

SUSTAINING AIDS MOBILIZATION: THE PROBLEM OF LATE-STAGE MOBILIZATION AMONG HIGH-RISK HIV/AIDS SUBPOPULATIONS¹

by

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Abstract

This research utilizes Cress and Snow's (2000) synthesis of mobilization theory in an attempt to explain trends in HIV/AIDS infections among gay and minority subpopulations of the United States between 1983 and 2001. Results only partially confirmed mobilization theory, revealing instead, contrary to theory, a new upswing of infection rates among two subpopulations, African Americans and young MSMs (men who have sex with men). A reformulation of mobilization theory is suggested to explain these anomalies based on the notion that mobilization phenomena should be divided into "early" versus "late-stage" mobilization. Changes in class dynamics within social movement organizations were related to the differences between the two stages of mobilization and their varying success with mobilization against HIV/AIDS.

AIDS and Mobilization Theory

Due to its continuing resistance to immunological remedies, attempts at containment/prevention of the HIV/AIDS epidemic based on social and political strategies have occupied a consistently strong role in long-term AIDS related strategic health planning (CDC 2001d). In the absence of an HIV vaccine, groups and organizations have collaborated to reduce the opportunity for infection. One could say that social and political mobilization has become a central AIDS prevention strategy. But despite a long history of mobilization research in sociology, such research has been underutilized in regard to these prevention efforts. The often heroic group mobilizations on behalf of AIDS prevention have not resulted from the application of mobilization science. For example, even though the epidemic severely tested the Men who have Sex with Men (MSM) population of the early 1980s, that group assembled an impressive mobilization effort that effectively and dramatically reduced the incidence of HIV/AIDS among MSMs by the early nineties.

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It is difficult to sustain such efforts, no matter how noteworthy, without the support of a well-researched knowledge base. Two new trends may be directly attributable to the lack of such a knowledge base—MSMs have reported a new upswing in infection rates and African Americans are now experiencing the highest rates of infection than any other demographic category (CDC 2001a & b). Both of these groups have exceptional mobilization experience: MSMs with their remarkable mobilization in the late eighties and early nineties, and African Americans with the Civil Rights movement of the sixties and seventies. Yet, both groups are suffering from rising rates of infection, and neither group has been effective at mobilizing to contain the new rate increases.

Let us look first at the African American trend. Whereas African-Americans make up only 12% of the American population, African Americans now constitute 37% of all AIDS infections in the United States, 63% of HIV infections among females, and 65% of infections among children. Further, the rate of African American AIDS infections in 1999 was 66.0 per 100,000 population, and this statistic is about eight times greater than the infection rate among whites (CDC 2001c).

The epidemic arose in the African American community during the 1980s and early 1990s amidst an environment of urban poverty, unemployment, fragmentation, and disorder (Cohen 1999; Patillo-McCoy 1998). Many African American leaders who found themselves in a position to initially effect beneficial changes in the community with regard to HIV and AIDS either failed to act or refused to do so. Many leaders pointed a finger of shame and disappointment toward the highest risk African Americans instead of addressing larger structural factors of marginalization and stratification within the African American community itself (Cohen 1999). Even the African American church, an institution that had traditionally transcended social divisions within the Black community (Patillo-McCoy 1998), was unable (or unwilling) to initially constitute an instrument of social action for combating the AIDS assault. First responses, when they emerged, were often both disapproving and judgmental (Cohen 1999). Despite decades of mobilization in response to social and economic factors of discrimination, and despite the formation of broadly structured organizations for mobilization in both political and economic spheres, African Americans have been unable to mobilize an effective response to the HIV/AIDS outbreak.

For the MSM population, research on sexually transmitted diseases (STDs) and sexual behavior indicates a new trend of growing incidence among young MSMs. While few recent studies have examined HIV in younger MSMs, the CDC recently analyzed data from the Young Men's Survey (YMS) to gain insights into this new high-risk group. The study confirmed high rates of HIV infection along with elevated risk behaviors among MSMs between the ages of fifteen and twenty-two (CDC 2001b).

We suggest that the alarming trends in both of these groups, MSMs and African Americans, might be alleviated through intensive research and development of mobilization theory for the specific purposes of epidemic containment and prevention. To focus mobilization theory on such health goals, we suggest a reformulation of mobilization theory to resolve the problems experienced by the MSM and African American populations. We reformulate mobilization theory to identify differences

between early- and late-stage mobilization. We then attribute MSMs' and African Americans' current mobilization difficulties to the problems of "late-stage mobilization." We shall attempt to show that late-stage mobilization is characterized by reduced capacity for producing micro-level, grass roots initiatives. Lacking this capacity, groups with substantial mobilization experience are nevertheless unable to respond to new mobilization needs. Furthermore, we will suggest that the main factor leading to the problem of late-stage mobilization is a class dynamic that is commonly recognized in sociological literature. In the following we will, (1) review the literature on mobilization and show how current formulations cannot explain the recent AIDS mobilization problems of MSMs and African Americans, (2) reformulate mobilization theory to take into consideration early- and late-stage mobilization differences and show how such a distinction explains the recent trends, and (3) we discuss how class dynamics motivate the changes from early to late-stage mobilization. We conclude with a discussion of the implications of the new mobilization theory for renewed mobilizations within both the MSM and African American populations, and a discussion of the role of mobilization theory for containment in health research.

Forming an AIDS Mobilization Theory

We shall focus primarily on the mobilization formulation of Cress and Snow (2000), which in our view effectively synthesizes previous research in mobilization. Cress and Snow's formulation is based on four factors related to mobilization—organizational attributes, tactics, framing, and political context—each of which is found singly or in combination in mobilization theories of the past.

Organizational attributes, which refer to the structure and goals of the particular organization, were often the subjects of resource mobilization theory. In this perspective, resources for mobilization can arise from ecological or geographic concentration. McAdam (1982) and Wilson (1973), for example, argued that the Civil Rights Movement of the 1960's was made possible by the migration of rural blacks into urban areas, effectively serving to transform a sparse and dispersed mass of individuals plagued by poverty into a concentrated and organized urban population. McAdam (1982) added a consideration of organizational characteristics related to institution-building, noting that the period of civil rights mobilization corresponded to a time of organizational growth in key areas like churches, colleges, and local NAACP chapters. The more organizations individuals are involved in (i.e., community or civic groups, SMOs, etc.), the greater the likelihood that those individuals will join a mobilization movement (McAdam et al. 1988).

Tactics refer to the methods that agents of mobilization employ in attempting to achieve outcomes. In *The Strategy of Social Protest* (1990), Gamson found, (1) groups that set forth demands on single issues tend to be more successful than groups addressing multiple issues, (2) there exists a positive relationship between the use of selective incentives and achieving successful outcomes, (3) the employment of violence and other disruptive tactics is generally associated with movement success, while being the target of violence made success much more difficult (see also, Button 1978), and (4) groups that

attain successful outcomes are likely to be more bureaucratized, centralized, and undivided internally.

Framing or frame alignment processes (McAdam et al. 1988) included a set of factors related to the cognitions that potential participants have of mobilization situations and to the transformation in the collective consciousness of individuals and groups involved. Framing has a long history in mobilization research under the more familiar terms of class consciousness, generalized beliefs, and cognitive liberation.

Political context, which refers to the general political environment within which mobilization efforts emerge, has become important to mobilization research in recognition of the changed nature of the state. With the rise of the modern, centralized state, movement organizations have also had to become larger and more centralized. Social movements have been called “politics by other means,” as these tools are often utilized by individuals and groups who would otherwise have little power to bring about political change. This also highlights the significance of political trends, political processes, and regional characteristics in the investigation of social movements (McAdam et al. 1988). Goldstone’s (1980) reanalysis of Gamson’s data revealed that the investigations of the outcomes of mobilization cannot fail to consider the political context by arguing that organizational variables and tactics were insignificant in regard to successful mobilization outcomes. The resource mobilization paradigm, he suggested, should be replaced with “political process models” that examine the impact of broader, systemic, national crises on successful movement outcomes (Amenta, Carruthers, and Zylan 1992; Amenta, Dunleavy, and Bernstein 1994).

The four factors in Cress and Snow’s (2000) synthesis of mobilization research can be tested on AIDS containment mobilization through their application to the case examples of MSM and African-American mobilization for HIV/AIDS reduction and prevention. The four factors should be able to explain both successful and unsuccessful mobilization, or, specifically, the successful MSM mobilization of the 1990’s and the unsuccessful African American AIDS mobilization, as well as more recent unsuccessful MSM mobilization. This application generates the following hypothesis:

- H1: The four factors of mobilization will be present in the case of successful mobilizations (the MSM 1990’s AIDS mobilization) and absent in the case of unsuccessful mobilizations (the African-American AIDS mobilization and the MSM post-1990’s AIDS mobilization).

Theory Modification for Early Versus Late-Stage Mobilization and AIDS

We suggest that the application of mobilization theory to health containment and prevention issues requires a reformulation of mobilization into early- and late-stage mobilization differences. On the basis of this expectation, we would re-classify the MSM mobilization in the 1990’s as early-stage mobilization, the current MSM mobilization as late-stage mobilization, the African-American Civil Rights mobilization as early-stage mobilization, and the African-American AIDS mobilization as late-stage mobilization.

This leads to a reformulation of hypothesis 1: hypothesis 1 will be correct for the two early-stage mobilizations and incorrect for the two late-stage mobilizations.

For the latter (i.e., late-stage mobilizations), we generate a new hypothesis based upon expected dynamics for late-stage mobilizations. The key dynamic we will focus on to explain the differences between early and late-stage mobilizations is the difference created by over-time changes in class related dynamics. We expect class dynamics to be minimized during the early-stage, but to become significantly disruptive during the late-stage, producing a group-consolidating (early) stage and a group-disintegrating (late) stage.

In the group-consolidating stage, members of a group are bound together in a spirit of relative solidarity where cultural factors (i.e., sexual orientation and race) cut across class boundaries in such a way that individuals are subsumed within a broader group consciousness aimed at mobilizing toward containment of a health crisis. Essentially, cultural factors override class dynamics. The framing of the implications of a significant health crisis for the MSM cultural community, for example, is able to transcend class divisions within the cultural community. Favorable mobilization outcomes are therefore more likely to come about during this group-consolidating stage.

In the group-disintegrating stage, the concept of social class becomes a significant social and economic element of division within cultural communities as the leadership begins to identify its own interests. During this phase, the leadership (of a previously cohesive cultural community) become focused on using the resources from the previous mobilization more or less for their own ends. Accordingly, while cultural factors had previously superseded class dynamics to bring individuals and groups together, the dynamics engendered by the leading social class now serve to separate and isolate individuals and groups into differentiated social strata. Culture-related framing is no longer able to transcend class boundaries. Group cohesion and/or consciousness begins to disintegrate. The end result is that the probabilities of achieving favorable mobilization outcomes during this stage become significantly lower than they were in the previous group-consolidating phase of development.

Our expectations for a class dynamic are similar to those of Marx and Engels ([1846] 1969: 65) when they said that class “in its turn achieves an independent existence over against the individuals, so that the latter find their conditions of existence predestined, and hence have their position in life and their personal development assigned to them by their class, become subsumed under it.” We differ from this view by suggesting that the power of class phenomena are mitigated during early stages of mobilization in the United States. The classic Marxian dynamic arises during the late-stage of mobilization when social class assumes a dominant role, overcomes cultural framing, and begins to either reduce the effectiveness of mobilization or channels mobilization toward ends consistent with the middle and upper-class segments of the movement. However, it is also important to note that this schema does not imply the absence of economic dynamics in the first stage, nor does it imply the absence of cultural factors within the second stage. Rather, cultural and economic factors are only more powerful in relative terms within the first and second stages, respectively.

The way we expect the class dynamic to manifest with regard to the four factors is primarily through a class-based redirection of structural and structurally-related factors. With regard to organizational attributes, we expect that a group's potential for internal organization and the group's capacity for establishing relationships with other organizations would both gradually come under the sway of the middle and upper class members of a movement as time progressed due to the greater organizational skills and resources of these members. Lower class members who were initially in such positions would gradually be replaced—those that remained would gradually be assimilated into the middle and upper class interests of their peers.

Following this process, perceived differences in health risk may arise differentiated by class. As the middle and upper classes are able to more effectively use mobilization resources to reduce their health risks, the goals for containment can change. They can change from a group-consolidating process where the whole group was perceived to be at risk to a group-disintegrating process where key class divisions are perceived to explain risk levels. Such processes produce a new containment goal of containing the higher risk class, i.e., the lower class. Then, because of stigma-related processes (where the health crisis is a stigma for the lower class sector, becoming increasingly framed as a result of the unhealthy behaviors of the lower class), the middle and upper class leadership of the early-stage mobilization begin to view the *political context* of mobilization as unfavorable, so much that other political groups will not want to be associated with a stigmatized group. This leads to further group division by class. Finally, in the newly *framed* mobilization environment where mobilization leaders view mobilization as no longer crucial to middle and upper class interests, and where such leaders view the political context as unfavorable, mobilization leaders will no longer use the most effective mobilization *tactics*. Such disruptive tactics would less likely be perceived as in the interests of a middle and upper class leadership that has successfully integrated their interests with extant social organization. They would be disrupting organization that is now (at the late-stage) conducive to their interests. Insertion of such a class dynamic into mobilization theory leads to the following hypothesis:

- H2: Late-stage mobilization will be characterized by high levels of structural and organizational development, but mobilization activities will only be present for activities consistent with middle and upper-class interests.

For all practical purposes, a late-stage non-mobilization will look very similar to an early stage, unsuccessful mobilization. The difference lies in the first half of hypothesis 2 —unsuccessful early-stage mobilizations will lack structural and organizational advantages while late-stage non-mobilizations will be characterized by high structural and organizational advantages. Implied in this difference is that the absence of organizational and grass-roots level mobilization (second half of H2) results not from the absence of the capacity to engage in mobilization, but from the absence of will for such activity because of the perceived inconsistency of the latter with middle and upper class interests.

PROCEDURES

Data

The quantitative data used in this analysis is from two sources, (1) the annual *HIV/AIDS Surveillance Report*, published by the Centers for Disease Control and Prevention (CDC) of the United States, and (2) the *Health, United States, 2002* report published annually by the National Center for Health Statistics (NCHS). The AIDS surveillance case definition on which these data were based was first expanded in 1985 to recognize the Human Immunodeficiency Virus (HIV) as the etiologic agent of AIDS. The definition was again revised in 1987 to include HIV wasting syndrome and other related conditions, and another revision came about in 1993 in response to the use of CD4+ T-lymphocyte counts in managing HIV infection (CDC 2000).

All fifty states, the District of Columbia, U.S. dependencies and possessions, and independent nations in free association with the United States report AIDS cases to the CDC by using a uniform surveillance case definition and report form (CDC 2001e). The case surveillance revisions noted above integrated a number of AIDS-indicator diseases and used further diagnostic testing to improve the sensitivity and specificity of the AIDS case definition (CDC 2001e). While complete reporting of confirmed AIDS cases to local and state health departments varies by patient population and geographic region, studies completed by local and state health departments show that reporting of AIDS cases in most regions of the United States is more than 85% complete. In addition, the reporting of AIDS deaths is estimated to be more than 90% complete (CDC 2001e).

The annual *HIV/AIDS Surveillance Report*, compiled and published by the Centers for Disease Control and Prevention (CDC) includes HIV case reports from thirty-nine areas that possess laws or regulations mandating confidential reporting of infection by name of adults, adolescents, and children with confirmed HIV infection, in addition to the reporting of persons with AIDS as of December 31, 2001 (CDC 2001e). However, HIV infection data should be interpreted cautiously, as surveillance reports may not always be representative of all persons with HIV infection. That is, not all persons infected in the United States have been tested for HIV. Accordingly, these data offer a minimum estimate of the number of individuals confirmed to have HIV infection in states with confidential reporting requirements (CDC 2001e).

For purposes of surveillance, HIV and AIDS cases are counted only once in a hierarchy of exposure categories. Individuals that report more than one mode of HIV exposure are classified in the exposure category that is first in the exposure hierarchy, with the exception of men with a history of sexual contact with other men and injecting drug use (CDC 2001e). These cases have been counted as a separate exposure category altogether. Cases included in the “men who have sex with men” category include males that report sexual contact with other males and men who report sexual contact with both men and women (i.e., bisexual contact). Cases included under the “heterosexual contact” category have reported specific heterosexual contact with an individual with HIV infection or at increased risk for such infection (i.e., an injecting drug user) (CDC 2001e).

One final note on the data generated by CDC involves reporting delays, or the time between diagnosis of HIV infection or AIDS and reporting to CDC. The reporting delays may vary among exposure category, geographic area, racial/ethnic group, age, sex, and vital status classification. Such delays have been up to several years for some AIDS cases (CDC 2001e). However, approximately 52% of all AIDS cases were reported to CDC within three months of diagnosis, and approximately 88% were reported within one year. For HIV infection, approximately 66% of cases were reported to CDC within three months of diagnosis, and approximately 93% were reported within one year.

Adjustments for reporting delays dealing with AIDS cases are calculated using a maximum likelihood statistical procedure, which considers differences in reporting delays among exposure category, geographic area, racial/ethnic group, age, sex, and vital status classification (CDC 2001e).

Methods

We integrate these quantitative data into our overall historical approach in a manner similar to the way historical sociologists have integrated descriptive historical data from historians into a more sociological, “analytical,” historical methodology. The latter embraces a more comprehensive understanding of the social world and the events unfolding within it (Singleton and Straits 1999). Specifically, we employed the following multi-modal methodology recommended by Singleton and Straits (1999): 1) descriptive reconstruction of events of the past, 2) application of theory to specific historical phenomena with a focus on how the theory explains phenomena, 3) tests of feasible explanations of historical events, 4) development of causal explanations of historical trends, and 5) the use of history as a mode of understanding the present by explaining how and why the present came to be what it is. Such an approach is similar to that recommended by Skocpol (1984) who suggested that sociological historical research should include questions about, (1) social structures or social processes that are notably situated within a particular time and place, (2) social processes over time, (3) the interplay of meaningful actions and structural contexts so that intended and unintended outcomes at both micro and macro levels of social reality can be studied, and (4) the specific types of social structural arrangements and patterns of social change.

We begin by assessing the descriptive quantitative data in order to identify salient epidemiological trends within the MSM and African American subpopulations. Next, we analyze sociological and historical data dealing with the composition, attributes, and dynamics of the American AIDS epidemic and selected high-risk populations, including documentation of social movement organization (SMO) behavior, to identify temporal relationships. Finally, we apply mobilization theory condensed to our two hypotheses to these identified trends and patterns.

ANALYSIS AND INTERPRETATION

Three Trends in AIDS and HIV Infections

Acquired immune deficiency syndrome (AIDS) emerged in the early 1980s as a new and perplexing disease that uniquely affected MSMs. The CDC's *Morbidity and*

Mortality Weekly Report (MMWR) of June 1981 noted five cases of pneumocystis carinii pneumonia that had been confirmed in Los Angeles, California. The fact that all five cases were young, previously healthy, homosexual males was of particular interest at this point. The first reports on this incident noted the males' common sexual orientation and commented on the possibility that some characteristic of the gay lifestyle may be responsible for the illness (Cohen 1999). The year 1981 was the historical starting point of the AIDS epidemic—in June of that year, the CDC released its first official report of a disease that would later come to be known as AIDS (CDC 2000).

Because epidemiological recognition of this new affliction was initially restricted to the white, gay male community, other susceptible and/or affected populations were for the most part ignored as AIDS cases continued to emerge in the United States (CDC 2001a; Cohen 1999). Despite prevention recommendations set forth by the CDC, AIDS cases and deaths attributed to HIV and AIDS rapidly increased throughout the 1980s, and this period of increased incidence was followed by relatively significant decreases in new infections and mortality in the late 1990s (see Figure 1). However, while the vast majority of the first AIDS reports were among whites, incidence among African Americans slowly continued to increase. In fact, by 1996, African Americans constituted the most afflicted racial or ethnic population in the United States (see Figure 2).

(Figures 1 and 2 about here)

By the end of 2000, the CDC had documented 774,467 reports of persons with AIDS in the United States, and 448,060 (approximately 58%) are now deceased. In addition, individuals living with AIDS amounted to 450,151 as of December 2000 in the United States. However, in 1999, the CDC estimated that approximately 800,000 to 900,000 Americans were living with HIV or AIDS (CDC 2000; CDC 2001a). The clear differences in these statistics are attributed to several factors. For example, some areas still do not have adequate reporting of HIV infection, and many individuals are likely not aware of being HIV-positive (CDC 2000). Regardless, the number of individuals currently living with AIDS, according to the CDC, is the highest ever reported (CDC 2001a).

Since the appearance of AIDS in the United States, about 85% of individuals diagnosed with the disease were between the ages of twenty and forty-nine years. By 1996 the composition of this infected population changed significantly from being predominantly MSMs to being predominantly African American (CDC 2001a). This composition pattern has continued despite the fact that the most common mode of HIV exposure among infected groups is male-to-male sex (46%), followed by injection drug use (25%) and heterosexual contact (11%) (see Figure 3). Through the mid-1990s, incidence sharply increased in each of these exposure categories, but since 1996, declines in incidence have been more notable among MSMs and injection drug users than among heterosexuals (CDC 2000; CDC 2001a). In sum, AIDS persists as an epidemic disease that directly and primarily affects the MSM population and racial and ethnic minority groups in the United States (CDC 2001a).

(Figure 3 about here)

While the HIV/AIDS epidemic in the U.S. is a complex phenomenon, three historical trends relate to the current two hypotheses: (1) while AIDS infections saw a general decline following 1993, MSMs had the greatest declines in new AIDS infections during the 1990s, (2) African Americans now report the highest levels of incidence of AIDS diagnoses than any other category and these rates are now increasing (CDC 2001a; National Center for Health Statistics 2002), and (3) recent CDC data suggest a resurgence of infections within younger, predominantly minority, MSM subpopulations (CDC 2001a; CDC 2001b).

Analysis of Three Trends: Hypothesis 1

We can examine the above three trends in light of hypothesis 1 by assessing the impact of the four factors of mobilization. For trend number 1, the MSM early 1990's AIDS decline, if some or all of the four factors were present among MSM organizations during the period preceding the decline, we will take this as support for hypothesis 1. For trend number 2, the African American 1990's AIDS increase, if some or all of the four factors were absent among African American organizations during the period preceding the 1990's increase, we will take this as support for hypothesis 1. For trend number 3, the recent upsurge in young and minority MSMs AIDS infections, if some or all of the four factors of mobilization declined for MSMs (following the increase in these four factors necessary to produce trend 1), we will take this as support for hypothesis 1.

Organizational attributes, the first mobilization factor, appears to disconfirm hypothesis 1 for each of the three trends. For trend 1, while MSMs likely had some organizational resources in place at the onset of HIV, by virtue of the Gay Rights Movement, their capacity for broad organizational mobilization appears to have been relatively lacking compared to African Americans. Perhaps the earliest Gay organization in the United States was the Cercle Hermaphroditos, which was primarily social and was formed around 1895 (Katz 1976). Later, pre-1980's organizations include the 1924 Chicago Society for Human Rights, the Mattachine Society in 1948, the Daughters of Bilitis in 1955, and the informal Stonewall Rebellion of 1969. Rayside (2001) and Kaiser (1997) noted that gay activist groups in the late 1960s and early 1970s, such as ACT-UP and Queer Nation had relatively narrow objectives and were rooted in the broader confrontational oppositionism of this period. MSMs development of this macro capacity for mobilization came later, we argue, after significant progress in the two micro factors discussed below, tactics and framing. For trend 3, while MSMs had few organizational resources at the beginning of the AIDS epidemic, by the 1990s they had substantial organizational strength such that from an organizational perspective, the new upsurge in young and minority MSM infections is difficult to explain. CDC researchers suggest that trend 3 is due to "risk reduction burnout" which produces mistaken beliefs that HIV is no longer a serious disease (CDC, 2001d). We conclude that with regard to AIDS prevention mobilizations, organizational factors have not operated as expected from past experiences with non-health related mobilizations.

African Americans, on the other hand, benefiting from the Civil Rights Movement of the sixties and seventies, had substantial organizational resources in place in both private and public organizations, and in both non-governmental and governmental organizations (Horton & Horton 2001; Trotter 2001; Colaiaco 1999). Trend 2, therefore, also contradicts hypothesis 1. Far-reaching organizations like the African American Church and other large civic and interest groups were able to effectively stir this population toward social and political gains, and these resources remained intact through the eighties. However, the 1980s political context backlash, discussed below, chipped away at African American organizations and may partially explain trend 2.

The use of tactics, the second mobilization factor, by both MSMs and African Americans supports hypothesis 1 for all three trends. For trend 1, MSMs made extensive use of mobilization tactics that were both disruptive, from national marches and legal challenges to confrontive media events, and non-disruptive, from national educational drives to street level offerings of condoms. MSM tactics in the 1980s continued, motivated by the predominant belief in the gay and lesbian communities that focusing on mainstream political processes was unproductive, a belief that was firmly rooted in the movements of the 1960s and 1970s (Rayside 2001; Kaiser 1997). Trends 2 and 3 were also as expected due to the relative absence, in the 1980s and 1990s, of either disruptive or non-disruptive tactics from both African American (Trotter 2001) and from late nineties MSM social movement organizations.

The issue of framing of AIDS, the third mobilization factor, was experienced in substantially different ways for MSMs and African Americans. The inherent sexual aspect of the disease produced widely different reactions in the two communities. In the MSM community, the disease was framed as attacking the very heart of the Gay lifestyle and culture, a culture which was already seeing a strongly positive upswing among Gay post WWII writers (Corber 1997). Gay sexuality was a source of pride and this translated into a new ethos that combined personal and political objectives (Blasius 1994), and into political strength when enormous resources were poured into activist organizations in the 1990s in the U.S., Canada, and Britain (Rayside 2001). African American mobilization framing from the middle of the century, on the other hand, was rooted in a religiously supported movement that based its framing strategies on legal fairness issues. For such a community history, framing in support of a sexually related disease, or a disease with strong ties to illegal drug use, has been a hard sell (Boykin 1996). Therefore, framing supports hypothesis 1 expectations in regard to trends 1 and 2. Trend 3, on the other hand, does not support hypothesis 1. With an established history of positive framing, hypothesis 1 cannot explain MSMs inability to effectively frame AIDS mobilization for young and minority MSMs.

In regard to political context, the fourth factor, the Civil Rights Movement was first and foremost a political movement and its many successes have produced a favorable political climate for mainstream African American initiatives (Horton & Horton 2001; Trotter 2001) within a frame limited by the conservative backlash of the Reagan-Bush years (Holt 2000: 338; Birnbaum & Taylor 2000: 717-718). Therefore, we must conclude that contrary to hypothesis 1, the political context for African American AIDS mobilization was positive, and though it was limited by the Reagan and Bush

years, the inability to mobilize against the dramatic rises in African American AIDS infections in the nineties, trend 2, cannot be explained by backlash alone.

The political context for MSMs, on the other hand, prior to the eighties and nineties was not supportive. Rayside (2001) notes that mainstream politics remained impermeable to gay and lesbian pressure from the 1960s – 1980s, and that police authorities did not lessen the ferocity of their attacks throughout this period. Rayside also suggested that the radical right provided potent opposition to mainstream gay and lesbian political organization in the 1990s. Kaiser (1997) agrees, noting the devastating effects on gay and lesbian political hopes caused by Clinton's failure to support gays in the military, and by signing the 1996 Defense of Marriage Act, banning government support of gay marriage. Therefore, trend 1 does not provide support for this factor either. Finally, with regard to recent young MSMs in trend 3, the political climate became much more favorable for MSMs in the nineties² beginning with the 1992 presidential election (Hertzog 1996). Also, the 1996 Supreme Court decision in *Romer v. Evans*, written by conservative Reagan appointee Anthony M. Kennedy reaffirming government protection of gays from discrimination laid the legal foundation for a new political atmosphere for gays (Kaiser 1997). Trend 3, therefore, also contradicts hypothesis 1.

In summary, contrary to hypothesis 1, the two macro factors, organizational attributes and political context, did not operate in the expected direction. Neither factor appeared to be necessary for the successful MSM mobilization in trend 1 and despite a presence of both factors for trends 2 and 3, successful mobilizations have not resulted for either African Americans or for current young and minority MSMs. The micro factors, on the other hand, showed mostly positive support for hypothesis 1. Tactics worked in the direction expected for all three trends and framing worked in the expected direction for both African Americans and early MSMs (trends 1 and 2), but not in the expected direction for young and minority MSMs (trend 3).

Analysis of Theoretical Reformulation: Hypothesis 2

Hypothesis 2 attempted to explain the above anomalies in hypothesis 1 by adding a notion of a movement's typical development over time. Hypothesis 2 suggested that the mobilization patterns expected by hypothesis 1 were only applicable during the early stages of a movement's development. Hypothesis 2 expected significant change to occur in any social movement's constituency and goals over time influenced by class-related processes. Similar to Michel's "iron law of oligarchy," hypothesis 2 expected that social movements would be co-opted by the middle and upper classes, redirecting movement resources toward interests other than those of the lower class. Once this process occurs,

² This seems to contradict what we just said in the last two sentences, but there we were portraying the earlier structural opposition, which we interpreted to disconfirm hypothesis 1, which stated that structural supports were needed for successful initial mobilization. Now we are suggesting that even though the Clinton administration had to contend with continuing opposition from the right, nevertheless the political climate began shifting significantly in support of gay issues.

new mobilization interests cannot grow out of the existing structural and organizational resources regardless of how well such resources have been developed. New mobilization must develop new structural resources out of the specific interests of those who want or need the mobilization. *Thus a group's continuing capacity for developing new mobilizations depends not on structural capacity, but on grass roots capacity to engender new structural capacity.*

All three trends appear to support the stage-differences expected by hypothesis 2. Following first-stage gains of the Civil Rights Movement, where class boundaries of African Americans were transcended and group consolidation as a whole was enhanced, second-stage group disintegration processes emerged, sustained by the emerging class interests of the upwardly mobile middle and upper classes. These developments signaled a decrease of the class-binding character within much of the African American community and heralded the oncoming dynamics of group-disintegration described by hypothesis 2. This change in group dynamics explains the lack of effect of African American organizational and structural resources on AIDS mobilization. Such mobilization would have served primarily the lower class African Americans that constituted the vast majority of new AIDS infections.

In contrast, the MSM AIDS movement was a new movement. In the face of a deadly threat, which also threatened the lifestyle and culture of all Gay Americans, a new social movement organization was created targeted toward the mobilization of all MSMs for the welfare of all MSMs. But the macro factors of this movement, organizational attributes and political context, were not developed before the AIDS mobilization but *out of* the micro mobilization factors, framing and tactics—*framing* what was at stake for Gay culture performed in conjunction with high visibility *tactics* which awakened the attention of both Gays and the larger society. We argue, therefore, that it was the micro factors which drove the formation of the macro factors and that the latter served the interests of the former.

This yields an image of mobilization that differs from what we have seen in non-health mobilizations studied in the majority of the mobilization literature. This image is much more of a movement with a grass roots character than it is of a movement arising out of changing structural conditions. This suggests that successful AIDS related mobilizations for high infection populations will most likely come not from well intended health support organizations, but from new grass roots initiatives within such populations.

Therefore, we suggest that the extensive social movement organizations and other structural resources currently in the African American community will not be effective for AIDS mobilization. Such structures *grew out of* grass roots mobilization and organization for civil rights, and the latter, we suggest, was the function of those structures. Furthermore, such structures have not grafted well onto the new functions related to AIDS mobilization. What this would suggest is that attempting to mobilize these essentially civil rights structures for AIDS mobilization is a mistaken strategy. Instead, new grass roots AIDS mobilization should be encouraged within the lower class African American populations most affected by the rising AIDS rates out of which new organizational and structural resources must be developed.

This same implication holds for trend 3, young and minority MSMs. Even though the macro factors of mobilization, MSM organizational attributes and favorable political context, has been generated by MSMs in the eighties and early nineties on behalf of an AIDS mobilization, this movement structure has already matured, we believe, past the group-consolidating phase. Such would be consistent with trend 3 which otherwise is hard to explain. “Risk reduction burnout” may explain part of trend 3, but it actually begs the question. If we view “risk reduction burnout” as a *belief* within the population, then we can ask why the extensive and effective MSM social movement organizations have been unable to reach young and minority MSMs to educate them about such mistaken *beliefs* when they were very effective at educating MSMs about a different set of *beliefs* related to prevention in the previous decade? It seems clear to us that the new generation of MSMs either need their own grass roots movement sensitive to their unique interests, or the already existing MSM organizations need to create space for a quasi-independent mobilization within their existing ranks where lower class interests can dominate without threatening the existing middle and upper class interests

CONCLUSIONS

It is hoped that the suggestions developed and presented here will represent a step forward from previous theories of mobilization that have not included the developmental, movement-stage orientation that is central to our reformulation. Past mobilization conceptions have not adequately accounted for the mobilization experiences and outcomes related to MSMs and African Americans as they have responded to HIV and AIDS. Our reformulation of mobilization theory, developed from the HIV/AIDS phenomenon within the United States, added the dimension of time to studies of mobilization positing different mobilization outcomes for early versus late-stage mobilization.

We began our analysis merely expecting to confirm that late-stage mobilization would be more difficult than early-stage because of the greater likelihood of group disintegrating factors. We found instead a more subtle difference. Mobilization differences over time for both MSMs and African Americans suggested that macro (structural) advantages were not sufficient for producing mobilization and in fact grew out of micro factors, framing and tactics. But before micro factors can become salient, the group or groups involved must see the mobilization as conducive to their interests. For both the African American and the MSM case studies, late-stage mobilizations were primarily in the interests of lower class and younger populations, and it is for this reason, we argued, that mobilizations preventing the spread of AIDS in these populations have not been as successful as the early-stage MSM mobilization. This analysis suggests that new mobilization cannot grow out of past successful mobilizations even if the latter have developed extensive structural advantages. Subgroups of past mobilizations must recognize the need for new mobilization framing and tactics focused on their own particular interests, and the need to either generate new organizational and political resources or gain special recognition and support within the macro resources of the earlier mobilization. However, the current analysis is only a beginning, and the ultimate

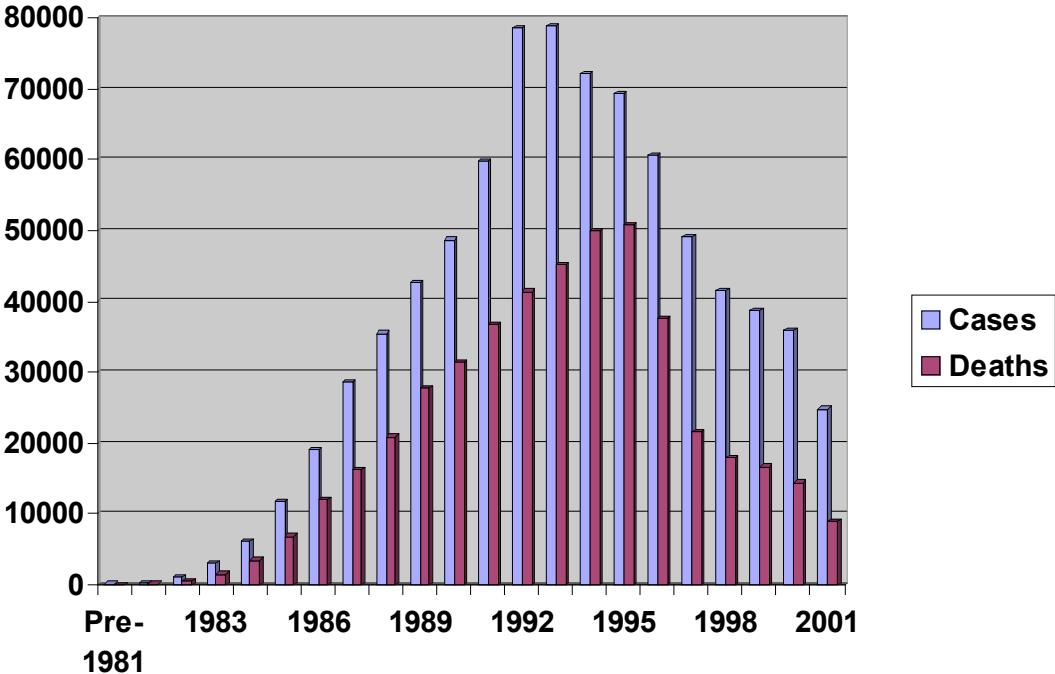
utility of this developmental approach for social mobilization depends on more thorough empirical investigation and more precise theoretical specification and development.

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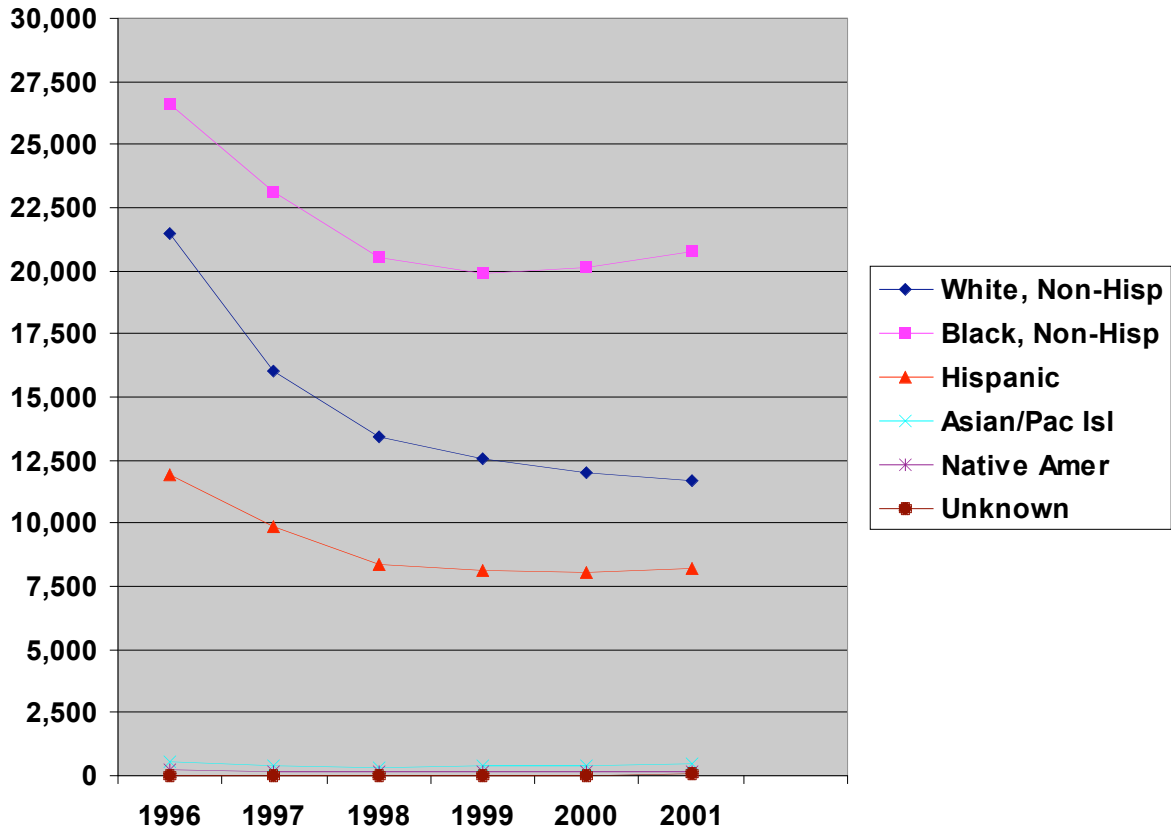
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Figure 1. Total AIDS Cases and Deaths by Year, 1981-2001³



³ Source: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2001; 13 (No. 2).

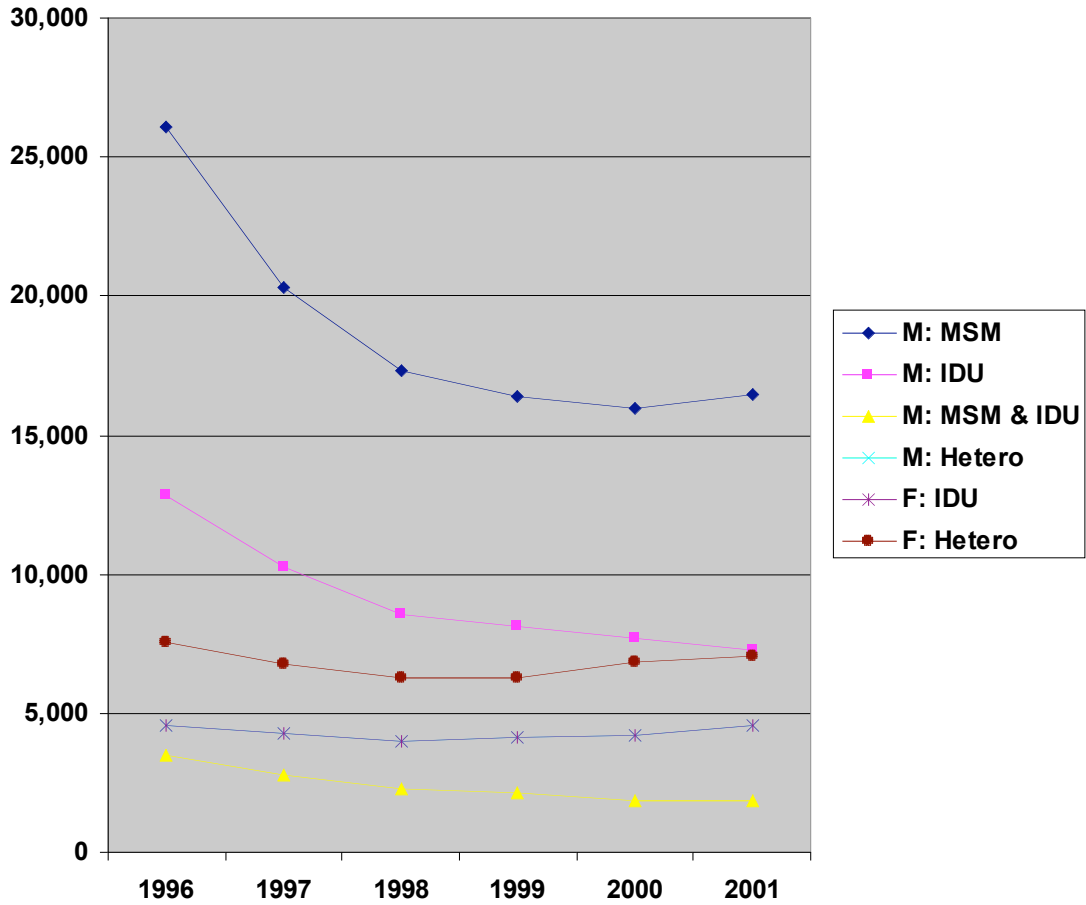
Figure 2. Estimated AIDS Incidence⁴ by Race and Year of Diagnosis, United States, 1996-2001⁵



⁴ These numbers do not represent actual cases among persons with AIDS diagnosed. Rather, these numbers are point estimates of cases diagnosed adjusted for reporting delays, but not for incomplete reporting.

⁵ Source: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2001; 13(No.2), Table 26.

Figure 3. Estimated AIDS Incidence⁶ by Gender, Exposure Category, and Year of Diagnosis, United States, 1996-2001⁷



⁶ These numbers do not represent actual cases among persons with AIDS diagnosed. Rather, these numbers are point estimates of cases diagnosed adjusted for reporting delays, but not for incomplete reporting.

⁷ Source: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2001; 13(No.2), Table 26.