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Call to Action:

A Community Responds

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This article will examine the early formation of the AIDS Action Committee of Massachusetts, and what it has become. It will examine particular philosophical and organizational conflicts, some unique to AIDS organizing, that have influenced the direction the group has taken. It will try to tease out some of the factors that have made the organization successful in delivering services, providing education, and affecting city and state policy. It will also examine some of the unresolved conflicts that threaten the organization.

The AIDS Action Committee of Massachusetts (AAC) began as a “rap group” in November 1982. By 1987, it had grown into an advocacy and service organization with a \$3 million budget; thirty-three staff, with funding for fifteen more pending; seven hundred active volunteers; and a national reputation. Welding strategies from social justice movements to concepts from social service management, the organization created a vision and structure to guide decision making through a complicated medical and political crisis that continues to unfold at lightning pace. The AAC has become a credible resource and an essential participant in community, city, and state AIDS policy development.

There were no chapters in textbooks which told us how to build an organization that could respond to a contemporary epidemic. Especially challenging were these two requirements:

1. balancing the needs of those diagnosed with AIDS or ARC with broader community issues related to the AIDS crisis, and
2. maintaining professional services and a grassroots volunteer base.

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While the conflicts inherent in these aims are faced by many volunteer-based organizations, several factors gave them unprecedented significance. AIDS is a new, incurable, infectious disease linked in the public's mind with controversial social practices. Preexisting racism, sexism, homophobia, and fear of addicts hindered the vision and actions of the agencies most needed to mount a rapid response to AIDS and the accompanying epidemic of fear. Those who first volunteered their time and talents risked accusation that they were members of the hidden minorities first affected by AIDS, and thus faced possible discrimination by offering of themselves. Patterns of prejudice obscured the line between realistic public health concerns and political opportunism that allowed repressive social agendas against the minorities first affected to cloud issues of testing and quarantine and of funding and allocation of medical and social resources.

Preconditions of AIDS Organizing in Boston

AIDS organizing in larger cities began within the existing predominantly gay male communities. Boston's gay and lesbian community was well organized and was perceived as a viable political constituency with recognizable issues, institutions, and leaders. There were important institutions with nearly a decade of service to the community: Fenway Community Health Center (FCHC), a gay-oriented health center; Gay and Lesbian Counseling Services (GLCS), a mental health center; *Gay Community News (GCN)*, a nationally distributed newspaper; and Gay and Lesbian Advocates and Defenders (GLAD), a gay legal organization with strong ties to mainstream civil liberties groups. There were several more locally oriented newspapers, and dozens of groups, from athletics clubs and professional and business fraternities to religious groups and political caucuses, many linked to state or national organizations.

In 1982, Boston had a mayoral liaison to the gay and lesbian community and would soon have an openly gay male city councillor and other openly gay and lesbian appointees to city human rights commissions and social service departments. The community infrastructure and the links with the liberal city government provided channels for communication within and outside the gay and lesbian community. There was a wide base of professional politicians and grassroots organizers expert in working within the gay and lesbian community and interfacing with government agencies. And yet, despite the large number of city agencies and community groups that could have taken on AIDS as a primary issue, most were reluctant: Fenway Community Health Center came closest, perhaps because AIDS was initially most obviously a medical problem.

Recognizing a Need

The AAC formed out of disparate organizational and individual foci of concern. Concern in Boston, a secondary epicenter, grew from observing what was happening in New York City (the nearest primary epicenter), which was overwhelmed with hundreds of cases in 1982, when Boston had fewer than a dozen.

The rap group that was the beginnings of the AAC was offered by two mental health providers at the Fenway Community Health Center. The AAC's current executive director, Larry Kessler, who early emerged as a leader and in August 1983 became the first staff person, joined the group in January 1983. Key people from other parts of the gay and lesbian community joined over the next year and formed the first steering committee,

operating as a subcommittee of the FCHC board of directors. The AAC functioned as a special project of the FCHC board until 1986, long after it had equaled and surpassed FCHC in size and budget.

Early organizers saw the AIDS crisis as similar to other social issues — there was an identifiable group with a need, who would be overlooked by mainstream society and systems and who faced isolation, stigma, and discrimination. Many of the problems that became crystallized with AIDS — poor organization of health care, fear of minorities, too few funds for human needs — are deeply entrenched aspects of American society. It became clear that personal contact and grassroots organizing could improve the position of those most affected by AIDS and could provide a basis for political education that could encourage some to tackle the broader issues shaping the AIDS crisis.

Founding members also believed that a volunteer response would meet both the needs of the diagnosed and the needs of volunteers who came with an urgent desire to quell their fears by gaining information and expressing their concern through action. Becoming a volunteer was also an opportunity to provide an experience of community, perhaps for the first time, for these members of the stigmatized subcultures.

The AAC mission statement grew out of simple statements by members about their concerns and experience. In 1982–83, most media reports expressed the isolation and discrimination faced by people with AIDS (PWAs). Simple and evocative observations such as “it seems most important to support the people with the diagnosis because the whole world is against them” were translated into the first mission of support. There was a tremendous fear of men with AIDS within the gay male community, so the emerging AAC assumed the role of befriending and supporting those diagnosed both in that community and in medical/social service institutions.

Second, AAC members observed that their fears had lessened once they learned facts about AIDS and discussed their worries with people who took them seriously. The mission of education was to duplicate that experience for others.

Third came advocacy, which concerned wresting a response from agencies that should have been concerned with AIDS but that were doing nothing. Advocacy initially focused on procuring federal and state money for research. In the early years of organizing, no cause had been identified (human T-cell lymphotropic virus type III [HTLV-III], now called human immunodeficiency virus [HIV], was identified in 1984), and it was hoped that AIDS would be quickly and easily cured.

Finally, outreach was defined as getting out the word that the AAC had answers and resources. The first major outreach project was the hotline, which today is part of the Education Department. Outreach was initially defined simply as making it possible for people to find the AAC.

In choosing projects, the AAC chipped away at an iceberg of ignorance, apathy, and denial. The added responsibility of coping with the anxiety of those at risk would come later, when people were better educated and realized that they, too, might be at risk for AIDS. Anxiety moved from group to group as different sectors of society came to understand their relationship to AIDS. Anxiety in Boston’s gay male community began in about 1984 and peaked in mid-1986, with continuing effects through other groups and agencies.

Needs Defined for Education and Services

The potential agenda of the AAC was immense. The emerging leadership pushed for proj-

ects that had a high probability of success in order to give the group an opportunity to see how members worked together, build a sense of confidence and cohesiveness, and establish credibility outside the group. The philosophy that emerged was volunteer involvement in practical projects of doing for others — either through direct service to PWAs or through defined projects like letter-writing campaigns and media watchdogging, producing educational materials and events, fund-raising, and organizational development (personnel and documentation).

The AAC formed subcommittees to accomplish each of these activities, with chairs serving as the steering committee. Serving on the steering committee were also FCHC board members and other “at large” members, invited because of their particular expertise or their tenure with the group. Policies developed in 1985 recognized subcommittee chairpersons through an election process by members of the subcommittee. Subcommittees that provided direct service functioned best and maintained a shared sense of purpose. Committees like education and media had a series of internal conflicts over strategy as well as conflicts with the steering committee over policy.

The early steering committee members were mainly liberals — with a few radicals and conservatives — who came from social service or community organizing backgrounds, with experience in democratic and collective group structures. The AAC sought a decision-making process that maximized participation and allowed time both for business and emotional support.

The line between business and support was not always easily drawn. Early members provided direct service and also performed other, less tangible functions. People brought strong emotions — grief, a sense of injustice, anger, fear, discouragement, incredulity — to the business of the organization. The wide range of emotional needs and the importance of attending to the social and political realities underlying the emotions are problems unique to building a volunteer organization to address AIDS.

The fact that many people doing AIDS organizing — gay men — were apparently “at risk” made it difficult to prioritize conflicting needs as strategies and programs were created. Of the two different approaches that emerged for understanding AIDS work, one now predominates in AAC organizational philosophy. The dominant view holds that in order to maintain the perspective necessary to set priorities, volunteers and staff should view their work as doing for others, a form of altruism well articulated in Catholic service movements, which strongly influence the executive director.

The second philosophy, drawn from liberation movements — including gay and black liberation — tried to engender a self-interest by encouraging people to perceive that their communities and friends were under attack, even if they personally were not involved with or did not know someone with AIDS. This view saw AIDS work as community building, linking these efforts with past and future projects in the respective communities.

Both ideas continue to inform decisions within the organization. Volunteer subcommittees represent both views as well as combinations of the two. Client Services tends to articulate the dominant idea, while the Education Department strongly reflects the second philosophy. The differing strategies used in each department permit a stable compromise between the two ideas: while they generate conflict over organizational strategies, they often lead simultaneously to novel solutions. On balance, the organization prioritizes immediate aid to those who are directly affected by a diagnosis or fear of a diagnosis, while setting less clear-cut funding and staffing policies for projects aimed at decreasing the number of future cases or future impediments to services.

Client Services: Professionalism in a Community of Difference

By 1985, the AAC was offering a mix of direct services, provided through volunteer subcommittees and some staff members. A staff mental health coordinator was hired to organize the services offered by these subcommittees. The coordinator soon saw the need to make a distinction between which services the AAC would provide directly and which it would advocate the provision of by existing agencies in the affected communities and in the health care system at large. The AAC wanted services provided in a manner consistent with its philosophy but knew that financial limitations would not permit it to become a full-service medical and social service agency. Mental health was subsumed under Client Services, which gave overall direction to the conglomerate of direct services, eliminated duplication, and provided professional accountability.

The current staff of Client Services consists of a coordinator of advocacy; six staff advocates; a coordinator of mental health and support groups; a holistic health coordinator; a buddies coordinator; and a housing coordinator. Newly funded positions include staff to develop additional public- and private-sector housing, mental health services, and home care services.

The department employs a case management model, drawn from mental health/social work agencies. Social workers serve as advocates who coordinate the care and support network for person(s) with AIDS/person(s) with AIDS-related complex (PWAs/PWARCs). They combine professional social worker skills with a mandate to ensure that services be provided with sensitivity to the prejudices faced by the affected minorities and with sensitivity to the particular stigma of an AIDS/ARC diagnosis.

Until this consolidation, the AAC had developed organically, trying to match the volunteer's need to provide help with the needs of those diagnosed with AIDS or ARC. Much more so than in other kinds of volunteer agencies, individuals volunteered out of a need for ongoing support, information, and at potential cost of being perceived as "gay." Although a study conducted at Gay Men's Health Crisis in New York shows that volunteers perceive their motives as altruistic, volunteers in fact describe concerns for their community and a sense of empowerment through action that are more characteristic of social justice motivations.

The AAC was faced with structuring direct and concretely defined services to PWAs/PWARCs and creating a place for volunteers with a range of needs and motivations. Creating an accessible structure for volunteerism was seen as providing a form of support — a service — to the worried well. The professional and lay services offered generally matched the services needed by those diagnosed and their families, friends, and lovers.

The buddy program retained its structure of peer supervision by tenured buddies who continued to provide companionship and practical help services to PWAs/PWARCs. The buddy program is modeled on a hospice concept, modified to meet the needs of people who, because of social stigma, may have diminished family and community ties.

The evolving volunteer hierarchy and the new professional hierarchy were retained and function in parallel. The interlocking structure of the two hierarchies permits professional accountability where needed as well as a grassroots-style support network that empowers the volunteer within the decision-making process. This solution provides the visible, professional accountability required by professional associations and funding sources while retaining a strong base of community involvement with real input into the AAC.

Simultaneously with the reorganization of Client Services, the AAC was separately incorporated as a 501-c(3) nonprofit, and a board of directors was formed. The first board was created in January 1987. The steering committee became a coordinating committee to supervise the volunteer function of the organization. The board is intended to take legal responsibility for the organization and set policy. The coordinating committee helps maintain volunteer input by creating a volunteer hierarchy that trains volunteers and promotes leadership. Recently, the key decision makers expressed the view that volunteers should work adjunctly to staff, rather than as staff enacting the will of a membership, as they do in some organizations. Though some have seen this as a move to decrease volunteer decision making, others believe it still allows volunteer input through the volunteer hierarchy, while recognizing that full-time staff are best situated to make day-to-day decisions. The extent to which the coordinating committee and board will project policy that the staff must follow is still at issue, and will be worked out only as the board finds its place and gains operational credibility with both staff and active volunteers.

While Client Services streamlined through developing a case management model, care has been taken to ensure that different styles of providing direct service are maintained. The mental health coordinator oversees a variety of groups whose services range from support to therapy and makes sure that clients have access to individual therapy or to goal-based groups such as stress management. In addition, the holistic health coordinator can refer clients to nontraditional therapies such as acupuncture, special diets, or movement classes which are adjunctive to their other medical care.

The AAC has also maintained strong ties with the National Association of People with AIDS (NAPWA) and works with Boston People with AIDS (BPWA) to foster a sense of empowerment for PWAs. The AAC has provided both financial and technical assistance to both groups and strives to allow the groups to determine their own priorities without imposing the agenda of people involved in providing services.

Refining Professional Services

In consolidating professional services and providing a clearer arena for community involvement, the AAC had to reach certain policy decisions by 1986. Among the most important were the following:

- The AAC does not provide professional treatment services — including medical, mental health, holistic health, legal, or other such services. Instead, advocates create and supervise the PWA/PWARC's network of services by referral. Advocates make certain that inpatient and outpatient services are coordinated, that home care planning meets the special needs of those with this unprecedented illness, and that clients understand and avail themselves of other AAC groups or activities as they wish.
- Institutionalization of the department director and advocates is an acknowledgment that group decisions are not possible in direct service administration.

The narrowing definition of what would be provided by the AAC allowed for a more coherent approach to services, but also generated resentment among some volunteers whose input into the organization was diminished. Although the intent of the parallel

volunteer and staff structure is to maintain volunteer input throughout the organization, this has not been fully worked out in practice. The novel structure is still supported by members of the organization; they hope to better delineate communication and policy definition within the interlocking structures. The interaction between volunteer subcommittees and paid staff works better in some instances than in others.

The AAC became a new kind of organization: there were mainstream groups willing to work with gay and lesbian clients and groups formed with a primarily gay and lesbian client base. The AAC was also the first major group in Boston to come out of the gay and lesbian community with a commitment to serve nongays. Thus, from its inception the AAC was committed to providing services to all PWAs/PWARCs and their family or friendship system. It was difficult to be sensitive to the varying needs of people from different communities and backgrounds in designing programs and literature. In addition, intravenous drug users, women, and minorities were more likely to question the authority of professionals than were white, middle-class gay men, who dominated early AIDS organizations and who believed that the government and the medical establishment could be quickly reformed to meet the needs of the AIDS crisis. The AAC retains the open style and values of the gay and lesbian community, although the internal culture of the organization has evolved to incorporate many kinds of differences.

When impediments to service arise, it is often difficult to know whether they stem from fear of AIDS or from the older stigmas faced by most PWAs — homophobia, racism, sexism, disdain of drug use. Some believe that working through AIDS will help eliminate these prejudices, while others believe that good AIDS strategies require directly confronting the preexisting problems. The AAC seeks to keep the need of the PWA/PWARC and the aim of social justice separate within the organization: when clients are prevented from getting services because of homophobia, sexism, racism, or other biases, then that battle is fought in that case. The AAC does not want clients to become causes célèbres, although some PWAs have chosen to pursue legal battles or to publicize their difficulties. No general effort is made within Client Services to attack social problems that impinge on PWAs/PWARCs. The leadership believes that political and legal advocacy are best handled by other groups that advocate for the rights of gays and lesbians, IV drug users, or women or minorities.

The AAC believes that the best way to ensure quality services to all PWAs/PWARCs is to work with medical and social service delivery systems to make changes that meet the varied social, legal, medical, and psychological problems faced by PWAs/PWARCs, who necessarily come from different backgrounds and bring different needs. Staff are being hired to develop new programs within the public and private sectors to address the specific and emerging needs of all PWAs/PWARCs.

Education Department: Speaking the Right Language

The first two paid education staff members were a health educator, hired in late 1984, and a hotline coordinator, hired soon afterward. These two positions were subsumed under the Education Department in the fall of 1985, when an education director was hired. Today, the department has four health educators working with target populations, with funding available for four more. There is an administrative staff person, with funding for a second. A communications expert who will organize print media will soon be hired. Three volunteer subcommittees — Education, Hotline, and Minority Concerns, each

comprised of a dozen task forces — work with health educators to staff the hotline, which operates twelve hours per day during the week, six hours on Saturday, and four hours on Sunday.

Since the inception of the AAC, groups have requested speakers and AAC health educators (volunteers from a wide range of backgrounds), often accompanied by a PWA, to give talks. As the level of awareness about AIDS has risen among citizens and health organizations, and as AAC programs have proven effective, the Education Department has become increasingly involved in the development of programs within certain settings or aimed at specific target audiences — for example, helping the Visiting Nurse Association organize a conference.

Limitations in funding and staff affect every program at the AAC, but especially the Education Department, because it is difficult to neatly define projects. Client Services can use the projected number of cases and statistical breakdowns of people served to define and evaluate specific projects. The Education Department must use more difficult tests of efficacy to define less tangible targets. What constitutes education, and who must be educated? How can projects address nuances of culture and prejudice? How many people can be grouped in a target audience without homogenizing an AIDS message to the point of meaninglessness? How specific can a pamphlet be without alienating subgroups within a target audience?

The consultative approach, in line with the organizational philosophy of promoting thoughtful response from existing agencies, has permitted other groups to educate some audiences while reserving for AAC educators hard-to-reach or newly discovered target groups. This has generally widened the range of effectiveness for the AAC. It has also enhanced the credibility of AAC staff and has permitted them to become involved in the early stages of policy and curriculum development, decreasing the need for “re-education” of well-meaning but ill-informed groups. AAC input is seen as vital to any programming about AIDS: media and organizations seek AAC approval and participation because the AAC educational programs are viewed as innovative and successful.

Targeted Education and Outreach Emerge

Disseminating the knowledge and techniques hammered out over the past few years, the Education Department continues to expand and experiment with new programs. These include a street corner outreach program aimed at IV drug users and prostitutes; “safety net” home education parties for gay men, soon to be made available to women considered to be at high risk; “hot, horny, and healthy” safer sex workshops; a program to distribute compact bleach bottles and information on cleaning drug works; efforts to install condom vending machines in gay bars; and a recent ad campaign called “The Road to Summer Fun,” which utilizes road signs and attractive men in hard hats to convey safer sex concepts. Although not everyone is comfortable with every program, educators are perceived as experts in designing effective targeted messages.

As time passed, the AAC recognized a need for broader impact through exposure of the AAC philosophy in media reports. The “general public” is more likely to get AIDS information from television or radio than to attend a seminar on AIDS. Consultation by the Education Department with the media, including three major local television and some local radio stations, provides media messages with AAC input and gives this information a legitimacy that an AAC program alone might not have. If radio and television personalities talk freely about AIDS, then citizens will view discussion of the topic as permissible.

The Education Department maintains a mix of educators who are responsive and committed to particular communities. This diversity helps ensure that AIDS messages are sensitive to the underlying social issues that increase the difficulties of PWAs/PWARCs from different cultures. The department recognizes that many agencies offer factually correct AIDS information, but that some agencies include messages that differ from the AAC's attempt to be nonjudgmental and sensitive to cultural meanings. The AAC has defined a set of concepts which it believes must be adhered to if AIDS educational material is to be effective. AAC printed materials and talks rarely address underlying social issues didactically, except in challenging stereotypes. However, great attention is paid to the language used to talk about risk behaviors and about people whose communities may have a high incidence of them. Risk behaviors — drug practices and certain sexual practices — are understood by the AAC as acts promoting social cohesion in subcultures. As such, risk behaviors have specific meaning and importance in the lives of individuals who engage in them. AAC messages are designed to inform about the dangers of some practices and suggest changes that reduce risk while promoting positive self-image.

AAC educational messages focus on risk behavior rather than on risk groups: overemphasis on groups can inflame prejudice and may prevent accurate risk assessment on the part of those who engage in risk behavior but who do not identify with the “risk group” as defined by the Centers for Disease Control or as self-defined by some communities.

This creates a paradox that requires sophisticated targeting: gay men or IV drug users, for example, who self-identify as part of the gay male or drug subculture may be best educated by material that makes reference to the details of subculture life. However, homosexually active men or IV drug users who do not perceive themselves as part of a subculture may well become hostile to a message that equates their behavior with a stigmatized group. They may reject the idea that they are “gay” or an “IV drug user” and may not make an accurate risk assessment. These people need a message that encourages risk reduction while remaining neutral on what engaging in those behaviors may mean to others in society.

The AAC's success in formulating these sensitive messages is due to involvement of staff and volunteers who understand the workings and language of various subcultures. These culturally sensitive educators — who may or may not have traditional health education training — are expert at identifying the subtle language choices that make the difference between a credible AIDS message and one that is ignorant or insulting.

Acknowledging Cultural Diversity

The AAC believes that attitudes about AIDS and attitudes toward minorities work hand in hand: undoing misconceptions in one diminishes prejudices in the other. For example, overcoming fear about AIDS makes it easier to care for or befriend a PWA and thus to acknowledge different cultures. The opportunity to work with groups of people who may have been feared as a result of social prejudice allows a health care worker or friend to separate AIDS fears from social prejudices. This kind of education has been extremely liberating for friends, families, and coworkers who may previously have been uncomfortable with a gay man or an IV drug user. Effective education about the disease and subtle, positive messages that combat prejudice allow people to move past stereotypes and fears that may have been immobilizing or that may have prevented them from being compassionate toward those directly affected by AIDS.

The AAC educational philosophy is designed to articulate a range of messages under

the umbrella of AIDS information. The Education Department believes that ultimately people will not understand the complex issues surrounding AIDS unless they are informed about the preexisting social problems.

The Education Department further recognizes that AIDS work done within and by the communities first affected — IV drug users and gay men — provides a model for other communities and for society at large. Gay men have made important subcultural and personal changes that have decreased the rate of HIV transmission. The anxiety, embarrassment, and fear caused by efforts to negotiate safer sex are similar regardless of gender or sexual preference. Educators incorporate the experience of gay men and their sexual community in sex education for heterosexuals. Educators also use the gay community's experience of death and grieving as a model for others and as a challenge to the general denial of mortality issues in American society.

The AAC also teaches people to be knowledgeable health care consumers. Drawing on the self-help movement, a long-standing countertrend to U.S. big medicine, the AAC has developed patient guidelines for asking good questions of medical providers. The involvement of lay educators from communities at risk challenges the notion that only doctors can provide good information and reinforces the belief that patients have a right to comprehensible answers. An important message in AAC literature is that individuals can and must take responsibility for their health and for AIDS prevention, and that AIDS awareness is a positive act of self-determination.

Whenever possible, the Education Department engages PWAs/PWARCs as speakers to give accounts of their experiences. The importance of meeting and shaking hands with a PWA who has a feared disease and who also may be a member of a stigmatized social group cannot be overestimated. This personal contact provides another layer of education — it makes those in an audience responsible for their attitudes toward a real individual. The message that people who have met a PWA take back to their friends and families may be one of the most powerful factors in changing attitudes about the disease, especially for people who have not had the experience of personally knowing someone with AIDS.

Fund-raising: Building a Sound Financial Base

Because the AAC grew out of grassroots organizations, its first fund-raising efforts consisted of small-scale events and direct mailings within the Boston community. It was sometimes difficult to involve bars and social clubs in fund-raising activities, given the denial of the seriousness of AIDS and the belief that the mention of AIDS would turn customers away. Resistance also occasionally came from other community organizations, which were afraid that AIDS fund-raisers would deplete their funding base. In 1983, asking the society at large to help fund this nascent organization working primarily with homosexuals and drug users needed to be done diplomatically and cautiously.

From the beginning, the AAC saw fund-raising as a three-part project: raise needed funds, provide educational opportunity, and afford a sense of participation in the effort to fight AIDS. The first major fund-raising event had an additional purpose: to consolidate morale and give organizers a concrete project that could realistically be accomplished.

That event was a major fund-raising and public relations success. It brought in \$25,000 — an unheard-of sum in the history of Boston gay and lesbian fund-raising in 1983 — and provided for those attending both a good time and a “good feeling” of being part of a community trying to help itself. The value of the good feeling was immediately obvious: new volunteers made contact with the committee during fund-raising events, and

media coverage put a compassionate face on a disease mostly reported in abstract scientific accounts or sensational stories.

As the AAC undertook educational projects and as PWAs met with apathy and discrimination, the need for money became urgent. There were pamphlets to be printed and phones to be installed. There were emergency loans to be made to people thrown out of their homes and food to be bought for those having difficulty working their way through the welfare system. There were wheelchairs to rent and funerals to pay for. The requests for money were difficult to prioritize, and as paid staff were hired, it was hard to decide which positions were immediately necessary and which committees could make do without paid staff backup.

The AAC attracted experienced fund-raisers early on, in part because of personal connections between committee members and people in the business community, and partly because some excellent fund-raisers had loved ones who had died of AIDS early in the epidemic. The need to raise money, combined with the accessibility of compassionate, experienced fund-raisers, allowed the AAC to aim for larger events and campaigns that would attract both gay and straight donors. The first large-scale event outside the gay male community was the ArtCetera Auction, first held in 1985. This was soon followed by several benefit concerts sponsored by the Boston branch of Saks Fifth Avenue and by local radio and television personalities.

At the same time that major fund-raising became possible outside the gay and lesbian community, more state and federal monies became available. The City of Boston had early given small grants to the AAC, and altogether, governmental monies made up about 40 percent of the AAC budget.

The organization's financial experts were aware of the need to keep a diversified funding base, and pursued private foundation money and in-kind donations, as well as continuing annual versions of several highly successful events, such as the art auction, the pledge event called "Walk for Life," and a fall gala.

In many organizations, the function of fund-raising seems remote, even opposite in values, from the other educational or services tasks. However, fund-raising at the AAC continues not only to raise money, but to integrate the missions of the AAC with financial realities. More so than some other major AIDS organizations, the AAC has combined the quest for a broad range of funding sources with high-profile education, group morale building, and a sense of participation on the part of those who attend or work on events. The fact that money is being raised for AIDS is not obscured, and the opportunity to educate is not deferred to another occasion. Fund-raising as a department provides an excellent model for integrating volunteers and paid staff. Those who have decided to devote their time to AIDS fund-raising are committed to the goals of the organization, using their personal skills to create successful events. Although many people perceive those doing fund-raising as personally remote from the daily realities of AIDS work, in fact, they share the passion for AIDS work with other kinds of staff and volunteer buddies.

The AAC of Tomorrow

The AAC is an exciting and frustrating organization for those inside and out. The current board is acutely aware of its mission to project a vision that guides the organization through the difficult years ahead, when the pressures to serve, advocate, and set policy — for the AAC and for society — will only increase.

The board has set two priorities: define better how the components of the organization

work together, and determine how the AAC can best relate to communities of color, who are now becoming the emergency arena in the AIDS crisis. The board plans to accomplish these goals through meetings outside the regular twice-monthly business format, which allows members to take a hard look at the organization and at themselves. The board will try to look at the issues and policies of the current AAC and determine whether these offer the best way to accomplish the mission.

Defining a relationship with communities of color for the predominantly gay and white AAC will be an organizational challenge and an opportunity to break down social barriers. The AAC could become a microcosm for a more compassionate, pluralistic society, in which each person's unique background enriches the organization and is not lost to mainstreaming. The AAC has experience with respecting and incorporating cultural differences, but a visionary cooperation between racial and sexual minorities will demand yet more. The delicate balance between "doing for others" and promoting community self-interest will loom large as the AAC works in communities of color that have their own political ideology and power infrastructure.

The AAC must balance cultural sensitivity with the urgency within communities of color, who currently have the highest percentage increases in spread of HIV and AIDS/ARC diagnosis. The AAC must come to grips with what the experience of the gay and lesbian community has been so it can share that experience with minorities who face other forms of oppression. It must define what it is capable of and experienced in providing, and it must be prepared to learn from the communities with whom it forms a partnership to combat AIDS.

Conclusion

The special historical conditions that determined the exact inception of the AAC include a liberal city government; significant existing ties between the gay and lesbian community and city social service agencies; a commitment on the part of government officials to deal with the AIDS crisis in a nondiscriminative way and to listen to the experts within the affected communities; the presence of long-standing medical, social, and psychological organizations within the gay and lesbian community; active gay and lesbian community news media and known locations for community contact; proximity, but not centrality, to the epidemiological center of the epidemic; and large numbers of teaching and research medical facilities in the area. But these conditions do not fully explain why the AAC has continued to evolve to meet the needs of the many communities and individuals that need support and education.

The AAC has a unique ability to adapt to new circumstances and confront internal conflict compassionately. Its quiet commitment to grassroots-organizing techniques and to understanding the special needs of different kinds of people affected by AIDS has enabled it to keep sight of its mission — to support, educate, advocate, and reach out. The success of the AAC derives from the commitment of the leadership and volunteers to listen to the many voices in need, and to keep focused on AIDS as the central concern. Where other groups have become enmeshed in either playing or avoiding politics, the AAC has achieved a balance between doing its work and making the necessary demands of a system fundamentally perplexed by AIDS and its social ramifications. The AAC has also achieved a level of fund-raising success unmatched in any similarly sized city — in part because of committed and experienced fund-raisers, and in part because the organization established credibility and a compassionate face early in its existence.

The history of the AAC provides a model of community resistance and compassion: it is the story of a group coming to understand the disaster that has befallen it, and to project its unique subcultural values to create a selfless yet self-defined movement to help itself and others. The members of the AAC who reflect on this experience are well prepared to learn about and overcome their own prejudices toward other affected groups and to continue to inform others about the prejudices they face.

The AAC will face more challenges in the years ahead, as AIDS continues to be a medical and social problem of unpredictable dimensions. Once a small, collectively oriented group of volunteers, and now a large, nonprofit corporation with dozens of staff and hundreds of volunteers, the AAC is adaptable because everyone involved is committed to making a difference in the lives of all people in any way affected by AIDS. It will continue to be an innovative organization carefully treading the line between bureaucracy and grassroots movement. The openness and willingness of individual staff and volunteers to look inside themselves and share their emotional and practical experience should militate against organizational stagnation. Whatever strategic errors are marked against the AAC, the sheer vision and willingness to struggle through a difficult crisis will write as heroes the many men and women who have been its members and staff. 🐦

"I'm a New Yorker, I'm a city boy. But like most city boys in New York, in the summertime, I went down south — to my grandmother's farm, and every so often, my Aunt Sweet, who lived to be one hundred and sixteen, Aunt Sweet would say, 'You children, you all stop playing and come in here.' And we would go in and she would be humming and singing a song, and every once in a while she would pull up her dress and she would show the scars from plantation life. And I realize I am one who came from that. AIDS can't do a damn thing to me."