of homosexuality is near universal and this provides a strong unifying plank in the overall conservative platform. On the foreign policy front the New Right advocates a hard line against communism and is generally supportive of an interventionist military.

The New Right consists of a wide variety of umbrella groups. Two examples include the American Conservative Union and the Conservative Caucus Political action committees like the National Committee for an Effective Congress use direct mail solicitation as a funding strategy designed to solicit small sums to organizational operations (Liebman and Wuthrow 1983; Vigerie 1981; Crawford 1980). Direct mail and televangelist campaigns that specifically utilize anti-Gay themes and the fear of AIDS to raise dollars are common. For example, the Jeffrey Dahmer serial murder case in Milwaukee, where a Gay man confessed and was sentenced for murdering at least fifteen other men, has ignited a new wave of anti-Gay hatred from New Right sources.

One of the most significant accomplishments of the New Right Coalition came with the 1980 election of presidential candidate Republican Ronald Reagan. President Reagan's position relative to the emerging AIDS crisis is best characterized by his silence on the AIDS issue.
Despite by that time over 20,000 deaths, Reagan's first public discussion of AIDS didn't come until six years into the epidemic (Shilts 1987). Reagan finally spoke at a ceremony where the U.S Department of Health and Human Services and the Pasteur Institute agreed to share patent rights and royalties related to diagnostic tests using the LAV and HTLV-III viruses. He declined to articulate a federal response to the AIDS crisis (Panem 1988).

Undoubtedly, the inaction of the Reagan administration is related to Reagan's close ties to the New Right confederation and its anti-AIDS countermovement activity (Viguerie 1981; Adam 1987; Patton 1985; Shilts 1986). Jerry Falwell, one of the New Right's charismatic leaders, called for mandatory HIV antibody testing and the creation of a central registry to track infected individuals, as well as quarantine and/or imprisonment for people living with AIDS (PLWAs). The new Christian Right leadership's most devastating contribution to the rhetoric of the epidemic was the pronouncement that "AIDS was God's punishment" upon homosexuals (Patton 1985; Adam 1987; Altman 1986, D'Emilio and Freedman 1988; Sontag 1989; Gilder 1989).

The link, though not absolute, between HIV infection and sexual activity influenced the politicization of the AIDS epidemic by the New Right coalition (Padgug 1989; Altman 1986; Patton 1985; Brandt 1985; Sontag 1989). The idea that AIDS was somehow punishment for the sexual revolution of the sixties and seventies struck a responsive chord for most conservative Christians (Shilts 1987; Patton 1985; Holleran 1988;
Peabody 1986; Adam 1987). Though it did not create the anti-Gay and Lesbian attitude that obstructed the federal response to AIDS, the New Right tapped into and exacerbated it (Viguerie 1981; Morganthan 1983; Klassen, Williams, and Levitt 1989).

One notable exception to the right wing response to AIDS came in the early crisis when Reagan's Surgeon General C. Everett Koop broke ranks with his former New Right comrades and urged comprehensive sex education and condom awareness efforts as strategies to prevent the spread of HIV infection. By 1983 Koop had confounded right wing ideologues, by joining with AIDS activists (Liebman and Wuthnow 1983; D'Emilio and Freedman 1988.)

Koop consistently broke the Reagan administration silence regarding AIDS prevention messages and became a national leader in the fight to increase AIDS awareness. Koop continues to play a highly visible role as a spokesperson on a broad range of public health issues including AIDS. Koop's actions as the nation's "family doctor" gave others in the public health field permission to speak out on AIDS as a public health concern.

The U.S. Congress was less accommodating to the New Right's organizational agendas then was Reagan and consistently allocated more AIDS funding than was requested by the administration (Perrow and Guillen 1990).\textsuperscript{15} Congressman Ted Weiss (D-New York) and Henry Waxman

\textsuperscript{15} For fiscal year 1982 the Congressional appropriation for AIDS funding was $5,555 while the president requested zero dollars. In 1983 the presidential request remained a zero while the appropriation increased to $28,730. The President's first request in 1984 was

Countermovements seek to re-establish prior class structures (Perry and Pugh 1978) arising in opposition to social movement efforts to change statuses, roles and relationships among groups within society (Miller 1985). The New Right arose from the same historical and cultural environment that birthed the AIDS epidemic. In a way, it is not surprising that a similar sense of political entitlement supported the emergence of both Christian fundamentalists and AIDS activists as political forces in the eighties (Liebman and Wuthnow 1983). But just as the New Right grew out of a pre-existing network of fundamentalist and evangelical Christian churches, so too did the AIDS movement owe its origins to a well organized Gay and Lesbian movement.

The Social Movement Sector: The Role of the Gay and Lesbian Social Movement

Tarrow (1988) notes that the presence of outside groups who support a social movement can positively affect that movement's ability to survive and succeed. To understand the rise of the AIDS movement, it is necessary to examine briefly the evolution of Gay and Lesbian political activism in the United States. Without the ideological support and

$39,827 while Congress appropriated $61,460. By 1985 the President requested $60,460 and Congress approved $108,618 (Panem 1988).
resources created by the modern movements to both expand Gay and Lesbi-
an rights and create Gay and Lesbian culture, it would be unlikely that
the AIDS movement in the U.S. would exist as it does today.

My analysis assumes three distinct periods of activism in the analy-
sis below: 1) the Gay liberation movement of the late 1960's and early
1970's, 2) the Gay and Lesbian civil rights movement of the mid-1970's
and 1980's and 3) the initially Gay-led AIDS movement which first
emerged in 1981 (Taylor 1991). These movements are typical of the
type of social movement activism that historically has arisen from
polyarchic, structurally differentiated political systems such as the
United States.

The Gay Liberation Movement

Gusfield (1989) notes that Gay and Lesbian mobilization and the result-
ing transformation of "homosexuality" from a "social problem" to a mat-
ter of political and social conflict is perhaps the most salient 20th
century example of the power of collective action to challenge social
constructions. The Homophile movement of the mid-20th century was a
precursor to Gay liberation (D'Emilio 1983; Gorman 1985; Marotta 1981).
Homophile efforts provided continuity between earlier and later activ-
ism, and this served to strengthen the evolution of the modern Gay and
Lesbian political struggle. Each segment of the movement borrowed tac-
tics and strategies, trained future leaders, and accessed resources

16 My thanks to Verta Taylor who introduced this periodization in a
lecture "Who Are The Gay People?: A Look at the Lesbian and Gay
Social Movement" held April 8, 1991 at the Ohio State University
College of Law.
developed both by earlier Gay activism and from other progressive movements occurring within the same historical era.

For example, the Homophile movement struggled to legitimate homosexuals as a "minority group" in urban centers like New York City, San Francisco and Los Angeles, while black people in the South were coalescing around issues including access to public accommodations, voting rights and school desegregation (Morris 1984; McAdam 1982). Additionally, the sixties were marked by a resurgence in the modern women's movement (Cassell 1977; Freeman 1975; Rupp and Taylor 1987), as well as the rise of the free speech, student's rights and anti-war movements (Useem 1983; Freeman 1983).

During this time period, old guard Homophile leaders were confronted by a younger, more aggressive, new leadership (Marotta 1981; Katz 1976; Jay and Allen 1972). Those new leaders increasingly advocated more militant tactics learned through their exposure to New Left strategical choices (Adam 1987; Freeman 1983). The new tactics and the more militant stance of Gay liberationists were borrowed in large part from the civil rights movement of the previous decade.

The modern Gay Liberation Movement began June 27–28, 1969 with the riots in Greenwich Village, New York at the Stonewall Inn (Adam 1987; D'Emilio 1983). In a period of U.S. history marked by significant urban rioting, African-American "drag queens" and white Lesbians led

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17 The Stonewall riots were a precipitating event not only for the Gay liberation movement in the United States, but also served as the symbolic beginnings of the modern Gay and Lesbian activism worldwide (Gough and Macnair 1985; Adam 1987).
the resistance to a police raid that sparked the creation of the self-proclaimed "revolutionary" Gay Liberation Front (GLF) (D'Emilio and Freedman 1988). An explosion in Gay activism occurred in the early seventies, with prominent organizations led by students and/or other former members of New Left organizations (Adam 1987; Marotta 1981).

Along with the New York based GLF, the Gay Activist Alliance (GAA) seized dominance of the movement from the Homophiles, and successfully campaigned for reforms of anti-Gay policies. Powerful institutions which had previously served to control and limit Gay and Lesbian life bowed to the political pressure brought to bear by Gay liberationists both from outside and within the organizations under challenge. Two such organizations undergoing forced change were the American Psychiatric Association with their 1973 decision to de-medicalize homosexuality and the federal Civil Service system which ended its anti-Gay ban in 1975 (Adam 1987; Marotta 1981; D'Emilio 1983).

Expanding on more traditional reform tactics directed at systems of social control, younger, more militant Gay liberationists created new tactics. "Coming out," or the public declaration of one's status as "Gay," was a major political consciousness raising tool of the movement. Additionally, advocacy around issues such as ending police entrapment and stopping Gay bar harassment reflected the agendas of a primarily male Gay leadership (Marotta 1981; D'Emilio 1983).

During the Gay liberationist period, other segments of the social movement sector were also expanding. For example, in the early seven-
ties, a well articulated and often separatist Lesbian feminist movement emerged (Taylor and Whittier 1992; Echols 1989; Ferree and Hess 1985; Bunch 1978; Raymond 1989; Faderman 1981; Wolf 1979). Many Lesbian feminist were frustrated both by the sexism of Gay male activists and the homophobia of heterosexual feminists. Not withstanding this frustration, Lesbians remain active in Gay liberation and women's activism often taking leadership roles in each movement.

The women's health movement (Marieskind and Ehrenreich 1975),--a spin off from the feminist movement-- also originated within this time frame and It provided both ideology and tactics that later would be utilized by AIDS activists of the 1980's (Boston Women's Health Book Collective 1984). Feminist health care activists emphasized wholistic approaches to wellness care, advocating for patients' rights, increasing consumer health education and rising scepticism directed towards the dominance of the traditional medical establishment and the physician's role as expert (Boston Women's Health Book Collective 1984).

In sum, Gay liberationists set a precedent within Gay and Lesbian politics for militant action that would re-surface in the late 1980's and early 1990's with the direct action approaches of such groups as the AIDS Coalition to Unleash Power (ACTUP) and the Gay and Lesbian civil rights organization Queer Nation. Like their Gay Liberation counterparts, the newer groups of the 1990's are dominated by students and other young people, though movement leaders like Larry Kramer of ACT-UP are well established movement veterans (Kramer 1989; ACTUP 1990).
Larry Kramer has been a founding member of two of the most influential AIDS organizations in the United States. In 1981, Kramer along with other concerned Gay men formed New York City's Gay Men's Health Crisis (GMHC), still in service today, GMHC is the largest AIDS service organization in the world (Perrow and Guillen 1990). In response to his own criticism of GMHC policies and politics, and under fire from members, Kramer founded the direct action organization the AIDS Coalition to Unleash Power (ACTUP). ACTUP is committed to confrontation strategies and dedicated to improving access to treatment for HIV infected people.

The Gay and Lesbian Civil Rights Movement

The period just preceding the emergence of the AIDS crisis witnessed an expansion of Gay and Lesbian organizations and further institutionalization of movement goals (Adam 1987; Cavin 1990). The groundwork established throughout the 1970's and early 1980's would serve as an invaluable basis for later AIDS organizing. Organizations, leaders, communication networks, and funding strategies developed in this period would later be utilized by subsequent AIDS activists.

In the late 1970's and early 1980's, national organizations led by professional veteran activists began to orient the movement towards a more liberal reform agenda. This new agenda concentrated on issues of civil rights protection for Gay men and Lesbians as well as legal reforms (Adam 1987). In addition to national organizations including the National Gay and Lesbian Task Force, Lambda Legal Defense Fund, Gay
Rights National Lobby, and the Human Rights Campaign, a myriad of other locally organized Gay and Lesbian groups developed around issues such as political affiliation, spirituality, sports, health care, and other social and recreational activities (Adam 1987). Gay and/or Lesbian bookstores, restaurants, music festivals, churches, and even bowling leagues proliferated in many major urban centers.

This era marks a period within Gay and Lesbian activism when culture building was a primary strategy used to further the movement's goals of legitimization. Throughout the 1970's and early 1980's the building of institutions within Gay and Lesbian-feminist communities increasingly consumed the energies of activist members (Adam 1987; Taylor and Whittier 1992; Taylor and Rupp 1992).

Beginning in the mid-seventies, Gay and Lesbian communities were also able to assert local political clout in progressive urban centers such as San Francisco and other smaller California communities (Shilts 1982; D'Emilio 1989). This political strength scored numerous election victories for acknowledged Gay or Lesbian political officials (Adam 1987; Shilts 1982; D'Emilio and Freedman 1988; 1990). The access to partisan politics established by the Gay and Lesbian civil rights movement provides resources valuable to later AIDS organizing.

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18 The most visible of the early candidates was San Francisco's Harvey Milk. Milk was elected to the city's Board of Supervisors in 1977 as an openly Gay man. He was assassinated November 27, 1978 by former Supervisor Dan White (Adam 1987; Shilts 1982).
Initially, Gay and Lesbian civil rights organizations made concrete demands on the U.S. government by advocating for anti-discrimination legislation at state and local levels (Altman 1988). Annually since 1975, the "Gay and Lesbian Civil Rights Bill" has been introduced with little success to the U.S. Congress, but it has, in the meantime, garnered a growing number of cosponsors. Lesbian custody rights were pressed for and sometimes won in state and federal courts. Demands increased to end employment discrimination by the federal government and the U.S. military. Movement demands shifted somewhat to meet the need for anti-HIV discrimination laws after the AIDS crisis emerged. The fight to ease the social stigma attached to a Gay or Lesbian sexual identity was easily expanded to be inclusive of struggles against anti-HIV stigmatization by people living with HIV disease.

Beginning in the early 1970's, local grassroots organizations around the country began to mobilize their constituencies for annual Gay pride marches in commemoration of the Stonewall riot each June. Using tactics popularized a decade earlier by the civil rights movement, Gays and Lesbians organized massive national mobilizations in 1979 and 1987. Local organizing has already begun for the next national Gay and Lesbian march scheduled for April 1993 in Washington D.C..

The 1987 "March on Washington," with a crowd estimated by organizers at over 500,000, featured the first display of Cleve Jones' The Names Project quilt. The Names Project quilt is an international effort that honors individuals who have died HIV infection-related deaths (Ruskin...
1988). The outpouring of support and emotion engendered by the Names Project at the 1987 march is one measure of the interconnectedness of the struggles against AIDS and for Gay and Lesbian civil rights (Krauss forthcoming).

Gay and Lesbian Communities Respond to AIDS

AIDS scholars generally agree that the introduction of the AIDS crisis has brought a re-medicalization and re-marginalization (Gilder 1989) of Gayness (Chauncey 1989; Epstein 1987; Adam 1986). After initial defensiveness and denial of the scope of the problem visited on the Gay community by the HIV crisis, a massive mobilization of community resources occurred in the larger urban centers (Shilts 1986; Kramer 1989). The sexual freedom many Gay men either experimented with and/or embraced in the 1970's turned first to fear for their own well being and the health of others. This fear turned to anger and thousands of previously non-political Gays turned to activism (Cavin 1990; Altman 1988). Along with tenured Gay and Lesbian activists they developed and sustained AIDS organizations (Adam 1987; Patton 1985).

Initially, the dual geographic epicenters for the AIDS crisis in the U.S. were located in New York City and San Francisco, California. Consequently the oldest SM0's and best developed AIDS organizing has occurred in epi-center locales. Founded in 1981, one of the earliest and best known AIDS specific organizations is the New York City based Gay Men's Health Crisis (GMHC) (Kramer 1989; Altman 1986; Shilts 1987). GMHC has grown into a complex organization with a multi-million dollar
annual budget and hundreds of paid staff members (Perrow and Guillen 1990).

GMHC drafts its leadership as well as thousands of volunteer staff from the Gay and Lesbian communities in the New York City area. GMHC has been extremely successful in producing multi-million dollar fundraising events. For example, in April 1983, GMHC held a gala fundraiser at New York City's Madison Square Garden and 18,000 people attended (Panem 1988). A direct services organization that also provides AIDS education and prevention, GMHC is somewhat ironically a model of the volunteerism ideal extolled by the Reagan and Bush administrations (Altman 1988).

The local response in San Francisco produced a vast network of organizations rather than a single lead agency (Perrow and Guillen 1990; Arno19 The differences in response between N.Y.C. and S.F. are at least partially a consequence of how local and state governments reacted to the crisis. The response in San Francisco came earlier with more local resources (Perrow and Guillen 1990).

One of the best known San Francisco organizations is the Shanti Project, which provides a wide variety of services for PLWAs (Shilts 1987; Altman 1986; Perrow and Guillen 1990). The development of the Shanti Project in many ways mirrored that of GMHC. Using funds originally raised within the Gay community, Gay male leaders guided the organization to increasing levels of bureaucratization and moved Shanti

from its initial focus on counseling for cancer patients to a sole concentration on assisting those men and women experiencing HIV disease (Perrow and Guillen 1990).

Hospice of San Francisco was another organization in the San Francisco community. Though founded prior to the onset of the HIV crisis, it became AIDS focused as the epidemic progressed (Arno 1986). All of the early AIDS specific organizations mobilized large cadres of agency trained, primarily Gay male volunteers to augment organizational staff and conduct activities. A very diverse set of programs are provided by AIDS specific organizations, ranging from HIV education for the general community and safer sex forums for targeted at risk populations, to direct client services like home health care, respite care, housekeeping, laundry, shopping, and even care for people's pets (Arno 1986; Rounds 1988; Shaw 1988).

Nationwide, AIDS organizations have been able to tap substantial resources by appealing to their local Gay and Lesbian communities. In the AIDS epi-centers, fundraising within the Gay male and celebrity communities contributed significant numbers of dollars to the financial status of many AIDS (Perrow and Guillen 1990; Kramer 1989; Shilts 1986). For example, Rock Hudson, shortly before he died, launched the American Foundation for AIDS Research (AMFAR) with a $250,000 donation. Elizabeth Taylor is AMFAR's national chairperson (Shilts 1987).

The early and massive mobilization of trained volunteers by AIDS specific organizations served to reduce the overall costs of HIV/AIDS
services while still requiring significant governmental and private foundation support to sustain their efforts (Arno 1986; Perrow and Guillen 1990). Patient services like "buddy programs" provide HIV infected individuals with practical support including transportation, shopping, laundry, and house cleaning services. These services are increasingly expensive to buy from health care and social service providers (Johnston and Hopkins 1990).

It must also be noted that many existing non-constituency institutions incorporated the AIDS agenda into their ongoing activities out of a sense of "moral entrepreneurship" (Tierney 1982). The blood banking system, many alcohol and other drug treatment facilities, nursing homes, hospices, hospitals, family planning agencies, and sexually transmitted disease clinics are all non-constituency institutions that were forced by medical and economic pressures to adapt their programs to meet the changes precipitated by the HIV epidemic.

After a slow initial response, the American Association of Blood Banks mobilized a nationwide AIDS awareness campaign in addition to the massive HIV screening program they conduct (Panem 1988; Shilts 1987). Alcohol and drug treatment programs provide AIDS education and risk assessments for clients as well as offering HIV testing and counseling services. Similarly, others delivering health care service have added HIV screening and/or education to their organizational activities.

In the high HIV prevalence areas, AIDS social movement organizations, like GMHC in New York City or the Shanti Project in San Franci-
co, arose out of the Gay male community in a response to the direct service needs of HIV infected individuals and the informational deficits found in both the Gay and general communities. Many AIDS SMOs in the major east and west coast epi-centers were led by a cadre of professional staff, often trained through their involvement in earlier Gay and Lesbian organizations (Altman 1986; Shilts 1986; Kramer 1989). These AIDS SMO's were successful because they tapped into a pre-existing network of social and political organizations.

Additionally, a new generation of Gay and Lesbian activists who had not previously been attracted to political organizing were mobilized and came in positions of involvement and leadership within the new movement (Cavin 1990; Altman 1988). Gay activists mobilized local resources with the creation of huge volunteer labor pools and by tapping local Gay fundraising sources (Patton 1985; ACTUP/NY). Eventually, local, state, and federal government funding was added as accessible financial resources increased (Panem 1988; Arno 1986; Himmelstein and Zald 1984). Gay and Lesbian Volunteers are mobilized to participate in local service organizations and AIDS Task Forces. Groups like AIDS Coalition to Unleash Power (ACTUP) attract small and dedicated cadres of individuals to direct action, where as an organization like the Names Project Quilt has involved tens of thousands of individuals in the making of quilt panels dedicated to lovers and friends (ACTUP/NY 1990; Ruskin 1988; Warner forthcoming).
Nationally, and in the epi-center cities, the AIDS crisis has fundamentally changed the relationship between government and the Gay and Lesbian communities (Patton 1985; Shilts 1986). The response of government was most aggressive in San Francisco. The S.F. County Health Department established a Task Force to deal with the emerging syndrome in 1981 (Panem 1988). Mayor Diane Feinstein made AIDS a clear priority by stressing the way this disease affected the whole city bureaucracy (Altman 1986). In New York, Mayor Ed Koch did not prioritize AIDS (Shilts 1987; Perrow and Guillen 1990). New York City did not appropriate its own funds for AIDS until 1983. By this time San Francisco was spending 4 million dollars of city money (Perrow and Guillen 1990; Arno 1986).

Gay dominated AIDS organizations have become legitimate players in local, state and national politics using tactics designed to include their voices in the process of government (Altman 1988). AIDS organizations are utilizing their pre-existing allies and liaisons in legislature and administrative branches of government, while pressing the judiciary for legal reforms to protect against anti-HIV discrimination. AIDS has forced governmental recognition and legitimation of Gay groups. The goals of the AIDS movement include increased funding at all levels of government for patient care and services, HIV education and prevention as well as increased resources for medical research and the development of effective treatments. This political agenda serves to place AIDS activists at the forefront of a much larger national debate on how to respond to the collapse of the American health system (Johnston and Hopkins 1990).
In the remaining chapters I turn to an analysis of the movement to combat AIDS in Ohio, and will review the similarities and dissimilarities between the emergence and institutionalization of AIDS organizing in the epi-centers and Ohio. I will argue that Gay and Lesbian actors, though crucially important, lack the political power base in Ohio which was present in many of the high HIV prevalence areas (i.e. New York City, San Francisco, Los Angeles) and that forced public health agencies and local political players to take greater responsibility for AIDS organizing. This, as we shall see, had important consequences on inter-organizational competition and the strength of the AIDS movement in Ohio.
CHAPTER IV
MOBILIZATION IN OHIO: INTER-ORGANIZATIONAL COOPERATION
AND COMPETITION

INTRODUCTION
My analysis of cooperation and competition within the Ohio AIDS SMI will rely heavily on assumptions made by the resource mobilization (RM) perspective. This perspective, in contrast to grievance based models (Gurr 1970; Turner and Killian 1972; and Smelser 1963), emphasizes organizational structure rather than psychological processes (McCarthy and Zald 1977). Classical social movement theory prioritizes notions such as the ideology and generalized beliefs. Further, classical approaches view the mobilization of movement participants to be a consequence of psychological factors, whereas, resource mobilization theory focuses on the dual issues of societal support and constraint of activism (Turner and Killian 1972; Smelser 1963).

In this chapter, I will examine how Ohio's AIDS SMOs both cooperate and compete inter-organizationally. Choosing cooperative rather than confrontive relations with other organizations in the AIDS industry has consequence for the strategic decision-making of participating groups. My analysis will show how SMO efforts to mobilize resources inevitably prevent the mobilization of a different set of opportunities for activism around AIDS education and service.
Scholars writing in the resource mobilization tradition have noted the importance of external support for the activities of social movement organizations (Jenkins and Perrow 1977; Barkan 1979). External environmental forces influence SMO choices regarding strategies and tactics, while also mitigating the facilitation or control efforts of authorities. As described in Chapter Three, the external environment may be either nurturant or hostile to the emergence of social movement activities, thereby facilitating or blocking their efforts. Drawing from these ideas, my intent is to examine how, at the time of this research interplay between the Ohio AIDS SMI's goals and available resources facilitated both cooperation and competition among its social movement organizations. Linkages between organizations will be considered. Additionally, I will outline the key role of local and state government as a con force.

Dilemmas of the Ohio AIDS Social Movement Industries
Attempts to mobilize elusive resources produce many of the strategic, tactical and organizational dilemmas faced by social movement organizations (Barkan 1979). Barkan (1979) found that SMO's must make strategic choices which inevitably emphasize the utilization of one set of resources at the expense of others. For SMOs in Ohio's AIDS social movement industry, two such dilemmas are paramount. First, AIDS SMOs must mobilize a membership and raise money to support the activities of their organizations. Movements need tangible resources - money, space and a way to publicize the movement's existence and ideas - in order to survive (Freeman 1983). People are the primary intangible resource
relieved on by the movement. Ohio's AIDS activists and volunteers, very necessary to the survival of most SMO experience a unique set of incentives and disincentives to their participation in the movement.  

Secondly, organizations must achieve legitimacy within their own geographic region, in order to negotiate relationships with other SMOs, the media, the government, and interested groups and/or individuals who have an interest in AIDS issues. These negotiations, particularly in communities where more than one AIDS SMO exists, are played out between organizations as struggles over geographic and/or programmatic "turf." To be successful, an AIDS SMO must establish itself as a legitimate participant in the local AIDS social movement, and the larger community.

The ability of any given SMO to mobilize tangible and intangible resources is mediated by its success in presenting itself as a legitimate representative on behalf of the larger cause it is pursuing. Because of the stigma and fear associated with HIV, AIDS leaders - like other SMS activists - have to legitimate not only their organization the cause they represent. Strategic decision-making shapes tactical choices made by movement leaders. The need for legitimacy often encourages compromise.

In the Ohio AIDS SMI, leaders face substantial organizational obstacles as a consequence of limited budgets, small or nonexistent staffs, and virtual isolation from the local mainstream political process.

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20 These issues are discussed at length in Chapter Six.
Most of Ohio's SMOs are consumed on a day-to-day basis with organizational survival, struggling to make the goals of their individual groups a reality. Though more isolated in the rural and small town regions, Ohio's AIDS activists do work within supportive networks of individuals and organizations. Supportive networks create a local context within which AIDS activism can be nurtured. To make up for limited resources and the lack of external support, the strategies of coalition building, networking, and inter-organizational cooperation are central to the AIDS movement.

INTER-ORGANIZATIONAL LINKAGES AND COALITIONS

The Ohio AIDS social movement is not unified. There is no federation of organizations, nor are there formal ties defining shared organizational purposes. The social movement industry is not dominated by a single social movement organ. Nor is the movement dominated by a particular individual leader. Further, the movement is decentralized. A variety of SMOs have emerged around the state and where linkages exist, they are held together by mutual interest in participation in response to the AIDS epidemic.

More specifically, social movement organizations are linked through both individual and institutional supportive constituencies (Zald and McCarthy 1980). Linkages for AIDS SMOs exist on at least three levels. First, linkages exist with non-AIDS specific organizations and public interest groups based on their common connection to the AIDS crisis as health care and other service providers, these include local Health
Departments, local American Red Cross chapters, hospitals, nursing homes, hospices, churches and universities. The financial resources dedicated to AIDS education and services by Ohio's non-AIDS-specific organizations are substantial.

For example, in Columbus Ohio, in 1990, the local chapter of the American Red Cross offered an in-house AIDS education program that consisted of one full-time staffer, and over 40 trained volunteer staff doing an average of 15 AIDS education sessions per month.\(^2\)

Coalitions within the Ohio AIDS social movement industry most often form when temporary alliances are created for the purpose of a limited activity, such as a conference or fundraising activities. For example, a paid staffer working in a small town community speaks of the cooperative relationship existing between her organization and the major local hospital.

St. Gregory's Medical Center has its own AIDS Task Force, primarily to do work within the hospital confines, but they also co-sponsored some of the educational services and things like that.

Secondly, AIDS Task Forces and service organizations - in locations where more than one such enterprise exists - are linked to one another. At this level linkages may be born out of common origin or may develop over time following the emergence of multiple organizations. Interorganizational relationships range from supportive and collegial to openly hostile and contentious. Some more rural regions within Ohio lack these linkages because only a single group has emerged (Miller

\(^2\) Information provided by Director of Health and Safety Services, Columbus chapter, American Red Cross.
As another example, in one urban center, the executive director describes how her agency helps facilitate the emergence of new organizations by providing consultation and in the sharing in the documentation of her agency's organizational development.

We have... been doing consulting with (new) Task Forces all over Ohio. I keep a list. I think we've worked with twenty-five different Task Forces, just in Ohio. And helping them with organizational development stuff, including personnel policies, and (Task Force) by-laws and structure. These resources include dedicating staff members (full or part time) to HIV prevention or patient care tasks, as well as conducting in-house HIV education and policy development. It is necessary to include these multi-issue agencies in any analysis of the industry.

A second illustration of inter-organizational linkages reports cooperative fundraising efforts. The executive director of a dominant organization in a large urban center describes the climate for collaboration in his city.

    For major affairs like the Gay pride dinner, or if there's a major fund raiser, they'll (AIDS groups) come together. Other than that, we're pretty separate.

Coalitions between social movement organizations do not occur randomly, but instead form in somewhat predictable ways. Coalitions benefit SMOs by creating relations that sustain component organizations and encourage individual involvement and commitment (Ryan Forthcoming). Coalitions enhance SMO visibility, and when successful, also may build organizational legitimacy; thereby expanding a group's ability to recruit and retain members.
At a third level, individuals are linked to the larger Ohio AIDS movement. Both beneficiary and conscience constituencies are mobilized by an unique set of incentives that facilitate their commitment. Coalition work helps build and sustain support for movements through shared constituencies (Kreisberg 1988). The personal networks out of which beneficiary and conscience constituencies are mobilized are of special importance.

AIDS industry membership overlaps with the membership of other related organizations within the larger social movement sector. This is particularly true for activists involved in the struggle for Gay and Lesbian rights (Rofes 1990; Vogel 1990). A Lesbian activist, and past president of her local Gay and Lesbian civil rights organization, discusses her own activism in the larger Lesbian and Gay movement.

I just would like to see more people doing both (Gay and AIDS activism). For AIDS organizations, for individual Gay men and individual Lesbians, you can't, in my opinion, I can't separate the two. I give money to the (AIDS) Task Force, I donate services to the Task Force, I donate services to various AIDS organizations at various times, and certainly try to be supportive in that way. Yes, (the Gay and Lesbian civil rights group) is my primary organization, but certainly I'm involved on some level with all these other ones.

In areas of Ohio where multiple AIDS SMOs exist, there are often overlapping memberships. Many times volunteers serve more than one agency. Organizational policy can facilitate this overlap. Often times, volunteers and/or staff members of one local AIDS organization will serve as a committee member for another agency or organization. Activists in the community may end a term serving as a board member for
one organization, and later take a seat on a board serving a different AIDS organization. An executive director of a large AIDS SMO notes her agency's involvement with other organizations working with AIDS concerns.

We, the staff and myself, sit on a million committees for other organizations, like I'm on the hemophiliac advisory committee, the AIDS Red Cross subcommittee, the dental committee, that's the state Health Department too, the city's AIDS coalitions public relations committee, we serve on the education, you know all those different organizations were represented on committees.

Over time, organizations may even exchange leadership. This can be a point of conflict. Consider one PLWA's experience.

I was on the (AIDS) Task Force for a while too. Until the AIDS service organization told me I had to resign. Because I was on the board of the AIDS service organization at the same time... And then, the board elected me on and I went back to the AIDS service organization and told them I am a PWA alternate rep with the Task Force now. And then the President of the AIDS service organization called me and told me it was a conflict of interest and that I should make a decision on which board I am going to serve on.

Beyond the already mentioned environmental conditions that affect coalition emergence - coalition building may meet the needs of individual organizations by providing opportunities to conserve limited resources or share resources with other more resource-rich organizations (Staggenborg 1986). Staggenborg demonstrated this pattern in her study of the abortion rights movement. Staggenborg notes that considerable organizational stress is created, however, through involvement in coalition maintenance efforts. Coalitions breakdown when ideological conflicts occur and/or when contributing organizations determine
coalition members are not equitably supporting the coalition (Kreisberg 1988; Staggenborg 1986). Longitudinal research is necessary to evaluate the success of coalition maintenance within the Ohio AIDS SMI over time.

**Inter-organizational Cooperation**

Among leaders within the AIDS industry, considerable discord exists regarding the motivations for supporting inter-organizational cooperation. Some movement leaders view inter-organizational cooperation with a cynical eye, and attribute participation to organizational self-interest. From this perspective, cooperation is motivated not by a philosophical commitment to coalition formation, but instead by what are the practical short term and long term benefits of such alliances.

Speaking for the pessimists, an activist from Ohio's Hispanic community says:

> Efforts in collaborating are purely practical. You know, that it's in the best interest to get a lot of support from the big institution and then the big institution feeling like well, we may tap into some funding here, or we've been getting pressure from this one group. So let's make the overture - at least on paper - that we're working together. I think there's a sincere effort there. People that do want to work together, but it seems sometimes to be more motivated by what you can gain versus how can you really work together.

A small city health commissioner (who also serves as president of his area's AIDS Task Force) is spokesperson for the optimists.

> For some reason it seems that the people on the Task Force can, even though they may be in agencies that compete with one another on the outside, but they laid down their swords at the door and come in and work together just to try to do everything we can do for people with the HIV infection. For the community. I've never noticed any riffs whatsoever, none.
Perceptions of conflict and cooperation vary among movement activists. Regardless of the motivations that produce cooperation, an examination of its consequence is warranted.

Inter-organizational cooperation can occur at multiple levels. Zald and McCarthy (1980) have proposed a multi-stage cooperation continuum by which to measure the degree of cooperation existing in a given social movement industry. At one end of the cooperation continuum minimal "ad hoc" exchanges take place between lower-level SMO personnel. At this stage members of one organization utilizes the services, products and/or facilities of competing organizations.

For example, virtually all of Ohio's AIDS service organizations and Task Forces have ad hoc relationships with the Ohio Department of Health and their local chapter of the American Red Cross. These two agencies produce and distribute a wide variety of free informational materials designed to facilitate AIDS awareness and educational activities. Copies of free materials can be received from the Ohio Department of Health, AIDS Activities Unit, P.O. Box 118, Columbus, Ohio 43266. American Red Cross materials are distributed through local chapters. Materials from both these sources include informational pamphlets and posters. The Ohio Department of Health provides monthly AIDS case statistics as well as "fact sheets", bibliographies and periodic analyses of surveillance data. The American Red Cross conducts informational sessions, trains HIV educators and has a series of HIV-related educational video tapes. Both the American Red Cross and the
Ohio Department of Health receive direct federal funding to support the
distribution of AIDS materials. These resources are intentionally eas-
ily cooptable.

Participation in ad hoc relationships is not always practiced by the
administrators of the well established organizations because of inter-
organizational competition for resources and legitimacy. Organizations.
An administrator of a large urban AIDS SMO notes this tension:

I think there's a real sense of cooperation particularly at
the staff level. I think when you start getting into the
director levels and stuff, we're all busy playing our poli-
tics and our turf issues because that's our job to protect
our organizations, and I think that you have less coopera-
tion at that level. And I have got to admit I've been
guilty before because I think this is the best AIDS orga-
ization and I've got to fight for my resources. But I think
on the other staff level they're much more cooperative.

Even when staff is aware of policies that restrict their inter-
organizational contacts, they may choose to form ad hoc relationships,
despite the policy. This AIDS educator discusses the risks associated
with engaging in networking that is not sanctioned by the organization
s/he represents:

The fact is that most of us take a risk, (by) working in
agencies that put some type of restraint on us ... but we
learn to work around it. ... I do know that in some agen-
cies, they're told not to do these kinds of things. So the
people take the risk anyway, and network anyway.

This same individual goes on to describe her ad hoc cooperation strat-
egy of exchanging pamphlets for condoms.

What we worked out was when they needed something from me,
like brochures, I'd gather up brochures for you, you bring
me condoms. We just do it, we don't tell anybody about it.
Zald and McCarthy's (1980) cooperation continuum is premised on the assumption that social movement organizations working within a given SMI will develop differentiated but interlocking roles. Increasingly cooperation between AIDS agencies is facilitated by efforts to coordinate and create rules governing organizational interchanges. Coordination attempts often produce interagency committees or liaison groups to monitor relations (Zald and McCarthy 1980). In all of Ohio's larger cities, interagency committees have, at some time on some level, been formed. Interagency committees allow for communication between organizations on issues such as task specialization. This is the process, noted by Zald and McCarthy, whereby organizations carve out "organizational niches" that they can dominate. The lines of demarcation between "niches" in the Ohio AIDS social movement industry relate to whether a group specializes in HIV prevention and/or service provision.

An administrator for a small rural AIDS organization related how she had successfully coopted training resources from her local American Red Cross chapter. This helped to establish her organization as the dominant provider of HIV education. She recounts how the Red Cross' education coordinator had solicited her involvement.

(S)he called ... and said "please, take this course, we'll pay for it, take it - that way you can do this stuff and we don't have to do it. You do it anyway, you do a good job at it. You might as well do it for the Red Cross too."

"Niches" separate organizations that specialize in AIDS education from those focusing on provision of services for HIV infected individuals. Some organizations provide both sets of services. These SMOs
tend to exist in communities that have only one organization dedicated to AIDS work, or where one group overwhelmingly dominates access to AIDS specific monies and other resources.

The Centers for Disease Control and the National Institute for Drug Abuse were major federal funding sources. The Robert Wood Johnson Foundation also made specific requests to fund AIDS activities in racial and ethnic communities. In the mid-1980's, specific monies became available from government and foundation sources to do AIDS education in so-called "minority" communities (Weisfeld 1991).

Often an issue like addressing AIDS in racial and ethnic communities provides the motivation for coalition formation. This is one example of how new "niches" are developed. The efforts to form interagency committees often mirror earlier strategies used to form SMO boards of directors. A leader in the African American Community discusses early efforts to form interagency "minority" committees around the state.

It was like all-star list of people from the community who would be interested. Very collaborative, very willing to work together... From churches to social service agencies, the Urban Leagues were involved, AIDS Task Forces were very, very involved ... local Health Departments, the STD (sexual transmitted disease) clinics, you name it.

The motivating force promoting task specialization is the need to avoid direct competition for limited funds. This AIDS activist noted how the prevention "turf" was divided in her community.

We've really worked hard to not go for funding in the same areas as everybody else, and to check with each other and say, "What are you doing? I'm doing women of childbearing age." If you notice no one in (her city) is doing women of childbearing age because I'm doing it. They'll help me do
it, but you didn't go for funding on that piece. Somebody else goes for teens.

Sometimes organizations are created to serve very specific needs. "Blood Sisters" recruits Lesbians to donate blood on behalf of Gay men who have been excluded as potential blood donors. An all-volunteer Lesbian feminist group "Blood Sisters" does not receive any outside funds.

More often task specialization occurred in direct response to SMOs perceptions of funding availability and shifting trends regarding "hot" fundable programming. A Gay man working in a region with multiple AIDS specific organizations competing for dominance of the AIDS "turf" explains how his priorities are based upon his recognition of transportation as a potentially fundable service.

I'm no fool. I'm looking at what services need to be provided that aren't being provided which can also be funded. Where can we find a niche that no one else is in? Everybody has jumped into support groups, I don't need to do that. (One agency) got case management. I don't need to do that. That's why we started going with transportation. No one has touched it.

Another administrator explains the motivation for cooperative inter-agency efforts and coordinated task specialization this way:

The rationale is pretty interesting. It says, there's a small pot of money, and if we all say we're going to do something different, maybe we also have a better chance of getting funded. Maybe we'll even get more money.

Task specialization and policy coordination only occurs in regions of the state where multiple groups and organizations have emerged.
Coalition participants include AIDS specific members of the Ohio AIDS SMI. Often, coalitions include allied organizations that invest some component of their larger organizational agenda to AIDS issues (i.e., hospitals, local health Departments, and local American Red Cross chapters). For example, a hospital may do staff inservices and serve infected patients, or a Health Department may provide HIV testing services or conduct youth education programs. When multiple AIDS SMO's exist within a community, the tendency towards task specialization is greater (Zald and McCarthy 1980).

"Domain consensus" exists when the level of policy coordination within a regional sub-section of the Ohio AIDS SMI becomes well coordinated, achieving a high degree of cooperation and task specialization (Zald and McCarthy 1980). It is possible for SMOs to reach improved levels of cooperation by working together to influence the external environment for mutual enhancement (Zald and McCarthy 1980). Changing circumstances, including fluctuations of outside money to support programming, promote instability within the SMI and can disrupt domain consensus (Zald and McCarthy 1980). In Ohio's major urban areas, varying degrees of domain consensus exist. An explicit explanation of domain consensus in particular cities would require a complete survey of all participating SMOs. This task is beyond the scope of this project.

One way a strategy of cooperation benefits SMOs is through the creation of program opportunities that utilize the resources of multiple
agencies. Annual events such as the World Health Organization's "World Health Day," "AIDS Awareness Week," designated by the Ohio Department of Health, and to a lesser extent, "National Condom Week," bring organizations together with the common purpose of promoting community awareness of AIDS education, prevention, and patient services. For instance, an agency might co-sponsor conferences, workshops, and/or educational campaigns cooperatively.

The "Names Project Quilt" has made numerous tours through Ohio. Often, AIDS specific and other allied organizations work cooperatively to bring the Quilt display to a particular location. One small AIDS SMO working in a rural Ohio region brought a segment of the Names Project to their town with the resources of two larger AIDS SMOs in cities more than 100 miles away. An individual working with a small town AIDS SMO explains:

The Methodist minister brought part of the Quilt here when it was in the Cincinnati/Columbus circuit. We got part of it here. We went to Cincinnati, and picked it up and displayed it here. And then we brought it back to Columbus. So we saved lots of money - (those) guys paid the shipping and we benefited from it.

As was described earlier, organizations will pool resources to produce educational workshops, seminars and conferences. Formal participation in joint programming is a mark of a high level of inter-agency cooperation. This cooperation allows for the attraction of greater media coverage, better community participation and the ability to bring nationally recognized AIDS experts to speak to local communities. SMOs may contribute money, staff time, space and/or their organ-
ization's credibility to coalition efforts. This is one strategy agencies use to build legitimacy within the larger social movements sector.

One small town AIDS SMO established a cooperative effort with the area's emergency hotline provider. The AIDS SMO's executive director explains:

(W)e got an AIDS component for their (the hotline) volunteers, so that when they get a phone call... they have a list of task force member volunteers who will be available from 4 to 11 pm in case there's an emergency and they need to talk to somebody.

The Ohio AIDS SMI is well established. In areas where multiple organizations are participating in various types of AIDS prevention programming and service provision, formal and informal domain agreements and exchanges emerge (Zald and McCarthy 1980). Most of Ohio's AIDS SMOs share relatively similar conceptions of their goals and acceptable tactics. This further facilitates cooperation. Organizations who have worked out issues of task specialization and domain consensus benefit the most from collaboration.

COMPETITION WITHIN THE OHIO AIDS SOCIAL MOVEMENT INDUSTRY

Social Movement scholars have more often focused on the organizational analysis of cooperation rather than competition between SMOs (Zald and McCarthy 1980). The notion of establishing organizational "niches" within a social movement industry is again useful for explaining how competition is negotiated. SMOs operate in an arena dominated by the forces of "imperfect competition" where all players do not have equal
access to resources. This uneven playing field facilitates the establishment of specialized providers (Zald and McCarthy 1980).

For example, one activist complains bitterly about the access a competing organization has to decision-making within the local public Health Department.

The only reason they (the competing organization) got it (funding) was because he steers all the money to them, I mean he does, no question about this. Here is a clear conflict of interest where the former president of the Task Force who is still on their board is the person (from the local Health Department) who steers all the money from the state.

Dominance of a niche is one strategy used by SMOs to achieve legitimacy. It must be remembered that securing and maintaining legitimation is one of the key dilemmas faced by all SMOs. The major niches - education and service - are created by specialization, and a of strategic choices made by organizations to attempt to avoid competition. One special aspect of the service niche - housing for people with AIDS - has spawned numerous special focus SMOs. I will focus on two major types of competition which exist within the Ohio AIDS social movement industry. These are intra-organizational competition and inter-organizational competition.

Intra-organizational competition can produce changes in leadership, organizational priorities or structure. In extreme cases, schisms may emerge and new groups may be founded. Competition exists at the inter-organizational level within the various geographical regions of the state, particularly when multiple groups are engaged in AIDS-specific
activities. At this level, inter-organizational competition tends to be focused on issues of "turf", and again center on competition for limited resources and legitimacy.

SMOs compete because it is necessary to secure human and financial resources if an organization is to pursue its goals. Money is needed for staff, transportation, rent, office supplies, utilities, postage and the other necessities of maintaining visibility (Zald and McCarthy 1980). Organizations also compete for human resources. Volunteer labor is of vital importance to Ohio’s AIDS social movement organizations. The more complex and formal an organization becomes, the greater are its financial and human resource needs.

SMOs compete for resources controlled both by organizations and by individuals (Zald and McCarthy 1980). Competition effecting the Ohio’s AIDS social movement includes not only AIDS SMOs, but also involves those non-constituency institutions outside the social movement sector with goals related to the AIDS crisis that are not AIDS specific (Freeman 1983).

**Intra-organizational Competition**

As discussed earlier, some new organizations form out of cooperative coalition efforts that begin with that purposive goal. Other organizations form out of intra-organizational conflict. Schisms within the Ohio AIDS SMI are not uncommon. A current Task Force president recounts the split which occurred early in her organization’s history. Two factions in the local Gay men’s community had a pre-existing pat-
tern of combative relations. Strong leaders from each faction initially attempted to work together on the AIDS crisis. Old agendas regarding sharing power within the group flared and an organizational schism occurred.

Now when people come into it (her organization) who did not like things, they split off... (the leader of the new group) got angry and moved off and did his own thing.

Conflict over the prioritization of SMO goals is a consistent source of tension that facilitates schisms. In one community, housing for people with AIDS was the issue being debated.

The second faction of folks said, "Well we think you ought to be doing housing". The Task Force (is) saying "We don't have the resources to do housing". So (the competing faction says) "We'll just start our own... and there was a real split with the volunteers, some stayed with the Task Force and some (joined the new organization focused on housing).

The breakaway group went on to develop a residential facility for people living with AIDS. The original organization continued to pursue its pre-existing goals.

Conflict at the intra-agency level does not inevitably lead to schism. Some organizations experience significant levels of intra-agency strife and continue to maintain their respective programming and AIDS-related focus. One staffer describes her position in an organization were AIDS is only a small component of a much larger multi-issue community health education program.

I think the political situation was interesting. I knew the political situation outside of the agency. It was the inside politics that I had neglected to look at.
This individual was disappointed by what she perceived to be a devaluing of the AIDS agenda within the organization, and by her immediate supervisors. She was consistently dismayed to discover the agency had other priorities than AIDS.

Expanding membership can lead to increased internal conflict and intra-organizational competition for control of the group (Friedman and McAdam 1987). Leaders within organizations are often confronted by internal divisions within their own agencies. Issues for debate may include challenges to leadership, changes in organizational structure such as the addition of paid staff or expanding the SMO’s goals by soliciting government or private foundation grant money. One activist decries this trend.

And then as new people get involved it’s like, "No we outta be like this," or "No we ought be doing this." So it caused splits in programs. Our fighting isn't directed at one entity now, the disease and the discrimination around it. There's more in-fighting among organizations I think, (over) turf and dollars.

A Gay activist describes the potential for competition across boundaries between the AIDS and the Gay/Lesbian civil rights movement.

Well, I think it (competition) could really go either way. It's going to depend on the specific organizations and the specific people involved because I certainly see a potential for problems - fighting and "you took my fundraiser" and that kind of thing. I think it's going to take careful work and coalition building between the two types of organizations (Gay and AIDS) to make sure that doesn't happen.

Nationwide, competition for Gay dollars between AIDS and civil rights SMOs is a particularly volatile issue in some communities (Rofes 1990). Some veterans of the Gay and Lesbian's civil rights struggle decry the
meager community support shown Gay political organizations. In contrast the AIDS issue has been capable of mobilizing much larger fundraising events and payoffs (Shilts 1989; Altman 1989; Kramer 1989).

**Inter-O rganizational Competition**

Inter-organizational competition, where it does exist, manifests itself on the three levels of inter-agency linkages discussed earlier. To review, these levels of linkages include: inter-agency links between AIDS specific organizations and nonconstituency institutions; inter-agency links between AIDS specific organizations; and links between AIDS SMOs and their beneficiary and conscience constituencies (Freeman 1983 and McCarthy and Zald 1977).

Inter-organization competition for "turf" arises as organizations struggle to achieve and sustain legitimacy as SMOs. An activist shares her thoughts on how organizational motivations have changed over time.

> We all used to be fighting for the same thing. You know, we were fighting for rights. We were fighting for education. We were fighting for non-discrimination. Now we are just fighting. We are fighting for dollars. We're fighting for "my organization is better than yours is," or "I want to be the only (group) in town (so I can collect the dollars)."

For example, when the Ohio Department of Health began a process of issuing "Requests For Proposals" (RFPs) for AIDS grants targeting the "minority" community, agencies which had already formed coalitions and/or other cooperative arrangements were forced into head to head competition for a limited set of dollars. Inter-organizational conflict and
competition happens on a regional level within the local AIDS movement, and is sometimes focused within a paraticular sub-section of the local industry. An activist in the African-American community recounts her own experience.

I think what has happended, when we moved out of the that spirit of cooperation in communities of color then we moved into competition. And that competition was, "I have the same program that you do and I call it something different and we'll fight (to provide services) for the same people."

The vast majority of PWAs worldwide are men, women and children of color (WHO 1990; Sabatier 1988). Racism is a powerful social force which will increasingly influences the responses of government and AIDS activists to the HIV crisis. In larger North American urban areas, the HIV epidemic is rapidly becoming the major health problem for poor urban African-Americans and Latino/as (Fox 1990; Dalton 1989). AIDS organizing within communities of color are a microcosm reproducing many of the opportunities for strategic choice that exist within the mainstream of AIDS activism.

Inter-organizational competition also occurs as SMOs struggle to achieve and maintain legitimacy within their local geographical region. One SMO board president describes the struggle to maintain legitimacy this way.

It's all the normal fear you have that once you've established yourself in an area, you want to keep it. Even though our role should be trying to go out of business.

Those agencies that prioritize dominating the local AIDS industry adjust their tactical choices with this goal in mind. A common strat-
egy used to gain the advantage relative to legitimacy is linking your SMO with local public health officials and local government (McCarthy and Zald 1979; Zald and McCarthy 1987; Gale 1986). The primary benefit of this relationship is the ability to facilitate the sponsorship of SMO activities with government support (Gale 1986; Kriesberg 1988). The most significant cost of association with a local established agency can be a loss of independent leadership and ability to set goals outside of the sponsoring agencies' mission.

The linkages between AIDS activists and local government are often bridged through the participation of local Health Department officials in the emergence or later development of AIDS SMOs (McCarthy and Zald 1987). There may be an overlap of duties between paid Health Department staffers and movement leaders. Often times employees are able to use paid work time to conduct SMO business. Individual's participation may be either assigned time or coopted time.

A leader of a competing organization bitterly complains of what he claims is a "conflict of interest" existing in the relationship between the Health Department and the locally funded AIDS specific group.

The (Commissioner from) the city Health Department was the chair of the original Task Force, and (a senior staff member) had such a personal investment in the Task Force. And they're the ones who control all the state (AIDS) money and they will use their position to favor the Task Force to screw everybody else.

The perception among many of my informants is that competition for dollars, and the legitimacy they bring an organization, has brought
substantial change to the Ohio AIDS SMI. According to AIDS activists local Health Departments have also used AIDS concerns as leverage to increase their own legitimacy.

Until there was money and a perception of power, they (local Health Department's) didn't care, once the money and the power started they thought, this is an issue that was going to give them credibility. Something they could develop and make the Department grow. That's what they wanted, power.

The activist quoted above goes on to discuss how the desire to pursue increased legitimacy was strong enough to motivate local government to re-examine the barriers to participation in the AIDS crisis that stem from the stigma of "homosexuality."

I think (homophobia) is subtle. I really think power is more of an issue, and money, than homophobia. Homophobia prevented them (health officials) from getting involved in the early days. Money and power overcame homophobia... they approached gingerly and carefully until such a time as they saw that it would do them some good to be in the front line of AIDS. And that there would be money in it. They went for broke.

Linkages between the state Health Department and local Health Departments are consistently criticized by activists whose agencies have been "left out of the loop." The practice of passing dollars for local community based programming through the local Health Department comes under severe criticism. This activist works with an agency that is not recieving funding from the state Health Department.

We have no (Ohio Department of Health) money ... The bureaucracy and the strings, the politics they're crazy. (The Ohio Department of Health) has wasted more money, they have dumped all the money into Health Departments, they're throwing money around willy nilly and giving it to incompetent people. They don't even know how to manage the money. It's a zoo. It's a disgrace.
Another activist complains.

And the state Health Department dumps all the money into Health Departments, they won't do direct contracts with agencies any more. So they don't really do any work to figure out who's the most appropriate - they've delegated that to the Health Departments, and (they have) been totally incompetent.

The question here is not the appropriateness of Ohio Department of Health policy that consistently (though not exclusively) prioritizes the distribution of funding through local Health Departments. Rather, I am instead interested in its effects on the social movement industry. This policy ignited competition for resources between social movement organizations (Gale 1986). Organizations that achieved linkage with state and local government are able to make an important claim to legitimacy denied their non-funded competitors.

State government officials acknowledge that competition between SMOs is in large measure a consequence of state Health Department policy (Zald and McCarthy 1987). This state official offers the following insight.

(W)e, as a state Health Department (and the feds), did something that was very stupid, and that was put out this large pot of money and started choosing our leaders. And that's basically what you do. We choose who would be the lead people and kind of pushed other folks to the side. And everybody knows once you have a little pot of money and have people scrabbling for money, you end up with lots of bruises. Out of those bruises comes competition. A lack of cooperation. And in some areas actual monopoly.

Inter-organizational competition contributes an additional dynamic to the strategic challenges that face AIDS organizations. In Ohio, the
federal government, acting through state and local Health Departments, has been a major provider of funding and legitimacy to the movement. AIDS SMOs compete for the services of activists, for money and for legitimacy. Groups that are able to establish linkages with state agencies secure a certain set of advantages related to receiving funding for their programs. Whether or not this linkage will prove to be a long-term advantage will require further study. Government linked organization may be vulnerable to government cooptation of programmatic priorities and organizational goals. Further, these groups are highly vulnerable to demise when government funding levels drop or are eliminated.

Conclusions

Social movement organizations make choices about cooperation and competition when making strategic plans. Most groups attempt to maximize the benefits for their own organization. Some SMOs strategic plans are straightforward and underdeveloped, while other organizations dedicate considerable time and resources to the development of sophisticated tactical game plans. The crucial strategic question examined in this chapter relates to the issues of cooperation and competition within and among members of the Ohio AIDS industry.

Two major dilemmas face AIDS organizations as they participate within the industry. First, there are the practical tasks of mobilizing people and money to support each group, and, secondly, the challenge of achieving and maintaining legitimacy within local regions. People are
mobilized through beneficiary and conscience constituencies using a series of incentives that counteract the considerable disincentive to movement activism that exists around AIDS in this region. Organizations cooperate and compete within sub-sections of the Ohio AIDS industry that are regionally and programatically bounded. Within regions, local Health Departments act as government agents and play significant roles in determining who are the dominant organizations locally. Gaining dominance over the local AIDS agenda is one way movement organizations achieve and maintain legitimacy.

Though competition is a driving force in the social movement industry, the mutual benefits that result from creating inter-organizational linkages, collaboration, and cooperative exchange make networking a powerful tool for AIDS organizations. Again it must be noted that groups can utilize cooperative relations to gain and maintain legitimacy within the AIDS industry. Cooperation exists in many forms, and can range from informal "ad hoc" relations between agency staffers to more formal collaborative efforts that are designed to eventually create additional independent AIDS organizations.

Within the Ohio AIDS industry, organizations have developed an unique set of inter-locking roles and cooperative arrangements. External environmental factors strongly influence the motivations of organizations to participate in either cooperative or competitive endeavors. The trend in the Ohio AIDS industry at the time of this research demonstrated increasing tendencies to reward organizations for dominating
their regions, thereby fostering a climate that produced opportunities for competition, and discouraged cooperative relations. Still, the benefits of cooperation are not to be underestimated. Further long range study of these issues is necessary to determine what specific conditions most significantly contribute to the support or failure of inter-organizational linkages.
CHAPTER V

STRATEGIC CHOICES IN THE OHIO AIDS SOCIAL MOVEMENT INDUSTRY

OHIO AIDS MOVEMENT EMERGENCE AND DEVELOPMENT

Working in the resource mobilization tradition, Mayer N. Zald and John D. McCarthy significantly advanced the development of social movement theory with their 1980 work in which they differentiated between a social movement (SM), social movements organizations (SMOs), and social movement industries (SMIs). Zald and McCarthy's analysis is presented below. Within a social movement, individuals share goals without necessarily working towards those goals in concert. The boundaries of social movements are relatively undefined. Within a social movement, a sub-set of individuals may choose to pursue a specified set of goals in the context of an organization.

These social movement organizations (SMOs) evolve correspondingly clearer boundaries. When multiple SMOs develop, each pursuing somewhat separate agendas and nurturing discrete sets of supporters, a social movement industry is formed. This chapter seeks to use the Ohio social movement industry as a case study to further examine how macro sociological conditions influence movement emergence and the establishment of an ideology and set of goals.

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Gerlach and Hine's (1970) discussion of decentralized, segmented, and reticulate linkages within a SMI is appropriately applied to the Ohio SMI. In Ohio, SMO boundaries are most often geographically defined around single or multi-county regions (see Table One, "Organization by county, 1990"). The type of SM linkages that exist within the Ohio AIDS SMI are loosely structured.

During the first years of the AIDS epidemic the network of Ohio AIDS SMOs has grown and extended throughout the various geographical areas. In many cases individual SMOs provide services to multi-county areas of the state (see Table Two, "Increase in Ohio AIDS Organizations 1986-1991"). Each of Ohio's eight major cities - Cleveland, Columbus, Cincinnati, Akron, Dayton, Toledo, Canton and Youngstown have one or more AIDS SMOs. Many of Ohio's smaller towns also sustain AIDS SMO activity. Thirty-two of Ohio's eighty-eight counties have at least one AIDS Task Force, and/or service organization listed in a document prepared to facilitate networking by the Ohio Department of Health, AIDS Activities Unit published April 1, 1990.
Table 1

**Organizations listed by County, 1990**

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<th>Statewide</th>
<th>AIDS Task Force of the Episcopal Church for the Southern Diocese of Ohio, Ohio AIDS Coalition, West Ohio Conference United Methodist Church AIDS Ministry Committee</th>
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<td>Athens County</td>
<td>Athens AIDS Task Force</td>
</tr>
<tr>
<td>Auglaize County</td>
<td>Auglaize County AIDS Task Force</td>
</tr>
<tr>
<td>Belmont County</td>
<td>AIDS Task Force of the Upper Ohio Valley</td>
</tr>
<tr>
<td>Butler County</td>
<td>Middletown AIDS Task Force</td>
</tr>
<tr>
<td>Cuyahoga County</td>
<td>AIDS Commission of Greater Cleveland AIDS Housing Council, Cleveland AIDS Coalition, Health Issues Task Force</td>
</tr>
<tr>
<td>Delaware County</td>
<td>Delaware County AIDS Task Force</td>
</tr>
<tr>
<td>Erie County</td>
<td>AGAPE Friends Helping Friends, Erie County AIDS Task Force</td>
</tr>
<tr>
<td>Franklin County</td>
<td>AIDS Service Connection, Columbus AIDS Task Force, Columbus PWA Coalition, Community Free Job List, Education and Research, Minority Education Committee on AIDS</td>
</tr>
<tr>
<td>Greene County</td>
<td>Greene County AIDS Task Force</td>
</tr>
<tr>
<td>Hamilton County</td>
<td>AVOC Caracole, Inc., Northern Kentucky AIDS Task Force, Greater Cincinnati AIDS Task Force, Minority AIDS Prevention Alliance</td>
</tr>
<tr>
<td>Hancock County</td>
<td>Hancock County AIDS Task Force</td>
</tr>
<tr>
<td>Jefferson County</td>
<td>Greater Steubenville Area AIDS Task Force</td>
</tr>
<tr>
<td>Lake County</td>
<td>Lake County AIDS Task Force</td>
</tr>
<tr>
<td>Licking County</td>
<td>Licking County AIDS Task Force</td>
</tr>
</tbody>
</table>
Table One continued

Lorain County..............Lorain County AIDS Task Force
Lucas County..............Toledo AIDS Task Force
Mahoning County............Mahoning AIDS Task Force
Marion County..............Marion Area AIDS Task Force
Montgomery County..........AIDS Foundation - Dayton
                        Dayton Area AIDS Task Force
                        Minority Advisory Committee
                        on AIDS
                        Southwest Regional Minority
                        AIDS Council
Muskingum County..........Muskingum Area AIDS Task Force
Portage County............Portage County AIDS Task Force
Richland County...........North Central Ohio AIDS Task Force
Sandusky County...........Sandusky County AIDS Task Force
Scioto County..............Southern Ohio AIDS Task Force
Seneca County..............Seneca County AIDS Task Force
Stark County..............Stark County AIDS Task Force
Summit County..............Multi-County AIDS Network
                        Northeast Ohio Task Force
                        on AIDS
Trumball County...........Trumball County Area AIDS Task Force
Wood County..............Wood County AIDS Task Force
Wyandot County............Wyandot County AIDS Task Force
Source - The Ohio Department of Health, 1990

Table 2

Increase in Ohio AIDS organizations, 1983-1992

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Organizations</th>
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<tbody>
<tr>
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<td>1990</td>
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</tr>
<tr>
<td>1991</td>
<td>57</td>
</tr>
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</table>

Source - The Ohio Department of Health
The Response in Ohio

State government was involved early in the AIDS crisis in Ohio. To review the AIDS case data see Table Three, "Increase in AIDS cases, 1983-1992". At the same time Gay initiated organizing is occurring in Cleveland, Columbus and Cincinnati the Ohio Department of Health begins to establish an official relationship to the emerging epidemic. Gay initiated groups are grassroots and form indigenous social movement organizations (Morris 1984). These groups are specifically Gay affirming, and include the participation of individuals who are Gay, Lesbian, and bisexual as well as a limited number of heterosexual supporters of those communities. Typically Gay initiated activities have a predominantly Gay male core that attracts heterosexual female or Lesbian participants from already established friendship networks. The few heterosexuals involved in the Gay initiated efforts tended to be already integrated into Gay networks prior to the onset of the AIDS crisis.

An Ohio Health Department official describes how the federal government initiated Ohio's involvement.

1983 ... springtime ... the Center for Disease Control decided that this disease was something more now than they could handle all by themselves. So they gave the responsibility for case reporting to the State Health Department. And that really took effect in May of 1983. And by that time, when they gave us their responsibility there were 11 cases on that first list.

At the local grassroots level, friendship networks within the Gay men's community were reacting to the illnesses of their own members. The origin stories of most AIDS groups are poorly documented because
responding to the immediate needs of infected people had priority over record keeping. Additionally, many of the earliest participants at the local level were themselves infected and have subsequently died. A current paid staffer describes the origin story of the Gay initiated organization where she is employed.

(It was during the early 1980's) that there were 14 individuals, concerned individuals sitting around someone's kitchen table and were eating and talking about the general state of affairs. And at that time this seed became germinated and the seed was called (the AIDS Task Force).

Another paid staffer similarly notes the mythology that encircles her group's grassroots emergence.

And it's amazing how many people consider themselves the founding mothers and fathers of the organization. To the best of my compilation of all of that there was – I think 5 men and 1 woman, possible 2 at that point had a friend that was diagnosed. And this was back in 1983. And there was literally no service for that person, people were obviously afraid of people because transmission, even the hospital system did not want to deal with this particular person. So this group kind of informally got together and decided they would provide the care for this person. That one person turned into I think 10 within the first year.

The connection between the official response to AIDS and the Gay community was established early. Below a State Health Department official describes the emerging process.

The Health Department had not had any involvement with the Gay community up to that point and so felt it was important to get some information and assistance from the Gay community, since at that point, that is where all the cases had been identified.

This individual goes on to relate how the process evolved.

(So) ... between May and July (1983) we set about identifying individuals from around the state who would be identified as being Gay or being involved with the Gay community
and invited them to come to a meeting at the Health Department to give them an idea of what we had done up to that point, but also ask them for their imput. What should we do? How do we go about making a relationship between our two entities, and getting prevention programs in place? You know, Ohio is not New York or San Francisco. How do we make Gay men aware of AIDS in Ohio?

This position of early intervention by government had a profound impact on the development of the AIDS social movement industry.

The early organizing model developed by the State Health Department would later be replicated as local public health officials and others initiated AIDS groups outside of the Gay community. A state official who participated in the early organizing recounts how the original group took form.

The people who were represented at the meeting in July of 1983 submitted names of people who might be involved. Then, the way advisory committees are typically done on the Department level; the director and the individuals involved in the program suggest folks that might be appropriate. We wanted the committee to be representative geographically (and) academically ... The committee started out with two or three physicians who by that time had identified as treating people with AIDS. We had a hemophiliac ... we had a sex therapist and counselor, we had a dermatologist because Kaposi Sarcoma was a big deal ... We had a representative of the blood banking industry ... We had a researcher epidemiologist. Someone from the STD area, a couple health commissioners ... Later on we had someone come onto the advisory committee that represented a drug treatment program. Later on we got a lawyer and an ethicist and another physician who represented a minority neighborhood clinic.

This early sensitivity to "representativeness" is a precursor to the principle of inclusiveness concept which serves to help frame the movement's ideological sense of itself.
Between the early 1980's and 1990 - when the bulk of this study's data was collected - both the number of AIDS organizations and the AIDS cases counted mushroomed dramatically. The official AIDS case count in September, 1983, was seventeen. By December 31, 1990, there were 2396 AIDS cases reported (see Table Three, "Increase in AIDS cases, 1983-1992").

Table 3

<table>
<thead>
<tr>
<th>Year</th>
<th>Ohio total number of cases:</th>
</tr>
</thead>
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<tr>
<td>1983</td>
<td>17</td>
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<tr>
<td>1984</td>
<td>25</td>
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<tr>
<td>1985</td>
<td>72</td>
</tr>
<tr>
<td>1986</td>
<td>152</td>
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<tr>
<td>1987</td>
<td>304</td>
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<td>1988</td>
<td>607</td>
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<tr>
<td>1989</td>
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<td>1991</td>
<td>2346</td>
</tr>
<tr>
<td>1992</td>
<td>3029</td>
</tr>
</tbody>
</table>

Source - The Ohio Department of Health

Throughout this period, the connection between the state Health Department and the Gay community endured. A Gay health consultant was hired as a liaison between ODH and Ohio's Gay communities in 1984. In 1989 and 1990 eight "Gay risk reduction specialist" positions were allocated $40,000 per city to initiate HIV prevention programs targeted at both
the visible Gay community as well as other men engaging in same sex behavior.

Following the November 1990 election of George Voinovich (R) for Governor this amount was reduced to $34,000 per city. Additionally the word "Gay" was removed from the officially designated program title. Though I have no evidence which directly connects the changes in Ohio Department of Health Gay initiatives to the new administration, staff reports a "chilling" effect regarding the perception that a Republican controlled agenda demanded a low profile for any Gay-related HIV initiatives.

Additional early landmarks in the development of Ohio's response include in 1984 the establishment of a statewide toll free AIDS hotline. In 1985, when the HIV antibody test became available, nine free and anonymous counseling and testing sites were established around the state (ODH 1987). In 1988 the East Central AIDS Training and Education Center (ECATEC) was founded with the mission of providing HIV education to health professionals. Within state government, the Departments of Education, Corrections, Health and Human Services plus the newly formed Department of Alcohol and Drug Addiction Services were all participating in AIDS specific programming by the late nineteen eighties. All of these efforts were funded with federally allocated dollars.
Ohio Politics and AIDS

During his first term in office, Governor Richard F. Celeste (D) signed an executive order banning sexual orientation discrimination in state employment. One incident in the 1986 Governor's race demonstrates how potentially controversial the "Gay issue" is in Ohio. In the 1986 campaign former Governor James Rhodes attempted to unseat then Governor Celeste. Rhodes' supporters purchased full page advertisements in Ohio's major newspapers berating Celeste for his support of the Gay community and the outreach work being done by the ODH AIDS Activities Unit Gay liaison (Columbus Dispatch 1986). Rhodes' strategy was eventually unsuccessful and Celeste was re-elected. Again, after re-election, Celeste was heavily criticized by some Christian fundamentalists for his designation of February 14-21, 1990 as "National Condom Week" in Ohio.

In 1990 after substantial revisions, a weakened version of Republican State Senator David Hobson's comprehensive AIDS legislation was passed and signed into law by Governor Celeste. A $3.2 million dollar appropriation accompanied the new legislation and prompted a rapid increase in state funding for local AIDS activities. The consequences of State funding for local AIDS programs was significant, as additional monies became quickly available (see Table Four, "State Funding by Fiscal Year, 1989-1991").
Table 4

State of Ohio AIDS funding by fiscal year (thousands)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY89 (7/88-6/89)</th>
<th>FY90 (7/89-6/90)</th>
<th>Start FY91 (7/90-12/90)</th>
<th>Mid FY91 (1/91-6/91)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance</td>
<td>364</td>
<td>549</td>
<td>490</td>
<td>408</td>
</tr>
<tr>
<td>Health educ/risk reduction</td>
<td>1,131</td>
<td>1,691</td>
<td>1,946</td>
<td>1,824</td>
</tr>
<tr>
<td>Counseling and testing</td>
<td>385</td>
<td>416</td>
<td>557</td>
<td>477</td>
</tr>
<tr>
<td>Minority-targeted</td>
<td>(a)</td>
<td>469</td>
<td>469</td>
<td>406</td>
</tr>
<tr>
<td>Care/support</td>
<td>223</td>
<td>1,475</td>
<td>1,138</td>
<td>1,110</td>
</tr>
<tr>
<td>Total</td>
<td>2,103</td>
<td>4,600</td>
<td>4,600</td>
<td>4,225</td>
</tr>
</tbody>
</table>

(a) - minority funding pooled with health education/risk reduction monies
Source - The Ohio Department of Health, 1992

DE-HOMOSEXUALIZATION AND THE INCLUSIVENESS

The de-homosexualization process describes a set of both individual and organizational actions that reduce the visibility of Gay and Lesbian contributions to a particular SMO (Rofes 1990). When the de-homosexualization process is effective, Gay men, and when present, Lesbian leaders are "closeted" or may be replaced altogether by heterosexual, usually female, administrators. These new leaders tend to be administrative professionals with nonprofit organizational experience.

This professionalization is anticipated by social movement theorists working in the resource mobilization tradition (Zald and McCarthy 1987;
McCardy and Zald 1977 and Staggenborg 1988). The establishment of a professional social movement organization (PSMO) can occur when social movement entrepreneurs - career social movement workers who have multiple movement allegiances throughout their careers - began to identify the AIDS SMI as sufficiently resource rich to be worthy of their association (Zald and McCarthy 1987; Jenkins and Perrow 1977; Jenkins 1985). PSMO's like many of Ohio's larger AIDS organizations have full-time paid staff, small core memberships and a tendency to identify themselves as speaking for a much larger constituency (Zald and McCarthy 1987). In Ohio the estimated 40,000 HIV infected citizens are often counted as that "larger constituency".

Reliance on Gay dollars continues but alternative funding sources expand the set of available income options. Local, state, federal or private foundation grants allow SMOs to hire paid staff. Salaries are uniformly low, ranging from the mid-teens to mid-$20,000's for front line prevention and service positions to mid-$30,000 for senior administrations. Salary information is available for organizations who have 501c3 status from the Internal Revenue System. This information, along with organizational "Article's of Incorporation", tax records and fiscal documents are available to public for both on-site inspection and for purchase. I requested and received information regarding the 1989 IRS records for all urban Ohio AIDS SMOs (see Table Five, "Incorporated Organizations in Urban Areas, 1989"). According to IRS records (Forms 990 and 990EZ, 1989), the total assets of Ohio incorporated AIDS organizations located in urban areas were $369,377; ranging from $7,416 to $238,269.
### Table 5
**Incorporated AIDS Organizations, 1989**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Staff Type</th>
<th>Total Assets</th>
<th>Government Grants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOLEDO AREA AIDS TASK FORCE:</strong></td>
<td>Toledo, Ohio</td>
<td>no paid staff</td>
<td>$7,416</td>
<td>$60,083</td>
</tr>
<tr>
<td><strong>NORTHEAST OHIO TASK FORCE ON AIDS:</strong></td>
<td>Akron, Ohio</td>
<td>no paid staff</td>
<td>$8,112</td>
<td>No government grants</td>
</tr>
<tr>
<td><strong>HEALTH ISSUES TASK FORCE OF CLEVELAND, INC.:</strong></td>
<td>Cleveland, Ohio</td>
<td>paid staff</td>
<td>$37,102</td>
<td>$11,097</td>
</tr>
</tbody>
</table>
- **COLUMBUS AIDS TASK FORCE:**
  - location - Columbus, Ohio
  - paid staff
  - total assets - $192,529
  - government grants totaling $188,793

- **DAYTON AREA AIDS TASK FORCE:**
  - location - Dayton, Ohio
  - no paid staff
  - total assets - $17,321
  - no government grants

PSMO staff sometimes lack the passionate commitment to the "AIDS cause" that volunteers possess, and are instead focused on doing their job and maintaining their funding. In larger PSMOs a Gay and Lesbian presence often remains but Gay affirmation loses priority as a SMO value. During the de-homosexualization process a SMO loses its identification as a "Gay male effort primarily intended to care for lovers and friends" and instead joins the larger social services non profit arena. The issue of professionalization of the Ohio AIDS SMOs is strictly tied to an organization's ability to cap sufficient financial resources.
Additionally, the de-homosexualization process occurs more readily in organizations that began without significant linkages to the local Gay community. In these SMOs Gay/Lesbian involvement is almost exclusively covert and from the assumed protection of "the closet". Exceptions prove the rule, and the rare individual who does publicly "come out" may be subjected to ridicule and harassment. In one small rural Ohio town, scandal plagued the local AIDS educator - a publicly "out" Gay man:

(The local educator) was totally what you would consider, tarred and feathered almost, and sent out of town because they (local citizens) thought he was using it (AIDS education) as his own little harem to get sex. And he had been with this guy for 15 years in Columbus and commuted to be with this person...he was put out by the people who run this town. It was like "don't invite him here", "you don't go here with him," "don't be seen with him because they'll think your are," and the men totally avoided him, women turned.

Out of the closet Gays take personal and professional risks.

In counterbalance to the de-homosexualization process, a new principle of inclusiveness emerges as the lead framework through which AIDS work in Ohio is being done. The inclusiveness principle is based on the concept that AIDS is "everyone's" problem, and that SMO goals and leadership should reflect a diverse set of agendas that value and serve the HIV related needs of a varied beneficiary constituency (Huber and Schneider 1992). Ohio's AIDS SMOs increasingly promote the inclusiveness principle within established organizations, and manifest it by attempting to diversify leadership, membership, as well as the shifting of programmatic priorities (Kreisberg 1988; Zald and McCarthy 1987).
Additional power sharing within organizational structures occurs when issues of gender parity, racial/ethnic representation or are given precedence (Cavin 1990).

By the early 1990's when this data was collected Ohio's AIDS policy-makers and activists possessed knowledge of the dynamics of the spread of HIV informed by an understanding that the earlier characterization, particularly supported in the media, that AIDS was exclusively an issue for "homosexual men" was false. Though in Ohio, practical experience demonstrated that the largest number of known AIDS cases were among white men who had sex with other men (see Table Six, "Increased case load: female by male; and Table Seven, "Increased case load: whites by all other races").

As community organizers familiar with local anti-Gay bias these activists recognized the serious barriers their efforts faced if their activity was perceived as an endorsement or support for "homosexuality" (see Table Eight, "Ohio Case increases by Mode of Transmission" for a breakdown of cases by risk factor).

Data collection began for this dissertation approximately eight years after Ohio reported its first AIDS case. To review, Ohio's first AIDS case was diagnosed in 1982. Informant interviews for this study were conducted from June 1990 to January 1991. This was a period of dynamic change within individual SMOs which produced dramatic shifts for the SMI as a whole as the numbers of organizations expanded (see
### Table 6

Increase in Ohio case load: male and female

<table>
<thead>
<tr>
<th>Date</th>
<th>Male: (n)</th>
<th>Male: (%)</th>
<th>Female: (n)</th>
<th>Female: (%)</th>
</tr>
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<tbody>
<tr>
<td>1983</td>
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<td>0</td>
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<td>2883</td>
<td>94</td>
<td>196</td>
<td>6</td>
</tr>
</tbody>
</table>

Source - The Ohio Department of Health. All numbers represent case-loads as of January of the year listed, except 1983 which is September's data.

Table Two, "Increase in Ohio AIDS Organizations, 1986-1991"). Organizations rapidly emerged, grew and moved to legitimize themselves within their local communities.

As the inclusiveness principle gains ideological dominance within the Ohio AIDS social movement industry efforts exist to distance the AIDS movement from its overt connection to the Gay and Lesbian communities. It is important to recognize that simultaneously the Ohio AIDS SMI is rapidly expanding into regions of the state with little or no visible Gay community and where few Gay men or Lesbians are willing to be publically "out of the closet".
Table 7

Increase in Ohio case load: white vs all other races

<table>
<thead>
<tr>
<th>date</th>
<th>white: (n)</th>
<th>(%)</th>
<th>all other races: (n)</th>
<th>(%)</th>
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</thead>
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<tr>
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Source - The Ohio Department of Health
Table 8

Ohio case increases: mode of transmission

<table>
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<tr>
<th>mode of transmission:</th>
<th>male-male sex</th>
<th>all other modes</th>
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<td>647</td>
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<td></td>
<td>79</td>
<td>21</td>
</tr>
</tbody>
</table>

Increase over time in Ohio AIDS cases among men who have sex with other men compared to all other modes of transmission.

Source - The Ohio Department of Health

THE OHIO AIDS INDUSTRY

Little consistent organizing occurs on a statewide basis. See Table Nine, "Organizations by geographic location, 1990" which notes the existence of only three statewide groups, two of which are sponsored by major Protestant denominations, and one which is grassroots initiated. The coordination of training seminars and statewide conferences is largely left as a duty for the state Health Department.
Table 9

AIDS organizations by geographic location, 1990

<table>
<thead>
<tr>
<th>type of geographic location:</th>
<th>small</th>
<th>large</th>
<th>small</th>
</tr>
</thead>
<tbody>
<tr>
<td>town:</td>
<td>urban:</td>
<td>urban:</td>
<td></td>
</tr>
</tbody>
</table>

organization:

Adams County AIDS Task Force........X
Allen County AIDS Task Force........X
Athens AIDS Task Force..............X
Auglaize County AIDS Task Force.....X
AIDS Task Force of the Upper Ohio Valley........X
Middletown AIDS Task Force........X
AIDS Commission of Greater Cleveland........................................X
AIDS Housing Council................X
Cleveland AIDS Coalition............X
Health Issues Task Force...........X
Delaware County AIDS Task Force........X
AGAPE Friends Helping Friends...............X
Erie County AIDS Task Force.......X
AIDS Service Connection...............X
Columbus AIDS Task Force...........X
Columbus PWA Coalition...............X
Community Free Job List..............X
The Ohio State University Education and Research................X
Minority Education Committee on AIDS................................X
Greene County AIDS Task Force......X
AVOC..................................X
Caracole, Inc........................X
Northern Kentucky AIDS Task Force.....X
Greater Cincinnati AIDS Task Force.....X
Minority AIDS Prevention Alliance.......X
Hancock County AIDS Task Force.....X
Greater Steubenville Area AIDS Task Force........X
Lake County AIDS Task Force........X
Licking County AIDS Task Force......X


Table Nine continued

Lorain County AIDS Task Force.................................X
Toledo AIDS Task Force-------------------------------X
Mahoning AIDS Task Force.................................X
Marion Area AIDS Task Force......X
AIDS Foundation - Dayton--------------------------X
Dayton Area AIDS Task Force..........................X
Minority Advisory Committee
on AIDS................................................X
Southwest Regional Minority AIDS Council.............X
Muskingum Area AIDS Task Force.......................X
Portage County AIDS Task Force.........................X
North Central Ohio AIDS Task Force....................X
Sandusky County AIDS Task Force.......................X
Southern Ohio AIDS Task Force........................X
Seneca County AIDS Task Force........................X
Stark County AIDS Task Force........................X
Multi-County AIDS Network..............................X
Northeast Ohio Task Force on AIDS........................X
Trumbull County AIDS Task Force.......................X
Wood County AIDS Task Force...........X
Wyandot County AIDS Task Force.......................X

The following example provides an illustration. In 1990, the Ohio Department of Health held a series of statewide conferences focusing on a variety of issues including infection control, women and AIDS, AIDS in racial and ethnic communities and AIDS in the workplace issues. A leader of the only Gay initiated group to emerge with a statewide agenda describes the consequence of the state Health Department involvement on his organization's priorities.

I think we had some statewide meetings and some programming, but at the same time what was happening at (the state
Health Department) was realizing that the great thing they could provide was statewide conferences, to have everybody from different task forces network, and they started doing the exact thing that (my organization) was born to do.

In Ohio, each SMO tends to operate independently of other organizations within the SMI. There is no federation and/or umbrella group attempting to represent or coordinate the efforts of Ohio's AIDS social movement organizations (Gerlach and Hine 1970). Individual organizations and/or their leaders may network informally, or temporarily organize to address legislative issues or to facilitate other short-term collective goals. For example, organizations throughout the state rallied in support of the "Hobson Bill", Ohio's comprehensive AIDS legislation spear-headed by then State Senator (R) David Hobson and passed into law in 1990.

Only state Senator Hobson (R) has consistently addressed AIDS issues and his departure from state government in 1990 left a vacuum, still unfulfilled in 1992. Segmentation within the Ohio AIDS SMI occurs as a result of differing local SMO goals and organizational priorities. Additionally, segmentary fissures may occur within a SMO, causing the organization to split. This segmentary process within an AIDS SMO can lead to the creation of new organizations, and most often occurs when differences arise concerning the determination of organizational priorities.

An example of the fissure process is described below by a member of the organization discussed.
And there were some coalitions too. PWA (people with AIDS) coalitions. The first one was called Our Town PWA coalition, and there was some animosity and jealousies in there, and then one of the members decided he didn't like the way things were going and formed his own chapter ... and the original coalition sat down one day and talked. And said, "This isn't what we wanted. This is getting too political, too stressful, and officers and committees - we are not about that. We need a social group." So we disbanded, and them came up with another group which eventually evolved into the one we have now.

Social movement organizations strive to create enduring organizational structures in an effort to ensure organizational survival. All the organized responses of activists and public health officials in Ohio to meet the political, medical and social demands realized by the onset of the AIDS epidemic are best characterized as reform oriented (Blumer 1951). Reform movements seek to change a specific component within the larger social order without directly challenging the basic principles of a society (Smelser 1963).

Nationally, the AIDS social movement has from the onset maintained a narrowly focused, AIDS specific movement agenda (Rofes 1990; Altman 1988; Shilts 1987; Patton 1985). Uniquely, as a reform movement, the AIDS SMI seeks both partial change at a supra-individual level and, simultaneously pursues alternative movement agendas with individuals who are at risk for AIDS and with those persons already HIV infected. The duality of purpose is unique because movements typically focus either on individual or societal specific change (Aberle 1967; Kriesberg et al 1988).
The goals of the Ohio AIDS SMI encompass both societal manipulation and personal transformation (Turner and Killian 1972). In the view of the movement, societal institutions such as the health and social services establishments must be transformed to make them accessible and sensitive to the needs of the already HIV infected. Institutions and organizations with educational missions must be coopted into addressing HIV prevention issues. Conversely, alternative movements call for a commitment to personal transformation (Aberle 1966). In the AIDS example this transformational message goes out to those uninfected but at risk for HIV, as well as to the HIV positive individual.

At the supraindividual level, the societal institutions targeted for HIV sensitivity training by AIDS activists include the medical, health care, social service and legal establishments as well as the political entities that regulate and control these institutions. AIDS advocacy, including lobbying and participation in policy determination, is a priority for SMOs in the national AIDS SMI. Nationally, the AIDS SMI may be characterized as a left-wing movement because of its attempts to increase freedom from discrimination and promote equality for people living with HIV infection (Wood and Jackson 1982).

The national AIDS SMI agenda is focused on advocating funding levels sufficient to promote medical research on HIV disease, developing and implementing HIV education/prevention activities and serving those already living within the HIV disease spectrum (Rofes 1990; Altman 1988; Shilts 1987). Most AIDS activism at the state level, including
activity here in Ohio, is concentrated on the latter two goals of education/prevention and provision of services for people living with HIV disease (Perrow and Guillen 1990; Arno and Hughes 1987). While Ohio's AIDS SMOs make organizational choices regarding the relative priority of educational efforts versus service provision, based on the source of organizational emergence, virtually all Ohio SMOs conduct one or both of these activities. The relative lack of a legislative focus for AIDS in Ohio is in part a consequence of the movement's overall failure to identify legislative advocates.

MOVEMENT IDEAS AND BELIEFS

Movement ideas and beliefs construct understandings of the events and people that shape a movement (Miller 1985). The ideological underpinnings of a social movement serve as a simplified frame of reference for participants. Providing an explanation of it's worldview movement ideology acts as a tangible expression of the value set that informs participants' perspectives concerning the activities of the movement (Freeman 1983).

Within the AIDS social movement an unique predicament appears because of the difficulty in distinguishing between movement ideology and Gay collective identity. Collective identity is the shared definition of a group that derives from member's common interest and solidarity (Taylor and Whittier 1992). Morris (1989) notes the importance of the relationship between collective action and group consciousness which is particularly powerful for Gay initiated indigenous groups.
The AIDS movement provides an explicit example of what new social movement theorist identify as "political organizing around a common identity" (Taylor and Whittier 1992; Tilly 1988; Epstein 1990). For both openly Gay and Lesbian activists, and their "closeted" associates, the everyday realities of negotiating lives in an heterosexist world informs their ideas and beliefs concerning AIDS. The resulting politicization of everyday life becomes both a tool for mobilization and a genesis for the creation of AIDS movement ideology.

Ralph H. Turner and Lewis M. Killian, in their landmark 1957 work Collective Behavior, outlined the role of ideology in social movements, and it informs the discipline today. According to Turner and Killian, ideologies facilitate the construction of a movement's account of the past while providing both a framework for critiquing the present and predicting the future. Ideological stances serve to cast movement goals as consistent with the welfare of the general populace, while morally elevating the movement's own constituency. Thus ideology functions to both define movement heroes and to identify movement villains.

For example, at both the local and national levels the heroes of the AIDS movement have been defined as those individuals who work on the frontline to accomplish the goals of the movement. Particularly heroic are those movement activists who are also personally struggling with their own HIV infection, or who have lost a family member or lover to AIDS. This identification of HIV infected activists as the heroes of the movement is consistent with the movement's commitment to embrace
those individuals living with HIV disease. And again supports the notion of inclusiveness.

Another set of heroes have been identified by the mainstream media (Rofes 1990). A parade of heterosexual celebrities have been associated with the AIDS cause including Elizabeth Taylor, Dionne Warwick and Whoopie Goldberg. Recently disclosed HIV infected celebrities like "Magic" Earvin Johnson and Arthur Ashe have received much more sympathetic treatment then earlier notables such as Rock Hudson or Liberace. This may again reflect the societal bias against same sex behavior as a source of HIV risk. Both Johnson and Ashe have been clearly identified as having "risk factors" which excluded Gay or bisexual encounters.

Conversely, the villains of the AIDS movement have also been defined at a national level (though local villains may also be identified), and include both the federal bureaucracies empowered to react to health crises (ie. the Centers for Disease Control and the Federal Drug Administration), and more specifically Presidents Reagan and Bush. Edward Koch, the former mayor of New York City was one\textsuperscript{22} The social stigma that surrounds the central issues related to AIDS - male to male sexual behavior, injection drug use, debilitating illness and death - do not readily lend themselves to the construction of a "morally uplifting" ideology. These stigmas have served to make the task of AIDS organizing yet more difficult.

\textsuperscript{22} such locally identified villain (Kramer 1989).
Turner and Killian also note that ideological stances may shift, evolving in response to changing events over time. The issue of shifting ideology is particularly important to understanding the emergence and development of the Ohio AIDS social movement. Ideological shifts in movements are most characterized by increased levels of refinement and the elaboration of ideological concepts aimed at encompassing ever more divergent movement memberships. I argue that the Ohio AIDS SMI is experiencing just such an ideological shift.

Ohio's Connection to the National AIDS SMI

The AIDS social movement in Ohio does not exist in a socio-political vacuum. One AIDS activist describes how Ohioans benefit from observing AIDS organizing in the high HIV prevalence regions.

(In Ohio we have) the brains to look at what's New York and San Francisco and Los Angeles and everybody is experiencing, cause if they're experiencing it now we'll see it in (Ohio) in a year or two.

The Ohio network of AIDS activists are significantly influenced by the national AIDS movement. The AIDS SMI at a national level has developed a sophisticated network of resources that have been distributed independently through movement networks. Additionally, federal government's resources like the National AIDS Clearinghouse; state AIDS hotlines and AIDS Clinical Trials system provide accessible information to a national constituency (Lingle and Wood 1988).\(^23\) AIDS SMOs utilize all these networks. SMO members subscribe to AIDS newsletters and spe-

\(^23\) The National AIDS Clearinghouse can be accessed through its toll free hotline nu AIDS clinical trials information is accessible at 1-800-TRIALSA.
cialized journals, attend regional and national HIV/AIDS conferences as well as pursuing other networking opportunities. Networking also occurs when nationally known figures are invited to speak in Ohio. One informant reported that over a thousand people attended a Kent State University lecture given by national known activist Larry Kramer.

Despite the influence of the National AIDS movement Ohio AIDS SMOs have resisted certain components of the national SM ideology. Ohio has consistently failed to support direct action groups who focus on issues of governmental accountability and legislative oversight. For example, the ideological messages of the AIDS SMI have been boldly symbolized through the artistry and tactical choices made by the direct action group organization the AIDS Coalition to Unleash Power ACTUP (Crimp 1987; Crimp and Ralston 1990; Gamson 1989; Kramer 1989).

Perhaps the best known example of ACTUP symbolism is found in their early "Silence = Death" imagery. Ohio's ACTUP chapters are among a few Ohio AIDS organizations with goals that focus explicitly on direct action and political advocacy. At the time of data collection ACTUP chapters are located in two of Ohio's larger cities and on the campuses of another two of the larger state supported universities. Ohio's first ACTUP chapter was not founded until February 1989. This slow evolution of explicitly political AIDS advocacy has significant consequences for the Ohio SMI.

Noted for militancy in their strategic and tactical choices, the ACTUP message is clearly defined in their organizational statement of purpose:
ACTUP (AIDS Coalition To Unleash Power) is a non-partisan group of diverse individuals united in anger and committed to direct action in the face of the AIDS crisis. We protest and demonstrate; we meet with government officials; we research and distribute the latest medical information. We are not silent.24

The ideological stance that frames the mission statements and organizational objectives of the majority of Ohio's AIDS SMOs are not born out of the type of confrontation politics that inspire the activism of various ACTUP chapters and their constituencies. Instead, the normative ideological proscription guiding the mainstream of Ohio's AIDS organizing is focused on the dual issues of HIV education and client care. More specifically, AIDS and HIV educational activities are designed to meet the perceived needs of the general community, while targeted audiences (i.e. men who have sex with other men, injection drug users and adolescents) receive prevention messages aimed at promoting behavioral change. Client care goals focus on providing emotional, practical and financial assistance for HIV infected people.

IDEOLOGICAL FRAMEWORKS

I have identified three major components of an ideological framework used to support the value system of the Ohio AIDS SMI: the "good of the community" rationalization, the principle of inclusiveness and the process of de-homosexualization. The first component of that belief system serves to, as Turner and Killian (1972) suggested, rationalize the need for the existence of the movement by stating that the AIDS epidemic

ic is a public health crisis requiring immediate and sustained mobilization of human and financial resources for the good of the entire community. The focus on the welfare of the general community is the bedrock out of which the later principle of inclusiveness evolves. The organizational commitment to the "good of the community" provides both leaders and members a way to legitimate SMO participation.

In one of Ohio's many mid-sized cities the local AIDS Task Force justifies its purpose:

AIDS is a health crisis which affects the total community - not only those persons with AIDS, but also their families, friends, co-workers, and employees. The public's need for accurate information and timely are important parts of the Task Force's work.

An AIDS SMO located in one of Ohio's major urban areas uses the following appeal in its self-promotional brochure.

AIDS is a health crisis which affects the whole community - not only persons with AIDS, but also their families, friends, companions, co-workers and employees. All these people need help, support and understanding in facing a positive diagnosis.

The Ohio AIDS SMI rationalizes its existence by linking the movement to the "morally uplifting" task of intervening in the AIDS crisis on behalf of the general public. This type of initial linkage with the larger community was not possible in epicenter cities, because AIDS organizing began before there was any significant understanding of the source or scope of the epidemic. In Ohio, AIDS organizers had a later start and the advantage of dealing with a better defined problem.
The second and third components of the ideological framework that inform Ohio's AIDS organizing revisit two of the central tenets discussed at the onset of this chapter: de-homosexualization and the principle of inclusiveness. Moving into the 1980's, AIDS organizing increasingly occurs within the context of a systematic de-homosexualization of the content of the movement (Rofes 1990). At the same time an inclusiveness principle is given ever more widespread acceptance, and encourages Ohio's AIDS SMOs to diversify leadership, membership and client bases (Dalton 1989; Randolph 1988 and Honey 1988). Together these tenents serve to rapidly conservatize the movement's ideology and understanding of itself (Zald and Ash 1966).

By the end of the 1980's the inclusiveness principle came to dominate the overall Ohio AIDS social movement ideology. For example, from the onset of the epidemic substantial AIDS movement resources toward the inclusion of individuals who are themselves experiencing the personal consequences of HIV disease. Initial organizing efforts included (and/or were initiated by) HIV positive individuals and these efforts provided the impetus for the development of what I identify as a general inclusiveness principle. One local AIDS service organization staffer remarked:

(Our agency) prides itself - as I'm sure any reputable AIDS group does - that HIV challenged persons are always invited and invited graciously. It's never a question at a sponsored event.

This commitment routinely goes beyond token representation at agency functions and is extended to inclusion in policy making roles. The Executive Director of one agency stated matter-of-factly:
We always have a PWA representative on the board.25

Another informant, who himself is HIV infected, makes the following case for this principle of inclusiveness.

We are qualified. We are the experts in this field... we have people with AIDS (in our organization), that makes us the experts.

Ohio's AIDS SMOs membership is largely a beneficiary constituency composed of members of the aggrieved group. From their beginnings, Ohio's SMOs activism represented the same constituency that bore those in need. Nationally, and in Ohio during the early 1980's this inclusion often happened as a matter of course. Many of the first participants in the AIDS SM were themselves HIV infected, and have subsequently been lost as leaders when they died.

The practical purpose of this principle of inclusiveness policy is explained by the administrator of another AIDS service organization.

(W)hen we structured the organization we reserved three positions to be filled by client advocates. Those can be PLWAs (people living with AIDS), they can be HIV infected people, they can be care-givers, but their job is to represent to the board the needs and perspectives of the community that we serve.26

More recently, the issue of inclusiveness is extended within many of Ohio's AIDS organizations to include attention to issues of racial and gender parity. The extension

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25 Note: "PWA" is used in reference to People With AIDS and is a chosen term intended by activists to empower rather than victimize those who are infected and presenting symptoms of HIV disease.

26 It should be noted that an evolution of terminology expanded the PWA concept to PLWA "people living with AIDS" as a conscious attempt to de-emphasize the notion that an AIDS diagnosis was a "death sentence". The earliest attempts at AIDS education tended to overemphasize death and fear based messages. In Ohio as late as 1989 the Ohio Department of Health conducted an AIDS prevention ad campaign that featured tombstone imagery.
of the inclusiveness principle to include men of color and women is an example of what Turner and Killian (1972) identify as a tendency in social movement ideologies to evolve over time in response to changing events. As is typical, this particular elaboration and refinement in movement ideology seeks to attract groups divergent from the primarily Gay male and/or professional nuclei that typically originated AIDS organizing efforts in Ohio (McAdam 1982; Morris 1984; Dalton 1989; Randolph 1988; and Honey 1988).

By valuing and attempting to implement the concepts of gender and racial parity SMOs acknowledge that some HIV infected people do not fit the dominant Gay white male profile. As a consequence greater attention is paid to the importance of serving diverse communities of HIV infected individuals. Below an administrator explains his agency's position.

(A)ses an AIDS organization that's always going to be to some extent grassroots oriented, there is a deliberate effort to make sure that the communities served are represented in the board (of directors) as well. And that means African American, Hispanic, women's and Gay representatives and a person with AIDS represented in the board membership.

Not all efforts to expand the inclusiveness concept have been successful. African-American and Latino leaders have sometimes opted to originate their own AIDS efforts and have chosen to center those efforts within Ohio's communities of color.

For example, one group which emerged from the African American community uses the Arts to address AIDS concerns. This organization's founder describes what motivated his involvement.

(I)t was very clear to me that as a community blacks had not taken ownership of the AIDS problem. We had taken something from the white community that I was very ashamed of - the ability to allow our prejudices to dictate the
way we deal with human beings. For the first time in my life I had seen black people turn their backs on sick among them because of AIDS. I see that as (a) very negative Eurocentric thing.

Attempts to prioritize gender parity have also met with mixed success. One administrator expresses her desire for gender parity on her agency's board of directors.

(W)e're trying to bring it (the board of directors) up to 12 members and make it six and six (male and female). So we have some kind of representation. I demanded that ...and so did my two Lesbian board members.

For women, parity issues have most often revolved around recognition of leadership and volunteer contributions, rather than the needs of female PLWAs. Statewide, only sporadic attempts have been made to integrate the special needs of HIV infected women into the service components of organizational missions. As of January 31, 1991, there were only 148 female AIDS cases reported in Ohio (see Table Six, "Increased case loads: female by male cases").

Educational outreach programs specifically targeting women have been somewhat more numerous. Ohio's family planning and reproductive health agencies, and women specific alcohol and other drug treatment programs have played a leadership role in doing outreach to women at risk for HIV infection. Street outreach to sex workers and programs to educate incarcerated females has also been conducted
throughout the state. Additionally services for women are often tied to the efforts of the Children's hospital in the larger cities.

The final component of the ideological framework guiding the Ohio SMI must be viewed in stark contrast to the inclusiveness principle. Social movement scholars have noted the tendency for institutionalization of movement activities to encourage conservatism in ideology. The effect of this conservatism on leadership is examined more carefully in the next chapter's section on the consequences of professionalization within SMOs (Oliver 1983; Jenkins and Eckert 1986; Staggenborg 1991). The "de-homosexualization process" is an example of such a tendency. The de-homosexualization of AIDS serves to accelerate the adoption of the inclusiveness principle by masking the involvement of Gays and Lesbians in the Ohio AIDS movement. De-homosexualization creates significant tension within the movement and explains the major differences that exist among SMOs concerning organizational emergence, organizational structure, and leadership.

The de-homosexualization of AIDS did not happen in Ohio alone. National leaders had previously decried this trend. Michael Callen, in the widely distributed PWA Coalition Newsline (March 1989) exclaimed:
AIDS IS A GAY DISEASE| There. I said it. And I believe it. If I hear one more time that AIDS is not a Gay disease, I shall vomit. AIDS is a Gay disease because a lot of Gay men get AIDS. Nationally, Gay and bisexual men still account for more than half of all the AIDS cases.27

In the high HIV prevalence epi-center cities the local mobilization of education and patient care services has been the direct result of the Lesbian and Gay community (Arno 1986; Shilts 1987; Patton 1985). The "AIDS-is-not-a-Gay-disease" rhetoric is an attempt to down play the contributions of Lesbians and Gay men.

The de-homosexualization process within established organizations can create opportunities for new non-Gay leadership in the movement. One such heterosexual female leader remarks:

Another transition for the agency ... was losing the 100 percent Gay identity, which is really difficult when you create something, it's your baby, you create it and you have to let it go, let it grow.

As Ohio's AIDS SMOs grow, and as resources originating outside of the Gay community become somewhat more available, the impetus for extending the inclusiveness concept to combat issues of homophobia and heterosexism wanes. If additionally resources had never been forthcoming perhaps the AIDS movement would have embraced Gay and Lesbian affirmation as a central tenant, and would not have moved toward

27 Callen is quoted in Rofes' (1990) Gay media published article focusing on the "war" between Gay movement and AIDS organizations.
professionalization.

Ohio's AIDS SMOs, particularly those serving small cities, towns and rural areas walking a narrow line between identification with, and service to, Ohio's Gay and bisexual male communities. There is an ongoing struggle within the Ohio AIDS SMI debating the relative merits and costs of adopting an ideological stance that is openly Gay affirming. One local AIDS SMO staffer working in Southern Ohio reflects:

(W)e ... now find ourselves somewhat concerned about being identified as some kind of Gay Rights activist organization.

Another volunteer for a small and struggling AIDS SMO discusses the pervasiveness of homophobia among local political administrators who have blocked all attempts to formalize the existing AIDS Task Force through the incorporation process.

The hesitancy has been to take steps to create an AIDS Service organization. One of the reasons that the powers that be are hesitant to allow that to happen, they're afraid that will be a first stepping stone, that will give something for the Gay community to rally around... (T)hey don't want to give "undesirables", and I use that term in quotations, a voice. They're really afraid.

Institutionalized heterosexism, or the manifestation of heterosexual privilege and bias within groups/organizations, is a constraint blocking the emergence of
independent organizing. As a consequence, AIDS educational activities and client service in this region are lacking.

An extraordinary ideological tension has developed within the Ohio AIDS SMI as a result of the dual commitments to the inclusiveness principle, and what is seen by many as the impracticality of embracing Gay affirmation publically. One tactic used to mediate the tension created by the de-homosexualization process is adoption of the rhetoric "AIDS is not a Gay disease." The first ideological principle, the perspective that AIDS effects all members of the community, provides the framework that supports the "AIDS is not a Gay disease" concept.

One Gay activist remarked:

(It) began to happen in 1987, maybe '88, there was the de-homosexualization of AIDS. The major campaign slogans seemed to be "AIDS is not a Gay disease." It almost went to the other extreme that Task Forces were non-Gay. That's where I see a lot of the big Task Forces today.

Another activist, a Lesbian working in a different area of the state also noted this same phenomenon:

Certainly I realize that the epidemic is going in a heterosexual direction in general, but that hasn't really happened (here) yet, and so it's kind of frustrating that they've (the local AIDS SMOs) have chosen to closet themselves.
The forces of both institutionalized and internalized heterosexism work to shape strategic choices made within Ohio's AIDS social movement relative to questions of Gay and Lesbian affirmation. The theoretical paradox of Ohio's AIDS organizing lies in the tension created by shifting ideology that simultaneously supports increasing levels of inclusiveness in leadership, membership and goal setting while discouraging too public an embrace of visible Gay male and Lesbian community. At an organizational level, the existence of reservations regarding the adoption of a public pro-Gay posture, though not surprising, are somewhat ironic. Tension stems from the widespread recognition that volunteer and financial support from the Gay community continues to be invaluable to virtually all AIDS service organization in Ohio.

MACRO CONDITIONS

Macro organizational conditions influence the receptiveness to AIDS activism in Ohio. The AIDS SM in Ohio is both connected to and different from the AIDS movement as it exists in the major east and west coast high HIV prevalence urban areas (Patton 1985; Rounds 1988). Regional differences exist regarding the diversity and visibility of sexual communities, the extent of pre-existing political organization among Gays and Lesbians, as well as the general level of social acceptance of "homosexuality" (Miller 1989).
Another macro condition influencing AIDS organizing in Ohio is the level of prior organization that existed within specific communities. Nationally, the most active HIV-related organizing has occurred in the larger urban settings or areas of ecological concentration. Somewhat ironically, the spread of HIV disease itself was initially facilitated by the existence of a relatively homogenous groups of men who had sex with other men co-existing in the high HIV prevalence urban settings (Ekstrand and Coates 1990; Mays and Cochran 1987; and McKusic et al 1985). This reality of urban life facilitated both the spread of HIV disease and the organized response by activists. In contrast with areas of higher ecological concentration, Ohio has not produced mass scale mobilization and/or a significant system of diversified political organizations.

A visible Gay and Lesbian community does exist in more metropolitan Ohio communities, but the political organizations are less numerous, have smaller support bases and are more prone to economic and/or scandalous ruin then are their San Francisco, Los Angeles and/or New York City counterparts. Stonewall's (of Cincinnati) annual dinner attracts over 1500 people each year, and the Gay Pride March sponsored by Stonewall Union in Columbus, Ohio with an annual attendance between 5,000 to 10,000 participants are two exceptions to this general trend of weak mass mobilization. Central Ohio residents are also strong supporters of the national Gay and Lesbian political action committee the Human Rights Campaign Fund. The central Ohio region is reported to be among the highest per capita donor pool for HRCF in the country.
I do not want to overestimate the political and/or financial stability of Gay/Lesbian political organizations in the large coastal urban areas. The entire Gay and Lesbian social movement sector is marginalized relative to other components of the political mainstream (Cavin 1990; Altman 1988). Gay and Lesbian issues remain often invisible within party politics, the labor movement, and other efforts directed towards progressive political change.

Gay and Lesbian bar culture flourishes in Ohio's largest cities, and exists in even some of the smaller towns. The 1990 Stonewall Union *The Ohio Gay Guide* lists Gay bars in all eight of Ohio's major urban communities - Cleveland, Columbus, Cincinnati, Toledo, Dayton and Canton - as well as in much smaller towns including Ashtabula, Lima, Lorain, Mansfield, Springfield and Steubenville. Affinity groups also prosper in Ohio's urban areas. Gay men and Lesbians come together recreationally to participate in bowling, softball, touch football, golf and many other sports. Additionally, there are social opportunities including Gay and Lesbian choruses, marching bands, and country and western dance groups. Affinity groups exist for devotees of sado-masochism and the leather culture. Numerous religious and/or spiritual organizations co-exist with other groups organized around issues of parenting, bisexuality, addiction and other topical concerns.

A myriad of options exist for Gay men and Lesbians to organize socially, recreationally, spiritually, and politically. The Gay and Lesbian communities of Ohio have developed an increasingly rich and
diverse cultural life (Taylor and Whittier 1992). Those individuals mobilized for specifically political purposes represent only a fraction of all the Gays and Lesbians mobilized through the activities of the community. Typically, the farther away one lives from an urban area, the more isolated one finds oneself from a visible Gay and/or Lesbian community (Miller 1989 and Rounds 1988).

In Ohio's Gay and Lesbian communities, pre-existing networks existed and were mobilized to meet the needs created by the AIDS crisis. Mobilization occurred most readily in larger cities and college towns where Gay networks were more visible. Organizers working within the local socio-political confines facilitated the emergence of the Ohio AIDS social movement.

Conclusions
This chapter delineates the roles played by the concepts of inclusiveness and de-homosexualization in shaping the history, organizational structure and leadership choices made by the Ohio AIDS social movement industry. The forces that shape the ideology of a social movement are variable and change in response to macro sociological conditions (McAdam, et al. 1988). Within the Ohio AIDS SMI macro sociological conditions create a fundamental cont between the two central tenets that frame the Ohio movement's ideological understandings of itself.

From various points of origin, the social movement simultaneously promotes an inclusiveness principle that requires respect for diversity and sensitivity to cultural differences while also conducting a "de-
homosexualization process" where Gay agendas, Gay/Lesbian leadership and Gay control of SMOs is systematically reduced. The Ohio movement, taking clues from AIDS organizations located in epi-center regions, began the process of "de-homosexualizing" the AIDS crisis late in the 1980's (Rofes 1990).

Social movement ideology not only provides rationalization and justification for the movement's existence, but also serves as a motivational appeal capable of attracting potential partisans. The Ohio AIDS social movement's goals are both credible to the movement's constituencies and capable of uniting activists in order to successfully produce the tangible accomplishments of the movement (Turner and Killian 1972).

In sum, using Zald and McCarthy (1980), it is useful to view AIDS SM activism in Ohio as facilitating the emergence of an SMI consisting of multiple AIDS focused SMOs (Zald and McCarthy 1980). The frame of reference for understanding AIDS issues in Ohio borrows heavily from AIDS activism occurring at a national level. The primary focus for participants in Ohio's AIDS SMOs revolves around issues of providing AIDS educational and patient care services that are inclusive of people living within the HIV spectrum, while attempting to be sensitive regarding cultural and gender-based issues. Over time, ideological commitments to inclusiveness have evolved under the dual pressures of a perceived escalating demand for services outside of the Gay community, and an anti-Gay sentiment among potential mainstream funding agencies and supporters of Ohio's AIDS social movement organizations. The next chapter further details the evolution of specific AIDS SMOs.
CHAPTER VI
ORGANIZATIONAL EMERGENCE, LEADERSHIP AND MEMBERSHIP

In Ohio, the AIDS movement took two separate but overlapping pathways as it emerged. See Table Ten, "The AIDS Social Movement Industry, Indigenous Social Movement Organizations," for a graphic depiction of the basic components this emergence pattern presents, including its organizational form, ideological framework, goals, primary local resource, and leadership pattern. The first pathway is grassroots characterized by almost exclusive involvement of Gays. Gay male activists, adapting the model of organization generally utilized in high HIV prevalence regions, took initiative and founded local AIDS Task Forces in their home communities (Altman 1988; Shilts 1986; Arno and Hughes 1987). This is a form of indigenous movement organization (Morris 1984).

In Ohio, Gay male initiated organizations typically are among the earliest to appear. By late 1983, at least two Gay AIDS groups existed. They were the Columbus AIDS Task Force and Health Issues Task Force in Cleveland. This organizational pathway emerged primarily in the largest urban areas as well as on a limited number of state affiliated university campuses. These groups were initially all volunteer staffed, and the earliest activists were almost exclusively Gay men.
Table 10

The AIDS Social Movement Industry, Indigenous SMO

- **DEFINITION OF PROBLEM:**
  - friends, family, partners and lovers who are ill or have died
  - fear of one's own infection

- **ORGANIZATIONAL EMERGENCE:**
  - indigenous social movement organization

- **IDEOLOGICAL FRAMEWORK:**
  - Gay collective identity
  - Gay affirmative
  - responsibility to PLWA's

- **GOALS:**
  - client care
  - education and HIV prevention
• PRIMARY LOCAL RESOURCE:
  • Gay/Lesbian community, and friends

• LEADERSHIP:
  • Gay/Lesbian community

The Gay men's community - through private contributions and Gay bar fundraisers - were the primary source of revenue for organizational activities.

The second emergence route originates through the efforts of local public health and social service professionals. See Table Eleven, "The AIDS Social Movement Industry, Professionally Sponsored Social Movement Organizations," for an illustration of this pathway, including its organizational form, ideological framework, goals, primary local resource, and leadership pattern. Professionalized AIDS organizations occur more often in smaller urban and small town areas of Ohio. This organizational form is connected to an institutional sponsor and is most often dominated by local health Departments although other community based organizations such as the American Red Cross, Planned Parenthood, "minority" organizations, and/or local hospitals may also initiate organizing. Institutional ties initially provide the group
with material resources like office space and/or telephone access. Additionally, the employees of sponsor agencies routinely utilize some segment of their paid work time to conduct SMO business.28

A typical example of the Gay male initiated pathway in a major urban area is described by a Gay male activist:

It was a fledgling organization started February 1984. It was still young, it was still entirely supported financially, almost entirely in terms of volunteers by the Gay community, specifically the Gay male community.

A former president of an AIDS SMO, a heterosexual white woman, describes the predominance of Gay men within her organization prior to her arrival:

The main focus (for the Task Force) was the Gay community because that's where the energy has come from for the whole Task Force.

In the beginning, Gay men were the individuals being served. Their community was the major source of funding and they also volunteered their own service.

Ohio's major urban areas all have AIDS SMOs with Gay origin (see Table Nine for a listing of Ohio's major urban areas). Gay male membership, and leadership positions during the emergent phase of the AIDS industry, was both necessary and invaluable. Early in the crisis there was a great deal of fear regarding the transmission of AIDS. It was

28 This research also examined AIDS organizing on college campuses. The original assumption that university-based and community-based organizing were comparable was abandoned after further analysis brought the recognition that university-based organizing originated at administrative levels and focused primarily on concerns relative to AIDS in the workplace. College town organizing that was not controlled by university administrations and included outreach to the non-university community is, however, included in this analysis.
Table 11

The AIDS Social Movement Industry, Professionally Sponsored SMO

- **DEFINITION OF PROBLEM:**
  - community health crisis
  - community service
  - involvement solicited by funders

- **ORGANIZATIONAL EMERGENCE:**
  - professional social movement organization

- **IDEOLOGICAL FRAMEWORK:**
  - good of community
  - de-homosexualization
  - principle of inclusiveness

- **GOALS:**
  - education and HIV prevention
  - client care
Table Eleven continued

- **PRIMARY LOCAL RESOURCE:**
  - non-profit, social service organizations

- **LEADERSHIP:**
  - public health and sponsoring organization staff

often difficult to find individuals who would risk contact with those whose infection was known. Gay men often cared for each other because there were literally no other alternatives (Patton 1985; Adam 1992; Wertz 1991). This activist notes:

The nucleus of the original members and groups that started things going, the majority were Gay.

In one of Ohio's many college dominated small towns, a Lesbian leader in her community's AIDS effort stated:

(T)here were only one or two people who were straight who happened to be with the Task Force, the rest of them were all Gay.

Gay identified emergence happened predominantly, and not coincidentally, in the locations where pre-existing and visible Gay/Lesbian networks existed.

Leaders in the AIDS movement consistently made reference to the importance of Gay male financial and volunteer support in the early years of organizing. The Executive Director of one AIDS SMO noted:
If the Gay community hadn't done what it has done, nobody would be where they are today.

Another local community leader spoke about her organization's earliest fundraising attempts:

They (fundraising events) were all Gay bar fundraising because they had a ball in the Gay bars.

Gay activism was the pivotal component in the earliest urban Ohio AIDS SMO organizing. AIDS fundraising in the Gay/Lesbian community and organizing, the role of volunteers as movement resources were invaluable. Grassroots activists had only their own resources. Initially there was no government funding of local education or service programs. The state first used federal dollars to fund AIDS projects in 1987. The state Health Department utilized dollars from the Federal Preventive Health Block Grant program to fund the "AIDS Mini-Grants" program. Grant applications were accepted in either "service-oriented" or "prevention-oriented" categories. Professionally sponsored groups had the benefit of basic material supports of the home agency. The state legislature in Ohio did not allocate funding for AIDS until 1989 (Rowe and Ryan 1988). Federally mandated surveillance activities started in 1983, but federal dollars for education/prevention activities did not begin until early 1984. This allowed for the hiring of a "Gay health consultant" to serve Ohio's Gay communities.
ORGANIZATIONAL STRUCTURE

During the period when I was engaging in participant observation and interviewing - between 1988 and 1990 - most AIDS SMOs serving the largest cities experienced growth, formalization, and further bureaucratization of their organizations. In Ohio's rural counties and small towns, new AIDS SMOs were founded and many earlier organizing efforts were expanded (see Table Two "Increase in Ohio AIDS Organization, 1986-1990."). This was a period of marked and steady increase in the AIDS caseload (see Table Three "Increase in AIDS Cases, 1983-1992."). Though it was not understood at the time, this period apparently marked the zenith for financial resource availability (see Table Four "State Funding by Fiscal Year," for an understanding of how state monies for AIDS peaked July 1989 to December 1990).

The year 1991 was a stark contrast to the pattern of federal allocations for AIDS that existed previously. Since the epidemic was identified in 1981, allocations increased each year. Nationally, 1991 marked the first reduction in dollars available to state Health Departments from the federal government. (see Table Twelve "Federal Funding by Calendar Year." for federal AIDS allocations in Ohio). Additionally, and as a consequence of the general economic downturn that occurred in 1991-1992, the annual state AIDS allocation was reduced more than one million dollars (Ohio Department of Health staff meeting notes 1991).
Table 12

Federal (Centers for Disease Control) AIDS funding

by calendar year (thousands)  

<table>
<thead>
<tr>
<th></th>
<th>1989</th>
<th>1990</th>
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<tbody>
<tr>
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<tr>
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<tr>
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<td>1,192</td>
</tr>
<tr>
<td>risk reduction</td>
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<td></td>
</tr>
<tr>
<td>counseling and testing</td>
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<tr>
<td>minority-</td>
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<td>656</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>total:</td>
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</tr>
</tbody>
</table>

(a) - minority-targeted pooled with health education/risk reduction

Organizational Structure

Virtually all of Ohio's AIDS organizations have some form of formal authority structure. The typical pattern consists of elected or appointed officers (i.e. president, vice-president and treasurer) chosen from the board of directors. Board members, or other organizational leaders, chair the various committees that coordinate and do the work of the organization. The committee structure tends to become more elaborate over time. SMOs begin with the core concerns of education and/or service and then expand the committee structure to include fundraising, public relations and volunteer coordination.

Over time, SMOs often experience shifts in their internal authority structures (Zald and Garner 1987). As SMOs expand their ability to
attract resources, paid staff may replace the chairs of committees and/or the entire function of the committee may be shifted to paid staff responsibility. This marks the beginning of a professionalization process for some SMOs, which can accelerate the de-homosexualization process noted above. The process happened to the early Gay initiated organizations in Columbus, Cincinnati and Cleveland, and as a consequence these organizations eventually developed into professional social movement organizations (Zald and McCarthy 1987; McCarthy and Zald 1977; Staggenborg 1988).

![Diagram]

**Figure 1:** Organizational Evolution

The oldest and largest of Ohio's AIDS SMOs have begun to resemble what McCarthy and Zald (1973, 1977) describe as professional social
movement organizations (PSMO). Within professional social movement organizations, career activists advocate for a largely hidden population and increasingly mobilize resources from outside the beneficiary constituency. Accessing resources from elites increasingly dominates strategic planning (Staggenborg 1991; Jenkins and Perrow 1977; Jenkins 1985).

Following Lofland's (1977) typology of social movement organizations, the SMOs in the Ohio AIDS industry can be classified as either "associations sustained by volunteers" or "bureaus employing staffers." In small towns and rural areas where the scope of the AIDS problem is smaller, many organizations are initiated and remain at the "all-volunteer" stage. At the emergence stage, the Gay initiated groups in Ohio's largest cities and some university towns were also "all-volunteer". The internal authority structure for organizations at this stage of development typically consisted of loosely defined committee structures with task orientations and a committee chairperson who is able to exercise considerable authority. Later organizational structures might become more formalized, with the election or appointing of officers.

A very significant shift occurs within an organization when it moves to utilize paid staff. Initially, Ohio AIDS organizations used grant monies to hire front line workers who provide direct client services or prevention education. Only later when organizations increased their financial stability were senior staff and/or paid administrators brought on board.
In these groups, senior staff and administration come from previous positions outside of AIDS activism where they already were leaders within the larger social movement sectors. Both nationally and locally, paid leadership positions within the movement are increasingly filled by individuals with nonprofit community based organizing expertise. These individuals are primarily white and heterosexual with administrative experience.

For example, Robert H. Brown became the executive director of the American Foundation for AIDS Research (AmFAR) in 1988. He was a veteran staffer, and had previously served 20 years with the March of Dimes. In Ohio, a former board president describes her organization's current executive director.

R: Funders don't realize how valuable it is to have that lead person, who is the point person out there for the community to say "Oh I know him, he's the Director of the AIDS Task Force.

I: He has a reputation in the community?

R: Right. He was Director of the Lung Association for years before he came to us, he already has a reputation.

Another leader describes her own background.

When they approached me in 1987, September '87, I had never heard of the organization, which was not unusual for this community. But I had been working with nonprofits doing professional development training and so I was familiar with 600 or 700 nonprofits in (our) county.

A third category of AIDS SMOs currently are caught in transition between these two organizational types. Transition can be a time of considerable organizational stress as volunteers and staff compete for
the day to day control of organizational activities and agendas. An official for the Ohio Department of Health reflects on the consequences associated with the transition made by some AIDS organizations.

It's interesting that the bigger Task Forces have kind of become businesses, they almost had a better form of organization than the ones who started out as Gay based organizations and then kind of evolved into businesses. Because it started out, the ones who started out with you know a nucleus with three to six concerned individuals. When it was three to six people, there was no problem with who was the president, who was the secretary, who was the treasurer and who was the president of the board. But as those organizations grew, then there came the fighting and who's going to be our president, who are we going to follow, who's going to lead us? That sort of thing.

Social movement scholars have recently begun considerations of the "channeling mechanisms" which control SMOs by restricting organizations' options regarding organizational structure and programming (Jenkins and Eckert 1986; McCarthy et al 1991). Specific mechanisms created by federal government to restrict activism include Internal Revenue Service codes regarding tax exemption, and U.S. Postal Service regulations. State created channeling mechanisms in conjunction with increased demand for services and the resulting need to explore more mainstream funding sources like the United Way have fueled the trend toward greater bureaucratization in the movement. Channeling mechanisms create a limited set of structures, goals, and tactics for SMOs in the U.S. (Jenkins 1987; Jenkins and Eckert 1986; Gale 1986; McCarthy et al, 1991). Additionally, the guidelines governing the distribution of resources by elite patronage groups (private foundations and trusts) also become part of the interlocking system of incentives that serve to
limit the range of goals and tactics available to SMOs who choose to access them (McCarthy and Zald 1987; McCarthy et al 1991; Weisfeld 1991; Winnows 1989).

One executive director describes the historical development of her group's decision to pursue incorporation as a tax exempt organization.

By February 1984, they decided at that point to incorporate, probably for financial reasons, they couldn't secure funding and that kind of thing without the 501c3.

Many of the older and formally institutionalized AIDS SMOs in Ohio have incorporated under the not-for-profit organizational status (501c3) administered by the Federal Internal Revenue Service (Jenkins 1987; McCarthy et al 1991). This 501c3 status is routinely required by government and private granting entities as a pre-condition to receive funding (McCarthy et al 1991; Weisfeld 1991). The strategic choice to seek incorporation for an AIDS SMO provides one impetus that leads to the creation of more formalized organizational structure (Zald and McCarthy 1980). Formalized structure makes explicit the rules and regulations of organizational life and serves to define the roles, rights and duties of members and leadership.

One organizational leader describes how channeling forces influenced her agency's transition.

I think the organization has been as successful as it has been because it has a strong emphasis on nonprofit organization ... that's what's made us a stable organization. I mean I have to look at it as a business.
It should also be noted that the interviewing component of this research was conducted from June 1990 to January 1991. This era marked a period of dramatically expanding financial resources for AIDS in Ohio. During this period, the federal government and the state legislature made additional AIDS funding available. Zald and Ash (1966) hypothesize that SMO leadership will accommodate shifts in movement ideology that result in access to greater material incentives. These shifts allow leaders to protect their own positions within the movement. Some of the new money available to AIDS SMOs was used for programming and expanding local staff through the creation of new HIV education/prevention initiatives, as well as for expanding client services.

An organization's Articles of Incorporation is one prerequisite required for securing the not-for-profit designation and the accompanying benefits of participation in channeled social movement activities. These benefits include decreased tax liability, access to discounted postal rates and the ability to offer tax deductions to donors (McCarthy et al 1991). One such agency's statement of purpose, filed early in 1984, reads in part:

This corporation is a nonprofit corporation organized and operated exclusively for educational and scientific purposes to be achieved by expenditure of its funds to actively address health issues which affect the Lesbian and Gay communities ... educate the community on problems caused by Acquired Immune Deficiency Syndrome (AIDS) ... Further, the corporation will assist those persons who suffer from these diseases in finding social and financial support while they suffer from these diseases.
This statement again demonstrates the dual commitment Ohio's AIDS SMOs have made to HIV education and client services. This agency is one of the few Ohio organizations that existed prior to the onset of the AIDS crisis. Uniquely, this group designed its statement of purpose specifically to meet the needs of Gay and Lesbian community members. Among the organizations reviewed, it is the only agency that specifically mentioned Gay issues in its Articles of Incorporation.

There is little evidence within the Ohio AIDS SMI of a systematic attempt by member organizations to monitor and/or critique the government decisions made that mitigated AIDS organizing in this region of the United States. Influencing the creation of state public health policy has not been a major priority (Rounds 1988). One consequence of the decision made by most SMOs to pursue a "not-for-profit" tax exempt status are limitations on political advocacy and lobbying. Organizations receiving tax exemptions are required to limit their operations and have restricted access to the legislative and political lobbying process (McCarthy et al., 1991). Fear of violation of tax codes will cause some organizations to completely avoid any participation in the mainstream political process.

As some Gay initiated groups grow to dominant in their region, they become increasingly formalized in their organizational structure, and shift towards professional social movement leadership and goals. At this point the de-homosexualization process described in Chapter five may become institutionalized. This pattern of transition from a Gay
initiated group to a more professional SMO model occurred repeatedly in Ohio. The Columbus AIDS Task Force (CATF) is the best example. CATF moved from its beginning as the collective effort of a Gay male friendship network in 1983 to a 1989 total revenue base of $464,830 for the organization (See Table Five, "Incorporated Organizations in Urban Areas, 1989.")

Other Gay initiated groups purposely avoid formalization and remain smaller scale operations that may lack the ability and/or desire to attract significant resources from outside the Gay community. Not all movement participants are pleased with the shifting direction of SMO organizational structure and leadership of some Gay grassroots organizations. One Gay male organizer complained bitterly of the shifting patterns of movement leadership:

I don't want to slam her too much because I've seen this happen with damn near every single fuckin' AIDS agency, they are taken over, either by default or invitation by a straight white female who tries to turn it into a United Way.

Parenthetically, it must also be acknowledged that the catalyst for the de-homosexualization process within the Ohio AIDS SM often comes from within the Gay community itself. The de-homosexualization process creates a pretext in which closeted Gays can shield suspicions concerning both their sexual orientation and their own involvement in the movement. After commenting on the dearth of visible Gay male leadership in her community, one heterosexual former AIDS SMO president remarked:
I saw down the road the possibility for United Way funding...
I recognized we could not go to the United Way board and have then say, "And who are these people, and why are they interested?", and say well they're interested because they're all Gay men. Number one, my board wouldn't let me do that. Number two, probably the United Way allocations committee would've fainted at that.

Repeatedly, this tension regarding Gay affirmation is noted. AIDS SMO leadership consistently frames its own actions in the context that AIDS and the issues of "homosexuality" must remain separate. Nationally the most dramatic example is New York City's Gay Men's Health Crisis (GMHC). This group also began out of the friendship and associate networks of the United State's earliest known AIDS cases, and eventually grew into a multi-million dollar professional social movement organization (Perrow and Guillen 1990; Kramer 1989; Shilts 1987).

In the white, middle-class, Gay-identified men's community, previously existing networks served to greatly facilitate later Gay initiated AIDS activism (Shilts 1987; Kramer 1989; Altman 1986). Conversely, many regions of the United States dominated by small towns did not possess this pre-existing network of Gay male activists and/or organizations (Miller 1989 and Rounds 1988). In Ohio, the general lack of legitimate, visible and activist Gay networks led to some public health initiated AIDS efforts, as well as to other joint mobilization attempts that covertly used informal "closeted" Gay male networks.

The trend towards de-homosexualization occurs at the same time that groups are shifting to employing paid staffers and professional administrators. A Gay male former SMO staffer sums up many Gay male activists feelings about the transition occurring in the AIDS movement.
It is a very unfortunate thing to have to do when you sacrifice the original ideals of an agency and the original culture of an agency to mainstream it and heterosexualize it.

This second, professional pathway, marks the emergence of another set of Ohio's AIDS SMOs. Sponsoring institutions, most often local Health Departments, either alone or in cooperation with local Red Cross chapters, religious groups, "minority organizations" and/or Planned Parenthood agencies, initiated AIDS organizing that made invisible the participation of Gay and Lesbian individuals. A Gay man reflects back on his participation in local Health Department dominated AIDS organizing:

"(L)ooking back, some of the delegates, or people chosen from agencies to be involved (in the Health Department's AIDS Task Force) were Gay people. Some of them were very closeted and so it was like, "Well, I'll help and I'll do what I can do, but I don't want to be real visible."

The participation of closeted Gays in Health Department initiated AIDS organizing was risky business for those involved. Participation in an AIDS SMO required individuals to redefine themselves relative to the general society. As a closeted person, an individual routinely separates their professional and personal worlds. A professional sponsored group brings together a diverse set of movement participants representing a variety of community groups, agencies and businesses. Particularly for men, exposing an interest in AIDS issues could lead to widespread speculation about sexual orientation. This is one explanation for the dearth of visible heterosexual male players in Ohio's AIDS arena."
The classic pluralist notion that when groups are tightly interwoven into society's mainstream by social, economic and cultural linkages they are less likely to participate in social movement activity must also be considered as a macro organizational condition relative to AIDS organizing (McCarthy and Zald 1973). The AIDS crisis forced to the forefront the issue of sexual identity for some "men who have sex with other men" but who do not self identify as Gay and challenged their ability to continue identification with the mainstream. Many Gay identified, middle-class men whose social and economic privilege had previously shielded them from the bulwark of anti-Gay sentiment found it increasingly difficult to identify with a mainstream culture that was apparently indifferent to the death and suffering of so many of their contemporaries (Altman 1988). Gay male activists in Ohio have also been mobilized by the failure of the institutional systems to respond quickly and adequately to the AIDS crisis.

Repeatedly, it is apparent that not all impetus for the dehomosexualization of the Ohio AIDS movement comes from members of the heterosexual community. Much of the Gay and Lesbian membership of Ohio's AIDS organizations chose to remain closeted in their publically identified role with the SMO. Sexual orientation status may be a shared secret of the exclusive core of the group, but it is most often not a part of the public identity of the AIDS SMO. Noting this trend, a former AIDS Task Force president remarks:

(Our area) is conservative, I know that's not the first place you've heard that, but it's one of the reasons that none of the Gay men in the community were willing to serve as president.
The former president of the board on one AIDS organization provides one explanation:

(T)here are some (Gay men) who feel very militant, and want that militancy to be at the forefront. And others ... who go "wait a minute, we shouldn't be a militant organization, we need to be a responding organization, we don't want to turn off the mainstream."

In other areas, local Health Departments, or other non-Gay identified AIDS organizing efforts were primarily or exclusively staffed by heterosexuals. One member recalls:

It's really interesting, because I think our Task Force here has been predominantly heterosexual. With some degree of homophobia existing.

This informant goes on to describe the agencies that came together in a local AIDS SMO initially organized through the local Health Department initiatives. They include local hospital representatives, infection control nurses, funeral home directors, dentists, and other human service providers.

In one of Ohio's smaller urban areas a typical non-Gay initiated effort is described by a current staffer.

Initially, how it got started, I think, was pretty much a joint effort on the parts of the (name) county health Department and the (name) county American Red Cross, and in fact those two organizations and many of their staff members initially formed a real nucleus of the Task Force and kind of held it together and kept it functional - long before the Task Force finally reached the place where it incorporated and was ready to do fundraising.

A state Health Department official who provided substantial technical assistance to emerging groups early in the epidemic describes the
relative advantage of institutionally sponsored organizational emergence.

The Task Forces that started in this "community representative" fashion, they didn't really have those same kinds of organizational frustrations. Power plays. Everyone knew why they were there, they knew what they represented ... They knew what their role was and their place, and they worked with each other. So there wasn't the struggling for power. And they've done very well.

Dominated by local Health Departments the efforts of AIDS SMOs to achieve independent identities are often seriously compromised by the high visibility of Health Department employees in positions of SMO leadership. This informant fails, however, to acknowledge the potential conflict of interest:

(W)here there is a void in the Task Force, we try to make up for it with the Health Department. We, I'm lucky, since I wear both hats I can intersperse what I do with both organizations ... The (county AIDS Task Force) is not health Department based. I just happen to be the president and the health commissioner. I can flip-flop, but it's a separate entity, as a 501C3 organization.

The dual roles assumed by Health Department employees as SMO leaders causes allegiances to be suspect. A former board president of a SMO located in one of Ohio's major urban centers rejects the accusation made by members of her organization and the larger AIDS community that her decision-making was biased because of her staff position with the local agency with oversight responsibility for government AIDS funding.

Unfortunately, the perception of some members of the community was that because I was a Health Department employee, I was controlled in my board activity by the health commissioner (and I couldn't be an independent actor).
Another variant of institutionally sponsored AIDS organizing occurs in the context of Ohio's communities of color. Started out of pre-existing "minority" organizations and/or networks of African-American and/or Latino/a public health professionals, these AIDS SMOs rarely have visible Gay or Lesbian members or leadership.

On a statewide level the Ohio Department of Health again acted as a catalyst for AIDS organizing among people of color by calling for the formation of a "Minority AIDS Task Force". (T)his Task Force was to do statewide planning. (Ohio Department of Health staff) got together about 35 people. Pharmacists, physicians, clergy, lay people, social workers, a couple of people from "Black and White Men Together" ... they identified the need for permanent staff persons (at the state health Department) as well as at least two consultants to do statewide AIDS prevention in communities of color.

But again, "closeted" Gays and Lesbians play pivotal roles within "minority" social movement organizations. There can also be a Gay connection to organizing in communities of color, and it is most often found either through informal personal networks or through connections with local chapters of the national Gay organization "Black and White Men Together" (BWMT). BWMT is an organization that supports multi-racial Gay couples.

In 1990 Stonewall Union's The Ohio Gay Guide listed multi-racial Gay groups in Cincinnati, Cleveland, Columbus and Dayton. By 1990, these same cities all have minority AIDS activities happening in an ongoing way (see Table Thirteen, "Organizations by Programmatic Priority").
Table 13

Programmatic priorities of AIDS organizations

<table>
<thead>
<tr>
<th>programmatic priorities:</th>
<th>housing: &quot;minority focus:&quot;</th>
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</thead>
<tbody>
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<td>service/education:</td>
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organization:

Adams County AIDS Task Force......X
Allen County AIDS Task Force......X
Athens AIDS Task Force............X
Auglaize County AIDS
Task Force........................X
AIDS Task Force of the
Upper Ohio Valley.................X
Middletown AIDS Task Force........X
AIDS Commission of Greater
Cleveland..........................X
AIDS Housing Council................X
Cleveland AIDS Coalition..........X
Health Issues Task Force..........X
Delaware County AIDS
Task Force......................X
AGAPE Friends Helping
Friends..........................X
Erie County AIDS Task Force.......X
AIDS Service Connection...........X
Columbus AIDS Task Force.........X
Columbus PWA Coalition............X
Community Free Job List...............X
Education and Research............X
Minority Education Committee
on AIDS................................X
Greene County AIDS Task Force.....X
AVOC................................X
Caracole, Inc........................X
Northern Kentucky AIDS Task
Force..............................X
Greater Cincinnati AIDS
Task Force........................X
Minority AIDS Prevention
Alliance............................X
Hancock County AIDS Task
Force..............................X
Greater Steubenville
Area AIDS Task Force...............X
Lake County AIDS Task Force.......X
Licking County AIDS Task
Force..............................X
Lorain County AIDS Task Force
Toledo AIDS Task Force
Mahoning AIDS Task Force
Marion Area AIDS Task Force
AIDS Foundation - Dayton
Dayton Area AIDS Task Force
Minority Advisory Committee on AIDS
Southwest Regional Minority AIDS Council
Muskingum Area AIDS Task Force
Portage County AIDS Task Force
North Central Ohio AIDS Task Force
Sandusky County AIDS Task Force
Southern Ohio AIDS Task Force
Seneca County AIDS Task Force
Stark County AIDS Task Force
Multi-County AIDS Network
Northeast Ohio Task Force on AIDS
Trumbull County Area AIDS Task Force
Wood County AIDS Task Force
Wyandot County AIDS Task Force

The slow response to the HIV epidemic by civic, religious and even medical professionals within communities of color is well documented, as is the need for culturally sensitive HIV prevention and client services (Dalton 1989; Randolph 1988; Mays and Cochran 1987; and de la Vega 1990). "Cultural sensitivity" requires respect and value be placed on the cultural and social diversity which exists among different racial and ethnic populations. Cultural specificity requires an acknowledgement that different racial and ethnic populations possess unique tradi-
tions and normative expectations which must be integrated into educational and service programs if they are to be effective.

In Ohio's racial and ethnic communities, the initiatives for organizing are varied. For example, one African-American AIDS organization developed as an outgrowth of another group working in the community on issues of more general concern. Eventually, because of the AIDS specific funding opportunities, the AIDS "sub-committee" outstripped the original organization, and became the dominate focus for the SMO.

Organizing in Ohio's Latino communities also occurred in combined response to unmet needs and funding opportunities. Some members of Ohio's Puerto Rican community organized themselves in affiliation with an older and well established AIDS coordinating body in one of the major urban areas. Though early organizers were Latino/a, the initial request to form an organization came from the mainstream sponsoring organization. Elsewhere in Ohio a predominately Mexican-American community had no formalized AIDS organizing until an "Hispanic" consultant was hired by the Ohio Department of Health in early 1990. Her charge was to initiate AIDS education and prevention activities. In this example pre-existing organizations serving a primarily migrant farm workers community were coopted for purposes of providing their clients with HIV education and prevention messages.
Membership Mobilization

The memberships of SMOs in the Ohio AIDS movement are generally inclusive. Depending on the size and scope of the organization, communication networks create crucial links between SMOs and their adherents. Individuals who are loosely connected to the SM through communication networks, including friendship networks, organizational newsletters, or the local media, have few demands placed on them by SMOs. These individuals, primarily conscience constituents, may send money to support the SMO, attend SMO events, and/or donate their own services to the effort (McCarthy and Zald 1977).

Ohio AIDS SMOs also have a more exclusive core set of volunteers. These individuals are often very dedicated and contribute heavily of their time, money and talent. Depending on the particular group's internal authority structure, they may be members of the board of directors and/or the chairpersons of various organizational committees. Or, they may not hold leadership positions, but simply have a substantial commitment to the organization. Core membership is not limited to beneficiary constituents, though beneficiary constituents are well represented in this group (McCarthy and Zald 1977).

Volunteers serving Ohio's AIDS SMOs contribute vast amounts of time and energy to the goals of the movement. The unpaid labor of those mobilized to participate not only contributes to the success of movement organizations, but also saves local, state and federal bureaucracies the expense of providing these same services for pay. Arno's
(1986) study of the nonprofit sector's response to the AIDS epidemic in San Francisco illustrates the value of volunteer efforts. During the fiscal year 1984–1985, over 130,000 hours were donated to three San Francisco AIDS organizations (Arno 1986).

AIDS SMO's have inclusive memberships, meaning there are few membership requirements, partial commitments and limited organizational loyalties (Zald and Ash 1966). Most of Ohio's AIDS SMOs do not have dues structures, and as a consequence, strategies for counting members vary from organization to organization. One executive director describes the complexities of answering the question, "How many members do you have?"

We have one (mailing list) as our volunteer base. That has approximately 400 people on it, and those are active volunteers in the organization. We have another list that's called "donor list", and those are people that have given us a check or anything. Even if it's only been one time in their entire life, they're on that list forever. That is around 6,000 people. We have a newsletter that goes to 2,000.

This SMO is one of the largest in the state. It's core group is not only significantly larger than most, it is also supplemented by a paid staff of more than ten people.

Other of Ohio's AIDS organizations are much smaller. One of the few statewide AIDS groups operates under a very different set of parameters than does the organization described above. A founding member reports on his group's membership.

I'd say the core (sic) group is around twenty. We have five or six people who are actively involved.
An AIDS SMO located in a predominately rural region of the state also has a much smaller membership base. A SMO staffer discusses the scope of volunteer support that has been mobilized by her agency.

I have eight that I can really depend on out of sixty-eight (volunteers). People want to be part of something but then when it comes to actively (getting involved) it's a whole different story.

Ohio's AIDS volunteers come largely from pre-existing cooptable constituencies. This places the AIDS movement in direct competition for members within other social movements such as the Gay and Lesbian civil rights movements. The cooptation of pre-existing constituencies is a common strategy used by social movements to expand membership (Carden 1989). The civil rights movement of the 1950's and 1960's was able to coopt the memberships of many southern black churches (Morris 1984). The women's movement of the late 1960's coopted young women from the civil rights, students and anti-war movements (Freeman 1983). Additionally, older women were also coopted into the feminist movement of this time through networks of businesswomen, female professionals and government workers (Freeman 1983).

A SMO staffer who coordinates volunteer activity describes his agency's recruits.

(A)lmost all of it's been Gay white men. Over half of them I'd specifically recruited from people that I knew in the community, and in the bars, and at parties, and whatnot.

The president of a local Gay and Lesbian civil rights organization notes the overlapping constituencies volunteering services to both AIDS and Gay efforts.
Some of them (volunteers) get involved directly with AIDS organizations, some of them get involved more generally with the Lesbian/Gay Civil Rights movement as well as AIDS specific organizations.

Gay grassroots AIDS organizations around the state have mobilized significant numbers of new recruits to activism. Many of these individuals would have never participated in a Gay civil rights organization, but do become active on behalf of AIDS.

Not all members of the AIDS social movement's beneficiary constituency are Gay men. The friends and families of individuals experiencing HIV disease also directly benefit from the movement. Once a minimum level of direct services have been established, SMOs tend to expand their agendas to include the needs of the extended family networks of people living with HIV disease. Those providing support to an ill person with AIDS need emotional and physical support. Some SMOs provide services including respite care and friends/family psycho-emotional support groups. A leader in a local SMO who is herself the mother of a Lesbian, describes her organization's general membership.

We have people who are HIV challenged, people with AIDS, and families and friends of people with AIDS, or who have died from AIDS.

Within SMOs that were not Gay initiated, conscience constituents are more likely to be among the leadership and be more numerous among the general membership. Conscience constituents are often public health and medical professionals who donate money and/or volunteer their time. These individuals are donating services to the social movement as individuals. Their contributions should be considered separately from
those who are assigned to participate in AIDS SMO activities as a part of their regular paid duties. The incentives to such behaviors are different.

Utilizing the resources of non-constituency institutions, including local Health Departments, hospitals and/or other agencies providing health promotion, AIDS SMOs mobilize resources from potential competitors. A distinction must be made between volunteers who are donating their time and those individuals who are participating in the context of their employment. Assigned "volunteers" bring with their contribution the agenda of the organization they represent.

The president of one SMO birthed out of a coalition of public health officials and other community organizers describes her organization's ability to mobilize conscience constituents.

We knew we had this cadre of professional volunteers who would have done anything we asked them to do.

A mid-size AIDS SMO president describes volunteer mobilization in her organization.

(Interviewer): Of those twenty, twenty-five (original) volunteers, would you say the majority were Gay men? (Informant): I would say half. And the other half were health professionals.

In sum, SMOs compete to mobilize individuals. Competition occurs on various levels both within the AIDS SMI and throughout the larger social movement sector. The incentives which ease mobilization are worthy of further exploration.
Incentives for Mobilizing Ohio AIDS Volunteers

I will assume that participants in social movement activity are rational actors and will suggest three sets of incentives that serve to motivate the participation of activists (Friedman and McAdam 1987). The three sets of incentives considered include material, purposive, and solidary incentives. Further, I will utilize the concept of emotional incentives as an extension of the purposive incentives concept. A rational choice model assumes that when the private benefits of movement participation outweigh the costs activism will occur (Friedman and McAdam 1987). The selective incentive concept provides an incomplete understanding of what motivates the diverse volunteer base utilized by Ohio's AIDS social movement. To understand Ohio's AIDS volunteer mobilization, disincentives as well as incentives must be considered (Kreisberg 1988).

The disincentives for participation are high because significant stigma continues to exist regarding AIDS (Weitz 1991; Centers for Disease Control 1989 and 1988; Hingson et al 1989). Beyond the fear of causal transmission of HIV comes a more generalizable stigma that defines AIDS, and particularly those individuals associated with the disease, as different and disgraced (Patton 1985; Altman 1986; Hammonds 1987). The stigma is certainly most pronounced for known HIV infected individuals, but extends to all those who associate with the movement. The incentives that facilitate individual participation in AIDS activism have to be powerful to overcome the "spoiled identities" that must be endured by its advocates (Goffman 1963).
HIV infected individuals most often experience a period of many years living with the disease in relative good health. During this time they show no outward signs of the disease. Health educators, and even service providers, are routinely assumed to be Gay/Lesbian and/or HIV infected by members of the uninformed general public. The underlying assumption that typically gets made is, "who else would voluntarily want to be associated with AIDS?"

Material Incentives

Material incentives are the tangible rewards of participation in a social movement which are readily priced in monetary terms (Wilson 1973 and Oliver 1983). Material incentives for clients of AIDS SMOs can include money, food, shelter, transportation and other concrete rewards provided for movement participants. For people living with HIV infection and/or AIDS, the material incentives of participation in the social movement are many, including emotional, practical and financial support.

The classic understanding of the "free-rider" concept is less relevant in the AIDS example because HIV infected individuals and their friends/families do not have an indefinite time period to wait for others to achieve the goals of the movement (Friedman and McAdam 1987). Only a small segment of those who utilize an AIDS organization's services bear any of the costs of movement participation and potential failure (Oliver 1983). All those eligible for services can receive them.
Non-client volunteers to the AIDS SM also can benefit from material incentives. The most substantial reward a non-client volunteer can receive is the opportunity to move into a paid staff position.

I had been a buddy. I was doing education committee things and public relations things and we decided we needed a speaker's bureau. ... We got the contract and (the executive director) asked me if I knew anybody who wanted to be a (name of position). Well sixteen people applied. I got the job. I was really happy. It was probably one of the best things that ever happened to me in my life because I was so excited, it was something I wanted to do. And I had a lot of experience in it.

The young man whose experience is described above is one of the many Gay activists who came to the SM with little or no experience in activism (Altman 1988; Patton 1985). Though material incentives are powerful, the pay and prestige associated with most paid staff positions within the Ohio AIDS SMOs are insufficient to attract all but those already dedicated to the movement. The young activist from the earlier quote noted this fact himself. His starting salary was only $15,000 annually.

Purposive Incentives

Activists are also mobilized through purposive incentives (Kreisberg 1988). These incentives encourage movement commitment by facilitating the acquisition of intangible rewards. More specifically, purposive incentives allow volunteers to derive a sense of satisfaction from having contributed to the attainment of the movement's goals (Oliver 1983 and Wilson 1973).
A state Health Department official describes the motivation of many early activists.

(Early activists were) playing a role in helping to solve a really difficult problem. "Doing the right thing." Being involved at the ground level.

Another state official offers this explanation of volunteers' motivations.

(T)here's a little claim to fame that might be gotten from being involved with this, and maybe historically, years later, people will look back and say, "Oh you were a real trooper. You were involved in AIDS education."

A SMO president who is employed by the local Health Department shares her motivation for participation.

I'm a traditional public health (activist), I mean I've always been a social activist, and ... there was a real need for people who had community organization and social activism skills. (And I) thought, it's a public health problem.

Purposive incentives may motivate both volunteers and paid participants in the AIDS movement. A past SMO president, herself an employee of the local Health Department, describes the mix of individuals drawn to participation in her AIDS SMO.

There are a few then that are the Health (Department) people, that are touched because it's their profession... Now, I got into this because of my work.

Purposive incentives help provide the powerful motivations necessary to recruit activists to a cause that carries the heavy stigma surrounding AIDS.

Emotional Incentives: A special form of purposive incentive is central to the recruitment of volunteers and paid staff to AIDS work.
This form of selective incentive an emotional incentive (Hochschild 1979). Emotional incentives exist within the context of the AIDS movement because SMOs are able to create a safe space for those who are experiencing AIDS-related losses. These volunteers share their pain and transform their grief into productive effort. Volunteers motivated by emotional incentives seek the company of individuals who, because of their common experience with AIDS, will be understanding and sympathetic to the devastation that an HIV diagnosis can engender.

Repeatedly, activists reported the most likely predictor of volunteerism was related to an individual having experienced a personal loss because of HIV/AIDS. Informants recount their own paths to commitment to the AIDS issue.

I had taken buddy training in April '88 because a young fellow who had been pretty much a son to me since he was five years old, had come back from San Francisco HIV positive. I was trying to learn enough to help him.

A person living with AIDS tells his story.

I realized in January of last year that I wasn't the only one who was going through this bullshit. AZT (an anti-viral drug) is too expensive. DDI (another experimental anti-viral) you can hardly reach DDI. I decided maybe there was enough of us (that) together to take our anger and then produce it in a positive manner.

An African-American public health official relates his emotional connection to HIV-related bereavement.

On a personal level, I got a first cousin, a drug user, who died (of AIDS related causes) about five years ago.

Another African American activist describes her current personal link to HIV.
I've had a lot of friends die. I have a friend right now that I'm trying to become a buddy to - I have known his family for fifteen years and now he has the virus.

The fear of losing one's own health may be the most potent form of emotional incentive. One AIDS SMO president reflects on the setting of priorities for her organization.

Where (intra-agency) competition came, I think I mentioned to you before, there were a group of folks who got very interested in establishing a buddy system. Hindsight of course is 20/20, Phyllis, and two of these folks are now dead of AIDS. At that time we were not talking about who was HIV positive. I now understand a lot more of the fire in the belly of people who are infected, who feel the need that if I don't do something, my time may be short.

The families and friends of HIV infected individuals also respond to emotional incentives, serving AIDS SMOs as volunteers. The support network for a particular PLWA (when it exists) may also garner incentives from the movement. Lovers, friends and families may participate in movement sponsored support groups, or utilize respite or adult day care services which provide temporary relief from caregiving responsibilities. Psychological and counseling services for the support network are also available in some Ohio regions.

Emotional incentives motivate people who are personally supportive to PLWA'S to become involved in the movement.

(A)s the heterosexuals came on board it was because somehow or another it had affected their lives. Either a relative or a friend or someone had the disease or had died from it, or something like that and they decided to get involved.
The death of a child can produce a powerful emotional incentive. One of the mainstream protestant denominations had its AIDS Task Force radicalized by an announcement made by its current chairperson.

The committee had begun, but I think it had really taken off since the person who has become the chair is personally involved and has shared that with others. It kind of motivates other people to get involved and to really do something, not just have your name on a list.

Activists recognize the power of emotional incentives, and discuss their use as a strategic tool. Organizers working in a rural part of the state with low numbers of reported AIDS cases talk about the power of emotional incentives.

I think, you don't wish it on anybody, but I think that once someone else who influences this community in some way and some of their family members or close friends are really infected. The purse strings are not going to be turned loose. There's not going to be anyone willing to donate their time, anything, until someone they know really well or comes close to home for them.

Even local politicians can be influenced by emotional incentives.

One of the members of the (local) city council had a cousin die from AIDS which changed her attitude a great deal... but now that it's touched her life, her attitudes have changed a lot.

Another local AIDS SMO found an organizer for area fundraising utilizing emotional incentives.

(W)e had a fundraiser this year in February called "Bands for AIDS", and a local guy ... plays in a band and his cousin died with AIDS last summer so it's become near and dear to his heart, and he organized all these bands.
Solidary Incentives

Another set of incentives that facilitates AIDS activism, and the mobilization of volunteers for specific AIDS SMOs, are solidary incentives. Solidary incentives provide the intangible rewards that arise from the association of others (Wilson 1973 and Oliver 1983). Solidary incentives can stimulate a spirit of cooperation between movement participants.

In the example below, a SMO staffer discusses her motivation to engage in ad hoc cooperation. As a member of a nonconstituency institution doing AIDS work for her agency, she finds it necessary to bypass the restrictions placed on her against cooperation (Freeman 1983).

We seem to do what we need to do to help each other, because we know each one of us is dedicated to getting the work done.

This woman is motivated by the dedication of those other activists staffing competing SMO’s programs. Solidary incentives help compensate for the lack of general social support for prioritizing AIDS by reinforcing the commitments and camaraderie of participants.

A movement sub-culture exists, and can serve to sustain AIDS SMO members (Lofland 1985). This culture is characterized by the normalization of HIV infection. This allows those stigmatized by HIV/AIDS to find a refuge from the discrimination, isolation and rejection they often find in the larger community. The culture of a social movement is embodied in its collective emotions, beliefs and actions (Taylor 1989). In the case of the AIDS social movement the collective emotions
and beliefs center on a valuing of individuals who are infected, and direct effort to assist people living with AIDS to be independent and live with dignity.

AIDS prevention specialists have to be particularly resourceful if they are to successfully recruit participants into their efforts. On one small town college campus, an organizational leader describes his motivational techniques that specifically stress the solidarity benefits of participation.

We tapped into some student leaders. We brought in people who weren't involved in much and had chosen this issue (safer sex) to become involved in. And we're fun and personable, they all want to work with us because we give great treats. Another Gay male leader in his local SMO speaks directly to the issue of the rewards of participation and friendship that can arise for those who do AIDS volunteer work.

I would say we need to channel (buddy program) volunteers, that's real important. Because I think as people do volunteer, and become involved, and they feel a part of, and they feel included. And that's real important.

This activist relates how conscience constituents can be motivated into volunteerism through introduction to the networks of individuals who have AIDS.

With some of them (volunteers), it's not necessarily anybody they know personally, but through their job they see something. People with the hospitals obviously had to deal a few times with people living with AIDS. So there is a personal connection, one way or another, that motivates. I think that's the motivation for the Task Force to keep working.

In sum, a complex and interconnected set of incentives are available to motivate the participation of AIDS movement activists. From tanga-
ble premiums for participation to intangible rewards associated with movement involvement, participants receive compensation for their activism. Members of the AIDS movement's core are particularly motivated by emotional incentives. This set of incentives provide participants with a supportive context to validate their own grief, fear and anger generated by personal losses they have experienced because of AIDS.

Conclusion
The Ohio AIDS SMI analytically illustrates that McAdam's (1988) insistence that both macro and micro levels of analyses are necessary to construct a more complete picture of the dynamics is correct. AIDS organizing in Ohio is shaped at a macro level by the failure of established systems to respond to needs generated by the crisis and by the existence of a potentially mobilizable constituency. Nevertheless, at a micro sociological level, individual players must negotiate their own involvement with the movement.

In this chapter two pathways to organizational emergence are identified. First, Gay male initiated groups were founded early in the epidemic primarily in Ohio's largest urban areas. These efforts were all volunteer, staffed and financed by various Gay communities. Gay male initiated organizing occurred where ever established, visible Gay and Lesbian communities existed.

The second pathway to movement emergence is the "collective community" approach. These groups typically emerged somewhat later in the
epidemic, and where located in the smaller urban centers and more rural regions of the state. These organizations were commonly connected to local sponsoring institutions who provided material resources like staff, office space and telephone services.

Over time many of the Gay initiated organizations grew into "bureaus employing staffs" (Lofland 1977). This transition has consequences for SMOs, and in some cases precipitated the "de-homosexualization" process in regards to agency goals and leadership. Ironically, this "de-homosexualization" process was often supported by closeted Gay male and Lesbian participants. A further consequence of changing organizational structures was the increasing influence of channeling restrictions that limit SMO activities.

Ohio's AIDS organizations mobilize constituents at two levels. First, a relatively inclusive appeal is made to conscience constituencies for support of organizations and the AIDS movement generally. On a second level a very dedicated, more exclusive core is mobilized to conduct the day to day business of the SMO. This core includes both conscience and beneficiary constituents.

A series of powerful incentives further serve to motivate activists' participation in the movement. These incentives counteract a strong set of disincentives to participation that primarily related to the stigma associated with AIDS-related concerns, as well as being Gay/ Lesbian. These stimuli include material incentives that provide tangible rewards for participants as well as purposive and solidarity incen-
atives that facilitate the intangible benefits of satisfaction and association with others.
CHAPTER VII

DESCRIPTIVE AND THEORETICAL OVERVIEW

The emergence and development of collective action in response to the AIDS crisis both within Ohio and nationally, has been a major accomplishment in movement mobilization. AIDS activism is all the more unique because of the abilities of activists to move forward in a political climate that is both hostile to the Gay community and unresponsive to the idea of government supported health care. Resource mobilization theory highlights the importance of the socio-political context within which movement activism occurs (Jenkins 1985; McAdam 1982). The political environment that birthed the AIDS movement can be characterized, for the most part as hostile, or at best, as ambivalent. The resurgence of religious, economic and political conservatism in the 1980's and early 1990's brought reductions in federal spending for education, housing, social services and other domestic issues. In Ohio, the onset of the AIDS epidemic and the resulting mobilization of Gay initiated and professionally sponsored resources not only made it possible to respond to a health and social problem of major magnitude, but it has had far reaching effects on the development of political activism within the Gay and Lesbian communities.

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My goal has been to examine the AIDS movement in Ohio in order to assess existing theoretical constructions of social movements. Consistent with the predictions of resource mobilization theory, a major finding is that multiple emergence paths for AIDS social movement organizations, shifting ideological frameworks, changing patterns of leadership, as well as governmental intervention into movement development has created a unique context for strategic decision-making.

This account of Ohio's response to the AIDS epidemic has significant implications for classical and resource mobilization theories of social movements. The classical perspective sets the study of social movements in the context of "collective behavior" (Miller 1985). This results in the grouping of social movement activity with other collective behavior phenomenon including mass hysteria, fads, crowds, riots and cults (Perry and Pugh 1978). Collective behavior is assumed to be a kind of spontaneous reaction to societal stresses, strains and disruptions, guided by the emotional and irrational beliefs of participants (Blumer 1951; Turner and Killian 1972; Smelser 1963). Later theorists working in the classical tradition reject earlier assumptions about the discontinuity between routine social behavior and collective behavior (Rupp and Taylor 1987; McPhail and Miller 1973; Morris 1984).

Following this more recent work, my analysis generally agrees with classical theory's identification of the social change potential of social movement activism. Perhaps the most significant contribution of classical collective behavior approaches was the emphasis on the role
of collective behavior in bringing about social change. In the case of the Ohio AIDS social movement industry, there is a deliberate social change component, though it is consistently framed in educational and public health rather than in political terms. AIDS activists are challenging the status quo by demanding that society accept responsibility to adequately and sensitively care for people living with HIV infection. When activists produce and disseminate educational and prevention programs that question social norms regarding discussions and negotiations of a diverse set of sexual and drug using behaviors and dominant representations of Gay and Lesbian people, their actions directly advocate for social change.

Contrary to the classical social movement approaches, resource mobilization theory dismisses ideology and beliefs as irrelevant (McCarthy and Zald 1977; Freeman 1979; Jenkins 1983). Instead, the resource mobilization perspective emphasizes organizational and structural factors and their relationship to organizing, mobilizing, and managing the resources necessary to movement survival (McCarthy and Zald 1973; McCarthy and Zald 1977; Oberschall 1973; Gamson 1975; Tilly 1978). The central contribution of resource mobilization theory has been its focus on social movement organizations as the primary unit of analysis (McAdam 1982; McCarthy and Zald 1973; Zald and Ash 1966). My study confirms the centrality of organizational and interorganizational processes for the understanding of movements.
ORGANIZATIONAL EMERGENCE AND DEVELOPMENT

Two pathways exist for SMO emergence in the Ohio AIDS SMI. The pathway followed by each group has important implications for the organizations' subsequent ideological frameworks, goals, local resource base, leadership patterns, and ultimate organizational evolution. When founding members of AIDS SMOs mobilize due to the illnesses and/or deaths of partners, friends, family members or lovers, or out of their own fears of HIV infection, the emergence pattern of these organizations is characterized as grassroots "Gay initiated." These are indigenous based organizations (Morris 1984). Gay initiated AIDS organizations typically occur in Ohio's large urban areas including Columbus, Cincinnati, Cleveland, Dayton and Akron, as well as in communities dominated by larger universities such as Athens, Ohio.

In contrast, when founding members of AIDS organizations consider the epidemic primarily in the context of a public health crisis, they are mobilized through a commitment to community service or because of professional mandate, a rather different pattern of service delivery emerges. Professional or institutionally sponsored AIDS organizations are typically located in smaller cities, towns and rural communities. Typically, sponsoring institutions, such as the American Red Cross or other social service agencies, dedicate a portion of their overall organizational agenda to the AIDS issue.

Examples of this emergence pattern are found in such Ohio cities as Canton, Akron and Youngstown as well as in smaller towns like Lima and
Middletown. Additionally, institutional sponsorship is associated with AIDS mobilization in Ohio's racial and ethnic communities and was described by informants working in Cleveland, Cincinnati and Toledo.

Indigenous Organizing at the Grassroots Level

Grassroots activism within the AIDS movement was birthed out of pre-existing Gay networks (Perrow and Guillian 1990; Altman 1988; Patton 1985 and Kramer 1989). The social movement literature generally agrees that the more extensive the linkages between members of a social group, the greater the potential exists for utilizing interpersonal ties, communication networks, and the values of shared culture to mobilize for later activism (Rupp and Taylor 1987; Tilly 1978; Freeman 1983; Morris 1984; and Jenkins 1983). Gay and Lesbian culture and its institutions develop a diverse base and provide a spring board for later AIDS organizing.

The infra-structure that facilitates mobilization for AIDS is further enhanced by the unique set of incentives which promote commitment to AIDS related concerns. Pre-existing political and social networks greatly facilitated the emergence of Gay-initiated organizing nationwide as well as in Ohio's major urban areas (Patton 1985; Altman 1986; Shilts 1987; Kramer 1989). Although the specific circumstances differ in Columbus, Cleveland, and Cincinnati, organized and visible Gay and Lesbian communities were best equipped to meet the challenge presented by the HIV epidemic when it emerged in their regions. The social movement literature generally agrees that Social movement scholars such as
Morris (1989) and McAdam (1982) note the connection between collective action and group consciousness. For Gays and Lesbians mobilized by the AIDS crisis, the collective identity they share facilitates their commitment to the cause. At the same time, the existence of a Gay collective identity so informs the creation of the ideological mission of the AIDS movement that it sometimes becomes difficult to distinguish between the two movements (Taylor and Whittier 1992).

A classical social movement approach is, therefore, most useful for analyzing Gay initiated SMOs because this framework acknowledges the role of grievances and recognizes that pre-existing levels of discontent influence a social movement's ability to mobilize its' constituency (Smelser 1963; Turner and Killian 1972). To understand AIDS organizing, it is imperative to acknowledge the new and devastating grievances the epidemic brought to Gay male communities (Patton 1985; Altman 1986; Shilts 1987; Kramer 1989). A good illustration of this devastation can be found in a review of the mortality statistics. Nationwide, 65% of all reported AIDS cases represent people who have now died. In Ohio, there has been 2000 deaths out of the 3157 cases reported as of February 29, 1992. Almost 80% of Ohio current cases are among men who have had sex with other men.

The presence of pre-existing Gay/Lesbian organizations has been crucial to the emergence of later AIDS activism. With the exception of a few college dominated towns, Ohio's smaller cities and rural areas do not possess visible Gay and Lesbian networks. If any identifiable Gay
life is present in these settings, it is most likely to revolve around the Gay/Lesbian bar scene and to have a social rather than a political orientation (Miller 1989; Rounds 1988). The complexities of negotiation of a Gay or Lesbian identity in a region of the United States that provides only minimal opportunities to connect with the larger Gay and Lesbian community, and where considerable stigma against "homosexuals" persists, has created both ideological and leadership dilemmas for AIDS organizations.

Professional Social Movement Organization Development

One set of organizations grew and eventually developed into professional institutions with complex divisions of labor, paid staffs, and dependence on financial support outside of the Gay community. Lofland (1977) refers to organizations of this type as "bureaus employing staffs." As Zald and McCarty (1987) suggest, many of these organizations' new leaders have pre-existing ties to administrative roles in other social movements. In this case study, the new leadership is dominated by heterosexuals who often lack involvement with previous AIDS work, but have extensive experience in the larger social movement sector.

When outside resources are pursued, even when the new leaders are Gay men and/or Lesbians, organizations typically begin to refocus their initial ideological goal of serving and affirming the Gay community. Instead, influenced by the priorities set by funding sources, these organizations develop a more global mission. The former connection to
Gay identity politics is replaced by an ideological commitment to serve the "good of the community." Career activists are attracted to the AIDS movement because of the perception that funding resources are available to address the issues it has framed as important (Zald and McCarthy 1987). Mobilizing resources from outside the beneficiary constituency of the movement becomes the priority of the new leadership (Staggenborg 1991; Jenkins and Perrow 1977; Jenkins 1985).

SMO's seek increased legitimacy, developing an improved ability to negotiate with other SMOs, local and state government, the media and other interested individuals and organizations. As SMO's undergo this process of legitimization, they begin either actively or passively a de-homosexualization process designed to minimize the visible connection between AIDS and the Gay community. Ohio's SMOs do not obtain "legitimacy by numbers" and do not mobilize mass constituencies (Rupp and Taylor 1987; Useem and Zald 1982). Instead, they acquire "legitimacy of means," convincing the public that their organization is an appropriate vehicle for addressing credible grievances and achieving movement goals.

Organizational "Burn-out"
A second pattern of development for Gay initiated groups does not include rapid expansion, professional leadership or heavy dependence on resources outside the Gay and Lesbian communities. Instead, these organizations remain small and minimally funded, suffering in part from a failure to present themselves as credible to the larger society
because of their visible association with serving predominantly Gay men and their often very visible and open Gay and Lesbian leadership.

This second path for Gay initiated organizations may lead to stagnation and/or demise. These SMOs remain small because of the finite pool of resources available from their local Gay community. Lacking the legitimacy provided organizations who participate in the channeling mechanisms, these SMOs tend not to attract dollars and/or volunteer support from outside the Gay and Lesbian community. It is difficult for Gay initiated SMOs, who do not have access to resources outside the Gay and Lesbian community, to continue to respond to the escalating demand for services. Under the pressures of volunteer loss and "burn out", and financial instability, many of these organizations simply do not survive. The Multi County AIDS Network based in Akron, Ohio is an example. In 1992, after eight years of existence, this Gay-initiated and largely Gay-operated organization disbanded.

Both Gay initiated SMOs that experience ideological shifts and institutionally sponsored groups have the potential to develop into professional social movement organizations. When sufficient resources make paid staff possible, Ohio's AIDS SMOs tend to develop the characteristics of professional social movement organizations. PSMOs place a priority on organizational perpetuation and often compete aggressively for resources within their local region. The Columbus AIDS Task Force is one Gay initiated SMO that followed this path. The Northeast Ohio Task Force on AIDS, in Akron, is an example of an institutionally spon-
sored organization that over time developed into a professional social movement organization. For AIDS organizations with institutional sponsors, the ideological and leadership dilemmas are further complicated by the closeted Gay men and/or Lesbians participating in these organizations. Again, the consequence of Gay collective identity in the AIDS movement rears its ugly head. The de-homosexualization process is often welcomed, even encouraged, by closeted Gays who feel vulnerable to exposure because of association with the AIDS cause.

Organizational Conflict and the Rise of New Social Movement Organizations

Resource mobilization theory has examined the dynamics existing between social movement organizations focused on the same concerns. Zald and McCarthy (1980) introduced a multi stage cooperation continuum that I use as a framework for assessing the level of cooperation existing in Ohio's AIDS SMI. The Ohio example illustrates all of their five modes of cooperation: ad hoc exchange between staffers, formal inter-agency policy coordination, coalition formation, joint programming, and the cooperative formation of new organizations.

Cooperation between SMO'S develops out of a set of tactical choices that typically produce a system of SMO'S with differentiated but interlocking roles (Zald and McCarthy 1980). In her study of the pro-choice movement, Staggenborg (1986) noted the ability of SMOs to conserve their limited resources or co-opt resources from wealthier groups. In Ohio, AIDS organizations, in regions of the state where linkages were
available, did utilize temporary coalitions to further collective and individual organizational goals. Coalition work benefits SMO'S by providing increased visibility and legitimacy in local community, access to positive media coverage and opportunities to recruit new volunteers. These added resources serve to help maintain and sustain participating organizations (Ryan Fortchoming).

Though somewhat understudied, the analysis of competition among social movement organizations has received limited attention by resource mobilization theorists. Both intra and inter-organization conflict can produce changes in SMO leadership, goals, and structure (McCarthy and Zald 1977; Freeman 1973). Focused on the creation and maintenance of legitimacy through the domination of organizational "turf," competition in Ohio's AIDS movement centers largely on the control of the industry's tangible and intangible resources (Freeman 1983; Zald and McCarthy 1980), namely dollars raised within the Gay community, grants from governmental or private foundation sources, in kind supplies and services and other volunteer activities.

Individually controlled resources, especially private donations of time and money, are invaluable to AIDS groups. Inclusive membership policies used by most SMO'S seek to expand participation by appealing to an ever widening conscious constituency. The recruitment of members outside of beneficiary constituencies creates, however, the potential for increased internal conflict and intra-organizational competition (Friedman and McAdam 1987). Further, the mobilization of participants
into the AIDS movement is complicated because of a series of disincentives that exist regarding movement participation (Adam 1992; Weitz 1991; Perrow and Guillen 1990). Adam (1992) and Weitz (1981) both confirm the connection I suggest here between Gay collective identity and recruitment into service on behalf of the AIDS movement. Much of the disincentive for participation which exists around AIDS is a consequence of negative stereotypes and attitudes about Gays and Lesbians.

One consequence of competition can be the production of schisms within an organization or coalition that result in the creation of a new organization. Schisms occurred within the Ohio AIDS SMI, and most often the precipitating events were conflict over organizational and mission goals, debates over movement structure, or conflicts over leadership by non-Gay and/or Lesbian persons. AIDS social movement organizations in Columbus, and Akron have utilized this second emergence pathway.

All institutionally sponsored professional AIDS organizations have some component of their organizational mission dedicated to HIV education and prevention. Health promotion and education on a wide variety of issues has traditionally been an issue of central concern for agencies such as Planned Parenthood, the American Red Cross and/or local Health Departments. Occasionally, institutionally sponsored SMOs expand their education/prevention goals to include the direct provision of services to HIV infected clients.

Conversely, Gay initiated SMOs universally have some component of their organizational mission dedicated to the goal of service provision
to people living with HIV infection. Over time, and often through the 
encouragement of an offer of financial subsidy from outside resources, 
some Gay initiated SMOs have expanded their goal statements to include 
education and prevention programming. Goal setting among Ohio AIDS 
SMOs varies in relative emphasis, but tightly adheres to the two cen-
tral themes of education/prevention and HIV infected client services.

Returning to an analysis of institutionally sponsored social move-
ment organization emergence, and utilizing a resource mobilization per-
spective, it becomes important to examine the advantages granted these 
orGANizations because of their relative ease of accessing necessary 
resources. Providing everything from SMO staff, telephone services and 
clerical support to office supplies and printing services, institution-
al sponsors most often have previous organizational commitments to pub-
lie health and/or community education. Among Ohio's smaller cities, 
Canton, Lima, Hamilton and Portsmouth are examples. The local Health 
Departments, local Chapters of the American Red Cross and/or local fam-
ily planning providers became institutional sponsors or co-sponsors 
promoting the emergence of regional AIDS organizing. Staffers of the 
sponsoring institution may have assigned duties related to the SMO and/
or may be serving AIDS in a volunteer capacity.

At the onset, the staff of Gay initiated SMOs are all volunteer. 
Members are mobilized out of pre-existing friendship networks primar-
ily consisting of Gay men, and their lovers, friends, and families. 
Tangible resources like money, office space and telephone access come
from the Gay community. Gay bar fundraisers bring in operating dollars. SMO offices and telephone access may be located in private individuals' homes.

The infrastructure that facilitates mobilization for AIDS is further enhanced by the unique set of incentives that promote commitment to AIDS-related concerns. These incentives include the tangible material advantages of movement participation as well as the social and self-esteem benefits of activism. Of particular significance is a type of emotional incentive that results from the association of individuals who share a sense of loss or bereavement on account of AIDS.

Leadership in institutionally sponsored AIDS SMOs comes primarily from the sponsoring organizations. Often senior administrators take on roles as committee chairs, board presidents or directors. While sponsoring entities may assign staffers to an SMO, leadership duties of senior staff tend to fall outside of paid responsibilities. In actuality, considerable cooptation of the sponsoring agency's resources occurs as leadership fulfills its responsibilities to the the larger cause of AIDS.

The leaders of Gay initiated SMOs are almost exclusively Gay. These men may or may not have previous experience in Gay political activism, but are almost always active participants in the Gay life of their home community. In the larger urban areas some Gay initiated organizations experience an ideological shift in which these organizations typically experience a transition in SMO leadership and organizational priori-
ties. Leadership becomes increasingly professionalized while organizational goals prioritize maintenance of the organization and continued access to institutional sources of funding outside the Gay community.

Freeman (1979) noted the affects of resource availability and the constraints placed on the utilization of resources for SMO strategic decision making. The shifts in ideological frameworks used by some SMOs mark another form of strategic decision making. As organizations move to "de-homosexualize" their leadership and de-emphasize the visibility of the Gay agenda within their organizational priorities, they are viewed as more legitimate and are able to attract resources from outside the movement's beneficiary constituency. New leaders may be career social movement activists with little or no previous commitment to the AIDS issue. The Gay community may continue to be tapped for financial support and volunteer resources, but it is no longer the major source of revenue.

Outside resources - primarily government and foundation grants - become the new basis for the this type of SMOs financial stability. Shifting organizational structures emerge as a consequence of the channeling mechanisms utilized by the new funding sources. The beneficiary constituency is no longer a controlling force in the organization.

The strategic choices of a social movement are inevitably shaped by the opportunity structure in which it operates, as well as its own base of mobilization and its position in the power structure (Useem and Zald 1982; Rupp and Taylor 1987). The opportunity structure out of which
the AIDS social movement industry emerges is not supportive of organizing, and this has had significant consequences for the tactical decision making by movement activists. In Ohio, AIDS SMOs concentrate on the goals of service provision to HIV infected individuals and/or HIV education and prevention activities. Unlike the national AIDS SMI, the movement in Ohio has not been able to sustain a political critique of the overall process that constrains the local industry.

In sum, AIDS organizing in Ohio emerges out of two diverse sets of social and political circumstances. Gay initiated organizing is a response to the illness, death and fear faced by the Gay community because of the HIV epidemic. The commitment to this form of AIDS organizing is grounded in a collective understanding of Gay identity and Gay community. In contrast, the professional or institutionally sponsored path of movement emergence defines AIDS as a public health issue and mobilizes established local community resources and leadership.

In Ohio, both of these pathways lead to similar organizational goals and priorities emphasizing HIV education and prevention programming as well as services for people living with HIV. Gay initiated organizing mobilizes its members from pre-existing Gay and Lesbian networks, while institutionally sponsored SMOs pull volunteers and members from public health and other community service organizations. With sufficient outside resources either emergence path may lead to the creation of a professional social movement organization with paid staff and an increasingly formalized structure.
In order to accomplish that, however, Gay initiated SMOs must undergo a shift in their ideological framework that de-emphasizes the Gay/Lesbian mission and contribution of the organization. This shift facilitates the acceptance of the transformed organization into the mainstream of the larger social movement sector.

**SUMMARY**

In this dissertation, I set out to trace the emergence of the education and social service delivery system which developed in Ohio as a response to the onset of the AIDS epidemic. This study had two major goals. The first goal is substantive. I provide a case history of the AIDS movement in a low HIV prevalence state, located outside the major movements centers in New York City, New York; Newark, New Jersey; Miami, Florida; Los Angeles and San Francisco, California. My second goal was to apply insights from social movement theory to understand the AIDS movement, and to use this case to assess major debates between classical and resource mobilization theory.

The response to AIDS in Ohio is in large measure the story of the emergence and transformation of a social movement. This study uses both resource mobilization and classical social movement approaches to analyze the Ohio AIDS movement. From a resource mobilization perspective, the ideal organizational model is the professional social movement organization, while for classical theory the common unit of analysis is the grassroots indigenous social movement. By demonstrating the centrality of both of these types of organizations in the AIDS move-
ment, the importance of retaining both theoretical approaches is emphasized.

This study makes the case for a reconsideration of the classical approach's examination of grassroots activism and grievances. Though professional social movement organizing plays a dominant role in the AIDS SMI, grassroots activism, the structural inequality and grievances of Gays and Lesbians, and emergent values and collective identity processes have played a central role in the rise and evolution of the AIDS movement (Smelser 1963; Turner and Killian 1972).

This research suggests a model for future explorations concerning the relevance of the processes of competition and cooperation in other movements. Future research should specifically explore the interaction between grassroots activists and professionals in other self-help movements, and how these relationships are mitigated by the forces of competition and cooperation.

Another future topic for additional research that is suggested by this study is an evaluation of the influence of AIDS organizing on the larger Gay and Lesbian movement (Cavin 1990; Altman 1988). From my study, it would appear the AIDS has both strengthened and weakened this movement. The movement has been strengthened due to increased legitimacy and access to government and other mainstream decision-makers that the Gay/Lesbian communities now possess. Tens of thousands of individuals have been mobilized and politicized by their involvement in AIDS issues. Gay and Lesbian leaders have developed increasingly more
sophisticated fundraising skills and direct action tactics. AIDS has brought Gay and Lesbian issues into mainstream discourse (Cavin 1990).

The Gay/Lesbian movement has been weakened by AIDS on two fronts. First, AIDS has exacted a terrible human toll in the Gay mens' community. More than 100,000 Gay men have died since 1981. Many deaths are not recorded in the official totals. These deaths are instead hidden in the suicide and accidental death figures (Weitz 1992; Adam 1991). Hundreds of thousands of Gay men are ill and/or HIV infected. There are entire friendship networks which no longer exist, and individual Gay men who have attended thousands of funerals (Kramer 1989). It is as if this generation of Gay men has gone to war. The personal costs for some are depression, chemical dependency, and despair. The second loss is intimately connected to the first. The death and illness total has sapped the Gay men's community of much of its veteran leadership. Individuals with experience and expertise in the civil rights struggle have been lost to AIDS.

In conclusion, through its examination of the role of grassroots activism in the response to AIDS, this study illustrates the organizational and cultural strength that has developed in the Gay and Lesbian community in Ohio. Further, this study emphasizes the importance of looking at the role of other aggrieved minority groups who have been denied access to mainstream institutions. Groups outside of the mainstream can and do play significant roles in mobilizing their constituencies to address social problems which confront society.
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Appendix A

SAMPLE COPY INTERVIEW GUIDE

I prepared a specific set of questions for each informant based on his/her role in the movement (organizational founder or leader, staff member, public health official, and/or Gay activist). All of the informants were questioned based on the general outline below. After each interview, I revised the interview schedule to focus it more closely on emerging themes.

SUMMARY OF INSTRUCTIONS

The purpose of this research is to learn more about how local and statewide communities have responded to the HIV/AIDS crisis, through the creation of community based AIDS service organizations. Specifically, this research project will seek to explore how community based organizations are structured, what access to resources have been developed within organizations, the goals of the organization, the tactics the organizations use, and the socio-political constraints which these community based organizations have encountered. This case study will also consider the wider social context out of which additional participating agencies and/or local governments make contributions to meeting the educational, prevention, and patient care needs generated by the HIV/AIDS crisis.

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This project involves gathering data from key informants working and/or volunteering within the AIDS industry. All of the interviews are being tape recorded. Any information obtained is strictly confidential. Your name will be removed from the taped interview and pseudonyms will be used in the final report for all individuals, agencies, and geographic locations.

Information gathered for this project will be used as dissertation research by Phyllis Gorman. This dissertation is being completed as the last requirement of Ph.D. candidacy at The Ohio State University. The advisor for this project is Dr. Verta Taylor, Associate Professor. All research and analysis will be conducted by Phyllis Gorman.

This research will describe the general patterns and processes associated with creating and maintaining community based HIV/AIDS service organizations. The details of one agency's experience is important mainly insofar as that information helps to determine the similarities and differences between organizations. The interview will take between 45 minutes to an hour. If there are specific questions that you wish no to answer, or if you wish not to respond to on tape, you may indicate this at any point during the interview.

If you agree to participate in the study, please sign below indicating that the purpose of this research project has been explained to you and that you are willing to participate in this project. I will leave a copy of this form with you. Thank you very much for agreeing to be involved in this project. If you would like a copy of the most signif-
icant results, they will be shared with you when the project is completed—anticipated date of completion is Spring of 1991. Please indicate if you would like a copy of these results by checking here: Yes No

Date: Signature of Interviewee:

Signature of Interviewer:

QUESTIONS

1. Describe your organization? (Probe: What is your mission; when did it start; who were the original organizers; describe size and nature of membership; who are the leaders?)

2. Describe the current activities of the organization. (Probe: Has there been change over time; what is your role?)

3. Does your organization have formal interaction with other agencies/organizations within your community/statewide? (Probe: informal relations; shared membership/leaders; co-sponsorships; what is the nature of relationship with local government/public health officials?)

4. Do you tend to view AIDS issues as public health concerns or political issues?
5. Describe your organization's priorities. (Probe: How are goals determined; what tactics are used to reach those goals?)

6. What factors make doing AIDS work within your organization/community difficult? (Probe: Do special local political concerns exist; Is there inter-organizational competition or cooperation; do "turf" issues exist?)

7. Describe the financial and volunteer resources being utilized by your organization. (Probe: Grants; governmental support; fundraising efforts; membership; volunteers?)

8. Describe your organizational relationship with local media. (Probe: Is there local Gay media; television vs. print media?)

9. What changes do you anticipate in the future? (Probe: Overall with the AIDS epidemic; within your own organization/community?)

10. Can you identify other AIDS leaders in your community? (Probe: Obtain names, addresses and phone numbers for future contacts.)

11. Any other issues we need to discuss to better understand AIDS organizing in this community?

Thank You. :h.1.Appendix Two

Code Words

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SMO structure
unmet needs
accessing resources
hidden agendas
turf issues
local AIDS Task Force
local Health Department
AIDS hysteria
clergy
Gay men's issues
SMO fundraising
family planning issues
connections between local Health dept.
and local AIDS Task Forces
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meeting schedules
local American Red Cross
hospitals
People Living With AIDS
People of Color's Issues
ideology
public health issues vs. political issues
college campus issues
state government issues
HIV testing issues
housing issues
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Table Eight continued

Table Nine continued

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Figure One continued