

In the Life: Accounting and Triage for Black LGBTQIA Communities in HIV Prevention

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Dedication

For Sharon, I hope you get to play tennis.

Abstract

The HIV/AIDS epidemic continues to persist into its fourth decade with black LGBTQIA communities at the center of its continuation. This dissertation examines black LGBTQIA communities' relationship to the HIV/AIDS epidemic through HIV prevention strategies in Atlanta, GA. I provide a Black Geographies study of HIV prevention with attention given to the theoretical relationship between biological citizenship, Black Feminist Thought, and Queer of Color Critique. I explore these relationships through an analysis of racial formations in HIV interventions and the ways in which community-based organization in Atlanta, GA navigate limited HIV prevention resources. My analysis uses the phrase the "hidden epidemic" as a conceptual tool understand the ways black LGBTQIA communities' access HIV/AIDS resources and HIV prevention strategies. My dissertation contributes to current geographical scholarship on health care, antiblackness, citizenship, and queer worldmaking.

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Chapter 1

Introduction

1.1 problem

In 2020, the Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS) epidemic still confounds researchers and the general public as it enters its fourth decade (Fauci 1999; Bailey et al 2019; Cheng, Juhasz and Shahani 2020; Klot and Nguyen 2011). Globally there has been a reduction in new HIV cases, however, concentrated pockets of HIV infection persist. In Southern Africa – Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe - HIV incident rates are over 10%, with heterosexual transmission as one of the primary drivers of the epidemic (Kaiser Family Foundation 2019). In the United States, black¹ men who have sex with men (BMSM) have a one in two lifetime chance of infection and are the primary risk group for transmission (Hess et al 2017). Although only 12% of the United States population, black communities account for 43% of new infections, 42% of people living with HIV, and 44% of all HIV/AIDS-related deaths (Centers for Disease Control 2019). Additionally, the United States South comprises 33% of the US population but accounts for 51% of new HIV infections (CDC 2019). Researchers point to a number of reasons for HIV/AIDS persistence in black Lesbian

¹ I chose not to capitalize “black” in order to point to the fluidity of blackness and black people. To capitalize black would assume that it is a real object and its properties are fully known. However, this isn’t the case given that black people have and continually exceed the constraints that have been placed onto in society. From slavery, reconstruction, Jim Crow to the Movement for black lives, black people evade easy definitions based in phenotype, culture, and social construction. For reference to these principles see (Wright 2015; Du Bois 1903; Spillers 1986; King 2019; Cruse 2005).

Gay Bisexual Transgender Queer Intersex and Asexual (LGBTQIA) ² communities highlighting social determinants of health (Dean and Fenton 2010; Gant et al 2019), sexual networks (Adimora et al 2006; Birkett 2019), a lack of health care access (Dorell et al 2011; Carter and Flores 2019), and a lack of sex education (Bazargan et al 2000; Payán et al 2019). Additionally, researchers highlight that with proper health resources (Gardner et al 2011), a political willingness (Cohen 1999), and reducing gender and sexuality stigma (Aggleton and Parker 2015), rates of infection for black LGBTQIA communities would mirror that of their white counterparts, who have a one in eleven lifetime chance of infection (Hess et al 2017). Therefore, a tension exists between the knowledge of the HIV epidemic and strategies to intervene that have had marginal gains with disproportionate rates of HIV infection in black LGBTQIA communities. With this tension in mind, I consider the ways society comes to know black LGBTQIA communities' relationship to HIV/AIDS epidemic, which provides a critical site of inquiry to understand health disparities as a product of knowledge production as it intersects with race, gender and sexuality.

² I use LGBTQIA not to impose singular categories on genders and sexualities but to approach the vastness of relationships within these umbrella terms. In line with the social, theoretical and political project of queer, my use of LGBTQIA is to call into question easy gender and sexual affiliations while also critiquing gender and sexuality as the sole basis of group affiliations. Additionally, blackness and indigeneity always accompany the use of LGBTQIA and point to the racialized foundations of gender and sexuality, which are inseparable from queer critiques of hetero and homo normativity. Therefore, I use of LGBTQIA with attention given to the diverse set of relationships that exceed the easy categorizations. I do this in order to delink the common public health language of men who has sex with men (MSM), which dominates understandings of sexual practices within HIV/AIDS discourse and limits empirical realities that there are more than cis-men who are sleeping with other cis-men as a driver of the epidemic.

I take knowledge produced about black LGBTQIA communities and the HIV/AIDS epidemic to understand the ways racialization processes, which place individuals and populations into hierarchies of difference, are made to seem natural with regard to health.³ My approach to understand the ways in which the HIV/AIDS epidemic comes to know black LGBTQIA communities is situated in a tradition of critical inquiry that seeks to understand the way individuals and populations are differentiated into hierarchies of racial, gender and sexual difference. Therefore, I engage biological citizenship literature as a critical theory to parcel a part and understand knowledge production, the HIV/AIDS epidemic and black LGBTQIA communities. Biological citizenship describes practices of rights and recognition through biological harms or mutations which become the basis of group identity formation. Adriana Petryna (2004) elaborates that biological citizenship reflects the ways in which “communities ‘at-risk’ come into being; to show how norms of citizenship are related to such circumstances [...]” (250). Biological citizenship provides a foundation to understand the racially uneven landscapes of the HIV/AIDS epidemic, in particular, the ways black LGBTQIA communities are limited in their response and adaptation to HIV prevention strategies. By looking at HIV prevention strategies, uneven landscapes of response to the HIV/AIDS epidemic emerges within black LGBTQIA communities at the intersections of race, gender and sexuality.

³ I take health as a social construct that represents a number of social, cultural, economic and political perspectives. This isn't to diminish that there are things that can cause ill health. Instead, I consider the ways health is a proxy for judgements to be made against individuals and populations. Additionally, I view health as a window to understand the ways ideology is reproduced onto marginalized populations. See (Metzal and Kirkland 2010; Douglas 1966; Sontag 1978).

In order to show the limitations of knowledge production and HIV/AIDS response for black LGBTQIA communities, I frame their experiences through the analytic of the “hidden epidemic” to explore the uneven distribution of race, gender and sexuality as they are co-constituted alongside the development of HIV interventions (Thrasher 2018; Millett and Peterson 2007; Villarosa 2017; Macfarlane et al 2018). The “hidden epidemic” challenges the recent proliferation of studies, reports and news coverage on black gay men and their disproportionate rates of infection to insist that black LGBTQIA communities have always carried the burden of the HIV/AIDS epidemic. The “hidden epidemic” speaks to the ways in which black LGBTQIA communities have *always* endured the HIV/AIDS epidemic. For example, the “hidden epidemic” considers the centrality of black communities to early understandings of the HIV/AIDS epidemic and how the statistical presence of disproportionate rates of HIV infection in black communities did not produce a public health response. Thus, the “hidden epidemic” is a form of “willful ignorance” among those with the power and resources to intervene in black LGBTQIA communities but instead chose to invest in denial or non-belief (Thrasher 2018; Villarosa 2017). Whether it was then Governor, Mike Pence refusing to expand HIV prevention to rural counties impacted by increased HIV infections (Woods 2020) or the Bush Administration spending \$1.4 billion dollars on abstinence only education to stop the spread of the HIV/AIDS epidemic (Doucleff 2016), the “hidden epidemic” is a choice. My dissertation considers the ways the “hidden epidemic” is reproduced through the development and implementation of HIV interventions.

I argue that the production of HIV research and interventions limits the ways black LGBTQIA communities are imagined addressing the HIV/AIDS epidemic. For example, HIV interventions' focus on individual psychosocial behavioral changes in order to alter population level HIV risk reduces the scope of what is deemed effective behavioral changes – condom use, limiting the number of partners – and dismisses homegrown community driven individual and population level changes. Hence, the demands of clinical research in the form of discrete populations, control trial intervention delivery, and time-based follow up, leaves little consideration of the political and geographic implications on populations in need of interventions. Additionally, as a researcher, I found it difficult to research HIV prevention and black LGBTQIA communities due to a lack of avenues outside STEM or biomedical research.⁴ Yet, as a student of the HIV/AIDS epidemic, the focus on STEM or biomedical interventions as the key research focus in HIV prevention blurs the rich social science and humanities literature that considers how the social, political, and geographic were central to advances in understanding the HIV/AIDS epidemic. However, the problem is that there are two eras of the HIV/AIDS epidemic - pre and post the introduction of antiretrovirals drugs, that stop the transition of HIV to AIDS - which limits the production of social science

⁴ The promotion of STEM or biomedical research as the preferred avenue to study the HIV/AIDS epidemic misplaces the role on social, cultural and economic in the proliferation of the epidemic in marginalized communities. STEM or Biomedical research has created advances that have made HIV into a manageable disease or a non-threat for HIV negative populations. However, these advances are situated within systems of difference which impacts the ways the HIV/AIDS epidemic is distributed unevenly. Therefore, research on HIV/AIDS works for some communities at the expense of other communities without a consideration of the ways in which marginalized communities are impacted through STEM or biomedical research.

research in the post-antiretroviral era.⁵ In 1996, the introduction of antiretrovirals changed the HIV/AIDS landscape giving people living with HIV/AIDS (PLWHA) a reprieve from the AIDS crisis. Antiretrovirals turned a positive HIV diagnosis from a certain death into a condition that could be managed. This had gargantuan epistemic and material implications for the HIV/AIDS epidemic as PLWHA had a tool to save people's lives. Therefore, I demarcate the pre-antiretrovirals era from 1981 to 1996 and the post-antiretroviral era from 1996 onward. I argue that the pre and post antiretroviral eras are central to biological citizenship claims, the ideal HIV/AIDS subject, and changes in how race, gender and sexuality are conceived to impact black LGBTQIA communities.

In the pre-antiretroviral era, critical social science scholarship on HIV/AIDS developed a foundational critique that centered on the ways in which the epidemic was social (Patton 1990; Farmer 1992; Sontag 1989; Epstein 1996; Shilts 1987; Wallace 1988). Scholarship pointed to how the lack of government response to the epidemic was due to the fact that gay men and injection drug users were the primary risk groups, which created a moral fixation as the disease spread. The lack of response from the United States government coupled with a lack of a cure from the scientific community created a crisis of credibility where the trust in science and government response to the epidemic faltered (Epstein 1996; Beck 1992; Lupton and Tulloch 1998). To fill the gap of credibility, People Living

⁵ The pre and post antiretroviral marks what many have called an end to the plague of the AIDS epidemic (Sullivan 1996; France 2012). The introduction of drugs to stop HIV's transmission to AIDS points to changes in the HIV/AIDS epidemic where prevention could be taken seriously given that the death sentence of the epidemic found a reprieve and that it could be managed. This not only changed approaches to stopping the spread of the disease, but it also changed who the ideal HIV/AIDS subject was in the epidemic.

With HIV/AIDS (PLWHA) put their bodies on the line to fight for recognition and response to the epidemic. Groups like AIDS Coalition to Unleash Power (ACT-UP) and Queer Nation emerge as a focal point of social science research on HIV/AIDS. This scholarship considers not only the implications of the virus and death but also the activism of sexual minorities who force a social and political response to the epidemic. This activism pushes a more grounded theoretical driven social science studies of health⁶ from the lives of HIV/AIDS activists and solidifies the emergence of Queer Studies⁷ as a discipline building from Feminist and Woman Studies. However, social science research on HIV/AIDS changes with the development of antiretrovirals which moves scholarship into the post-antiretroviral era.

The post-antiretroviral era is marked by changes in HIV/AIDS knowledge production as the narrative of the HIV/AIDS epidemic around activism and advocacy in the United States gives way to the global HIV/AIDS movement where the United States AIDS industry is at the forefront of research and stopping the global spread of the epidemic. In 1995, the introduction of antiretrovirals changed HIV prevention and social science

⁶ I trace Susan Sontag's (1989) *AIDS and Its Metaphors* as the mainstream foundational piece that speaks to the significance of HIV/AIDS and the lack of response for a society. Within academic scholarship Paul Treichler's (1987) and Douglas Crimp (1988) bring cultural theory to health and trace the connections between homophobia within biomedical discourse. Both academic and mainstream depictions coincide with activism movements, in particular, the rise ACT-UP in 1987 and the Denver Principles (1983).

⁷ I use Michael Warner (1993) *Fear of a Queer Planet* as a jump off point for the institutionalization of queer students with the United States Academy. I would call this a normative reading of the emergence of queer studies that builds from the outgrowth of scholarship and mainstream activism. As Queer of color and Black Feminist have pointed out, the mainstreaming of queer was built of the labor of racial and ethnic minorities within queer spaces (Cohen 1999, 2001).

studies of HIV/AIDS. Antiretrovirals allow those who were HIV positive to live (somewhat) normal lives and ushers in a pharmaceutical revolution as US based companies sought to pillage the global market of HIV infections. Therefore, HIV/AIDS becomes a tool of international development, as Non-Government Organizations (NGOs) were furthering the Global North/South divide through the HIV/AIDS prevention and antiretroviral drug access. Similarly, social science scholarship shifted focus to the global reach of the epidemic as this illuminated a change in US imperialism and the further marginalization in the Global South, in particular, the African continent, as countries were brought into unequal exchanges for HIV/AIDS resources.

Additionally, HIV prevention research during the pre-antiretroviral era was limited due to the social stigma of engaging people who were HIV positive. Given the high death rate of people who were HIV positive, People Living With HIV/AIDS (PLWHA) needed long term care options due to HIV/AIDS requiring high health care cost and end of life care. Therefore, HIV prevention strategies focused on HIV-negative populations rather than trying to stop PLWHA populations sexual behaviors. The introduction of antiretrovirals changes HIV prevention as PLWHA people are living longer with more opportunities to spread the HIV virus. Antiretrovirals gave HIV prevention strategies justification for providing prevention to people who were HIV/AIDS positive. Antiretrovirals allowed PLWHAs to move out of care structures and into HIV prevention strategies, as living longer created more opportunities to infect HIV-negative people.

This dissertation argues that academic research in the post-antiretroviral era has to contend with the global movement of HIV/AIDS scientific research, a lack of visible social justice activism, and a social imaginary where AIDS is seen as a problem of the past. What emerges are two problems that impact academic research on HIV/AIDS and hinders a deeper engagement with black LGBTQIA communities and the HIV/AIDS epidemic. First, research on black communities and the HIV/AIDS epidemic connect race to HIV risk, as a deterrent for HIV infection. With the global movement of HIV/AIDS funding and research away from a focus on the Global North, the epidemic domestically underwent a demographic change where racial and ethnic minority communities became statistically the primary bearers of the HIV/AIDS epidemic. Much of the pre-antiretroviral era social science and humanities scholarship sought to understand and parcel apart how sexuality in the form of homophobia was central to the lack of response to the HIV/AIDS epidemic. However, this research wasn't extended to understand how the intersections of race and sexuality came together to impact the lives of those who sat at these intersections. Similarly, the focus in HIV prevention research on individual behavioral change failed to incorporate larger systemic relationships, like racism and homophobia into the interventions study design. Interventions weren't able to account for the ways that racism and homophobia impact individuals within a study. To illustrate this point, Lane et al. (2004) notes that "public health's predominant focus on individual lifestyle risk factors of behavior largely ignores the institutional disadvantages constraining healthy behaviors among different racial and ethnic groups" (320). Thus, HIV interventions' focus on individual behaviors limits how systematic forms of oppression translate to individuals at risk of infection.

Second, social science research on global HIV/AIDS prevention does not produce a strong critique on HIV prevention in the United States. There has been a small body on scholarship on HIV Prevention that looks at interventions' impact within the United States (Collins and Sapiano 2016), HIV prevention costs (Auerbach and Coates 2000), and the lack of culturally relevant interventions (Millett et al 2006; Peterson and Jones 2009). The focus on United States domestic HIV prevention builds from a larger body of scholarship within Medical Sociology and Anthropology that demonstrates the limitations of western HIV intervention with within the Global South (Nguyen 2009; Parker 2002; Ingram 2007; Weiser 2006). For example, three randomized control trials of male circumcision, as a public health strategy for reducing new HIV infections, were found to have efficacy within study groups in different parts of Africa. As a result, NGO and other charity-based funding came to support societal transition to promote male circumcision. However, what has been lost in debates regardless of the efficacy, is the inability of foreign HIV prevention aid and interventions to change cultural perspectives on circumcision, especially in locations where uptake is low. For example, Lukobo and Bailey (2007) point to the ways in which socioeconomic and cultural factors play a larger role in Zambian communities seeking HIV prevention strategies, in particular male circumcision, which aren't considered in global funding directives due to their limited scope. Therefore, social, cultural and economic considerations that impact uptake of HIV prevention strategies in local contexts need to be considered, especially within the United States where structural determining factors like housing, HIV-related stigma, and health care access impacts black LGBTQIA communities' relationship to the HIV/AIDS epidemic (TAG 2017). Taking structural factors to HIV prevention accesses alongside

HIV interventions' efficacy allows for a deeper engagement with the ways race, gender and sexual difference are mutually constituted and produced through the HIV/AIDS epidemic.

The failure of the post-antiretroviral era to consider HIV/AIDS history and HIV preventions lack of consideration of structural factors creates two limitations that impact the ways knowledge is produced about the HIV/AIDS epidemic. First is that the HIV/AIDS' historical narrative focuses on the past and white gay men living in coastal cities. This creates a perpetual loop cycle where black communities are found to be impacted by the epidemic and thus hidden until found again in places outside of normative imaginaries. As such, my use of the "hidden epidemic" points to how HIV risk and the use of statistics have *found* black communities to be disproportionately impacted from the beginning of the epidemic. Yet, black LGBTQIA communities have never been the ideal HIV/AIDS subject. Within HIV interventions, the language of "hard to reach" as part of prevention discourse becomes a moniker to denote how the epidemic is found in racialized communities, inner cities, segregated exurbs and rural areas. The use of "hard to reach" furthers the dominant narrative that the HIV/AIDS primarily impacts white gay communities in Los Angeles, San Francisco or New York City. Second, social science research has not addressed how the HIV/AIDS epidemic blurs the relationship between clinical interventions and population health, which is a problem between individual interventions and their impact on population level changes. In the post-antiretroviral era, HIV prevention narrowly focus on individual behavioral changes rather than interventions that work at the population level. Instead of polices or health care

access at the population level as a means of addressing HIV-related risks and HIV infections, individual changes are prioritized. The focus on the individual behavior incorrectly places blame on individuals rather than trying to change structural factors. Thus, research on HIV prevention must connect individual prevention as part of a larger population body. The cost of not addressing narratives and the relationship between individual and population interventions is an inability to see black LGBTQIA communities as bearers of the epidemic.

1.2 Argument

I argue that the “hidden epidemic” is produced through a lack of consideration of the ways in which antiblackness and homophobia shape HIV prevention and interventions. If the concept of the “hidden epidemic” makes clear that the HIV/AIDS epidemic’s entrenchment into places (rural and Southern) and communities (low income, racial and ethnic minority communities) outside of the dominant narrative, then there needs to be a deeper engagement in how limitations in knowledge production shapes our understanding of black health. Therefore, I draw from the Black Health Tradition as a body of scholarship to illuminate connections between health, illness and black communities. For example, McBride (1991) demonstrates the ways black health philanthropy during the early 1900s in response to tuberculosis creates a model of health advocacy for non-black communities. From tuberculosis to HIV/AIDS, McBride’s scholarship places black communities at the center of health knowledge and public health response. Likewise, Black geographies, developed through the scholarship of Katherine McKittrick and Clyde Woods (2007), centralizes black people and their geographic concerns as foundational to

the production of space. Black Geographies emphasizes how black knowledge in opposition to oppression provides insights to untangling the role of dominance in traditional geographies (McKittrick 2006; Hawthorne 2019). McKittrick and Woods (2006) highlight how “geographies disclose how the racialized production of space is made possible in the explicit demarcations of the spaces of *les damnés* as invisible/forgettable at the same time as the invisible/forgettable is producing space – always, and in all sorts of ways” (3, emphasis theirs). Therefore, Black Geographies takes black people and their concerns by operationalizing a black sense of place. Combining Black Geographies and the Black Health tradition to the HIV/AIDS epidemic creates an approach to understand and argue that the epidemic is shaped through the actions of black communities. Understanding the centrality of black people to the HIV/AIDS epidemic requires understanding technologies that promote the “hidden epidemic” which create conditions of domination that are challenged by black communities through their own spatial practices. I take HIV interventions as the site from which black LGBTQIA engage and challenge the HIV/AIDS epidemic.

With disproportionate rates of HIV infection in the post-antiretroviral era, I argue that we cannot understand the ways in which black LGBTQIA communities are central to the HIV/AIDS epidemic without understanding how power operates at the intersections of race, gender and sexuality. To do this, I examine the production of HIV interventions and community-based organizations tasked with delivering them, which forms a continuum of knowledge production and translation from scientific research of HIV prevention strategies to communities in need of interventions. I trace the documentation of black

LGBTQIA communities within HIV interventions, alongside public health reports, memos, and records of black communities as the HIV/AIDS epidemic is found, again and again, to impact this community. Additionally, I follow the lifespan of HIV interventions as part of the CDC's introduction and implementation of interventions within the CDC's national HIV prevention programs. This empirical focus coheres how the "hidden epidemic" is reproduced through HIV prevention strategies and how the logics that undergird the production of HIV prevention is mediated through black LGBTQIA community's relationship to the HIV/AIDS epidemic. I center the ways HIV/AIDS knowledge production and translation through HIV prevention impacts black queer communities, which sits at the intersections of race, gender, sexuality and place.

I draw from the Black Feminist Tradition (Hull, Bell-Scott, Smith 1982; Lorde 1984, McKittrick 2006, Collins 1980, Spillers 2003, Hartman 1997) and Queer Theory (Ferguson 2004; Munoz 1999; Halberstam 2005; Puar 2005; Edelman 2004) to read across a diverse set of archives to understand how black LGBTQIA communities are hidden sites of knowledge production and material action. Therefore, the "hidden epidemic" traces how knowledge production conceals the centrality of black LGBTQIA communities, which is built on legacies of racism and homophobia. Racism and homophobia cohere through antiblack violence within the knowledge produced and material action drawn from black LGBTQIA communities. I consider the following question: **How is the "hidden epidemic" reproduced through antiblack practices at the intersections of race, gender and sexuality?** I focus on knowledge production and how it articulates a historical genealogy of meaning making that subsumes black

communities into regimes of antiblack violence. This stems from a recognition that slavery and bondage produced during the Transatlantic slave trade are still present today as it is articulated through racialization practices and antiblack violence. I define articulation through the work of Stuart Hall (1980) who defines it as a “connection or link which is not necessarily given in all cases, as a law or a fact of life, but which requires particular conditions of existence to appear at all [...]” (113-114; footnote 2). Therefore, antiblackness is premised on the conditions of slavery and bondage which transforms it from its original applications into new uses, which connects slavery’s afterlife to the present. Antiblackness is found within historical archives and reproduces oppression in form of the past finding itself in the present and future. To inspect the history of HIV/AIDS, I work with the afterlife of slavery as it shapes how black LGBTQIA communities experience HIV prevention.

Additionally, I use the process and outcomes of HIV prevention knowledge production and the ways in which community organizations interact with HIV prevention strategies as an empirical case study to develop a critical engagement with antiblackness. I ask:

How are black LGBTQIA communities brought into the production and implementation of HIV Prevention and interventions? HIV interventions provide an underexplored critical technology of HIV prevention in the post-antiretroviral era of the HIV/AIDS epidemic. How HIV interventions are produced and translated complements the theoretical focus of antiblackness as it allows for an inspection of race, gender and sexuality at a number of difference scales that demonstrates how black LGBTQIA communities are situated within HIV prevention. HIV prevention is central to

understanding how interventions and community-based organizations that implement intervention strategies impact local black LGBTQIA communities.

The two questions above on the role of antiblackness and HIV interventions generate two concerns that I address throughout the dissertation. First, I consider how the past nostalgia of HIV/AIDS research and history diminishes a societal and political effort to understand the ways black LGBTQIA communities bear the burden of the epidemic. I do this from the position of a researcher in solidarity with communities who have been written out of official HIV/AIDS discourses. The task is placing black LGBTQIA communities at the center of response to the epidemic from the beginning. Scholarship critical of the whitewashing of the epidemic has called attention to how the historical narrative of ACT-UP diminishes the contributions of communities of color and lesbians who were central to the group's formation (Shahani 2016). Additionally, the fight against HIV/AIDS leads to the consideration that "the end of AIDS" is near, as overall new cases globally go down and people are access lifesaving drugs (Deeks et al 2013). San Francisco, a one-time epicenter of the epidemic, has achieved 90-90-90 status where 90 percent of those at risk know their status, are receiving routine care, and are virally suppressant (Bansi-Matharu et al 2019). This is a testament to activists, the LGBTQ community, and local public health response. However, the process of writing black LGBTQIA communities into HIV history isn't to slow down above progress in the epidemic but to point to barriers that people face while seeking HIV/AIDS resources. I argue that understanding how antiblackness is entwined within black LGBTQIA communities is central.

The second move I make in this dissertation is to clarify the spatial implications for terms like antiblackness, slavery and its afterlife, and the ways in which gender and sexuality are constituted through race. Building within Black Geographies from an explicit framework of Black Feminism and Queer of Color Critique, I aim to show the ways antiblackness is co-constituted through gender and sexual domination. This extends the project of Black Geographies (McKittrick and Woods 2005; Gilmore 2002; Shabazz 2015; Reese 2019) in demonstrating that “black matters are spatial matters” by centering black LGBTQIA communities in the HIV/AIDS epidemic as necessary to dominant spatial practices and the fight against anti-black violence (McKittrick 2006, p.xiii). This will uncover the ways black LGBTQIA communities are continually hidden only to reappear as those disproportionately impacted by the HIV/AIDS epidemic. Central to this is showing how the black LGBTQIA community, unassuming to the historical narrative of the HIV/AIDS epidemic, has produced a response in places like Atlanta, Georgia, which were crucial to how the epidemic came to center white gay men in San Francisco and New York City. With research on HIV prevention in Atlanta, I show the ways black LGBTQIA communities shape spaces, places and landscapes as they address the impacts of the epidemic. Hence, a particular challenge is to not render flat the articulations of black communities in the United States South, given that the barriers faced are dynamic and multi-faceted.

1.3 Terminology

A central term that this dissertation employs is anti-blackness which has been adopted by scholars of critical race and ethnic studies to refer to processes of value making that render black people into property relations as part of the conditions produced during enslavement (Vargas 2018; Sexton 2010; Spillers 1987; Hartman 1997). If blackness speaks to an unfetter quality of sociality that extend beyond phenotype and into kinship and belonging social formations, then anti-blackness can be thought of as the conditions that strip black people of the ability to build these relationships. Antiblackness structures the ways black people are made legible in society through a continual negation of freedom of one's self. Additionally, how the United States exercises freedom - "as economic value, political category, legal right, cultural practice, lived experiences" – is from the enslavement of black people and limited freedom in slavery's afterlife (Sexton 2011 17). Antiblackness illuminates the relationship between slavery and freedom to show how black communities experience societal barriers post-emancipation.

Additionally, Hartman (1997) connects antiblackness to "the advent of freedom [that] marked the transition from the pained and minimally sensate existence of the slave to the burdened individuality of the responsible and encumbered freeperson" (117). Without resources, formerly enslaved people were brought into a system where their freedom was bound to those who had resources as they were left to the "burden individuality" of capitalism and a social system based on their subordination.

Antiblackness illuminates the material technologies that limit black freedom as black people wrestle with struggles for alienable rights, liberty, or property of oneself. For

example, freedom to have a nuclear family was limited for black women living in projects. Housing projects had a policy against men living in the housing, so single mothers were prevented from having a two-person, two income household (Turner, Popkin, Rawlings 2009). If antiblackness is expressed as the limits of freedom, racism sorts black individuals and populations into systems of value. Gilmore has famously argued that racism is best understood “as a practice of abstraction, a death dealing displacement of difference into hierarchies that organize relations within and between the planet’s sovereign political territories” (Gilmore 2012 16). Here, she signals that race exists only to differentiate populations into hierarchies of difference. Racism mobilizes antiblackness through placing racialized populations into the status of “the other.” Antiblackness and racism – as two different but interconnected valuation systems - combine to promote disproportionate relationships of black communities to incarceration (Gilmore 2007; Shabazz 2015), health (Washington 2006; Davis 2019), capitalism (Leong 2013; Wright and Bledsoe 2019), and other embodied experiences (Browne 2015; Sharpe 2010).

I develop the concepts of accounting and triage as essential technologies of antiblackness and racism, which are found within HIV prevention and intervention strategies.

Accounting, as I develop it here, is a technology of documentation that allows for black people to be evaluated. Accounting entails the use of measurement and standardizing practices to transform a qualitative occurrence into a quantitative enumeration. In this sense, accounting can be understood as a social practice of world making developed between the intimacies of those who account and those who are the objects of accounting.

Despite the cold calculus that accounting presumes, I argue that it is an intimacy that translates everyday life into measurable units. For example, the slave ledger on ships crossing the Atlantic is an accounting technology. Ledgers create new subject positions for former free Africans who were brought onto ships and made into slaves. McKittrick (2014) demonstrates the ways accounting brought slaves into plantation regimes which misappropriates black substantiations of freedom, which are indigenous ways that black communities understood themselves in the world. McKittrick elaborates “that black freedom is embedded within an economy of race and violence and unfolds as an indeterminate impossibility: wench, property of, likely lad, nearly worn out; certified to be free, says she was born free, formerly slave to. Says she was born free” (17). The repetition of “born free” points to another form of accounting that isn’t documented through formal channels. Accounting creates an official record of events where all the elements are known. Accounting is central to making objects ready for capital accumulation practices and standardizes populations within emerging nation/states (Scott 1998; Rose 1991; Hacking 1986; Porter 1996). I argue that accounting can be understood as an intimate process that unfolds between those in power who “count” and enumerate and those who account for themselves as something different. As explored in Chapter 3, accounting has a number of different logics that work together to build our understanding of the HIV/AIDS epidemic and HIV prevention strategies.

Triage represents the material outcomes of accounting practices and refers to processes that determine the ways in which resources will be allocated to individuals and populations in need of interventions. Triage operates through the production of crisis

based in scarcity as a means to differentiate those who receive care and those who don't due to limited resources. In the case of HIV/AIDS prevention in the United States, triage represents limited funding for service providers and black gender and sexual minority communities in need of HIV resources. Triage gives power through the making, defining and determination of specific requirements individuals and groups of people must occupy in order to receive resources. VK Nguyen (2010) notes that "trriage is a complex process where 'objective' assessments of value are carried out, in the case of AIDS, by a range of institutional practices that elicit, cue and assess narratives by would-be beneficiaries" (208). Triage creates an objective assessment of need which creates stratification among populations in need of resources. Triage explains the ways in which black gender and sexual minority communities lack a certain objective criterion to prompt the delivery of adequate resources in the fight against HIV/AIDS, while their (white) gay counterparts have found a reprieve from the HIV/AIDS epidemic. Therefore, if antiblackness structures our understanding of freedom, triage informs how citizenship for black LGBTQIA communities who seek resources and an adequate response from public health institutions is limited. Additionally, triage impacts how researchers negotiate antiblack racism and homophobia in scholarship. Clyde Woods' (2002) use of triage critiques researchers' decisions to enforce systems of oppression unwittingly rather than showing how these systems are informed through contestation between those in power and those who are the objects of power. Triage proliferates social and political difference. However, triage doesn't produce an impossibility of freedom that is key to antiblack violence. It shows that antiblack violence is not totalizing. Taking this limitation of power to heart, Woods (2002) calls for a smaller research design as an approach "because

official urban and metropolitan boundaries do not begin to encompass the dimensions of power, the weight of history, or the presence of contending ontologies” (65). As such, triage is particular to a geography and reflects place based contingent processes that are grounded in local history which are differentiated and stratified.

To this end, I trace the ways in which accounting and triage operate in HIV interventions through the concept of assemblage, which frames my approach to empirical research. My use of assemblage brings together a number of elements that work together to (re)produce how black people are hidden in the HIV/AIDS epidemic. The City of Atlanta, GA, arguably as the new epicenter of the HIV/AIDS epidemic, grounds my research as there has been a concerted effort among local activists to force local and national public health authorities to respond to the epidemic in the post-antiretroviral era. My dissertation uses the concept of assemblage to show how place is constructed from a number of different elements that make HIV prevention in place, particular and unique. Puar (2005) building from the work of Deleuze and Guattari (1988) defines assemblage as a “series of dispersed but mutually implicated networks, [that] draws together enunciation and dissolution, causality and effect” (127). Although Puar’s argument troubles the stable categories of identity within feminist studies, my use of assemblage situates black LGBTQIA communities into HIV prevention as occupying a number of relationships that produce subjectivities. With accounting and triage, assemblage allows us to see how the seemingly stable identity categories –race, gender, sexuality and place – when brought together creates a unique set of experiences that elude easy categorizations, especially when contextualized into place. This reflects how the United States South has a unique

relationship to the HIV/AIDS epidemic with regards to rates of infection, sexual networks and response to the epidemic. This place-based relationship to the HIV/AIDS epidemic creates a number of different avenues for race, gender and sexuality to articulate. Assemblage is an analytic to understand how Atlanta and its residents have a unique perspective to the epidemic from a number of different sites. What brings this assemblage together are four dimensions that shape how I experienced my research in Atlanta. The assemblage creates a material coherence through which power is exercised on black LGBTQIA communities. These dimensions limit access to HIV prevention and also contribute to reproducing the “hidden epidemic.”

1.3.1 HIV/AIDS Prevention: Statistics

To undertake this analysis, I first identify HIV/AIDS statistics and epidemiology as key sites for understanding the ways in which accounting and triage operate to differentiate black LGBTQIA communities. Statistics define how health, as a socially constructed value, deviates from the norm (Peterson and Lupton 1996). Within the HIV/AIDS epidemic, statistics connects the HIV virus to sexual behaviors. Adam Geary (2014) calls for a materialist approach to epidemiology as the narrow focus on the virus and behavior, which inform HIV prevention efforts, “de-socializes health and illness, treating viral disease epidemics as simply the transmission of the virus from individual to individual on a mass scale” (7). Epidemiological derived statistics carry assumptions about who is at risk for transmission. Therefore, statistics are a site of knowledge production that places the burden of risk on individuals who need to change. Additionally, Peterson and Lupton (1996) point to how “what is routinely glossed over in official accounts of

epidemiological research [...] is the socially constructed nature of the findings” (33). Those who are at risk carry a *biomedical individualism* (Fee and Krieger 1993). Biomedical individualism speaks to how individuals at risk of infection are considered free not to engage in sexual behaviors that put them at risk for infection. For example, the statistic 1 in 2 black MSM will be HIV-positive in their lifetime establishes a norm where it is assumed that one’s relationship to harm, in this case HIV/AIDS, are a product of black MSM as individuals, rather than a group of people who have a structural relationship to the epidemic. Statistics generate stigma as black MSM’s sexuality are connected to rates of HIV infection. Therefore, in my research site, Atlanta, GA, community-based organizations in Atlanta must navigate disproportionate rates of infection and the stigma numbers carry for black LGBTQIA communities. As such, black MSM are limited in the types of sexual behaviors they can engage in given that the broad statistical descriptions of transmission risk are placed on individuals who then must make changes with little regard to black queer sexual culture (Arnold and Bailey 2009).

1.3.2 HIV/AIDS Prevention: Textual Grammars

The second portion that contextualizes my empirical study are the textual grammars of HIV prevention that distribute knowledge about black LGBTQIA communities. Central to this is the ways antiblackness is mobilized in prevention strategies. Textual grammars refer to a set of discourses and knowledges that structure the ways in which black LGBTQIA communities understood in HIV prevention materials. HIV intervention messaging, funding proposals, call for proposal, and programs all contribute to the ways black LGBTQIA communities are understood in relationship to the HIV epidemic. For

example, HIV prevention campaigns are structured through discourses that reduce black LGBTQIA communities into objects to be intervened on. In Atlanta, these are local public health campaigns for HIV testing and more recently messaging to get people on to PrEP, which is a pill that prevents HIV infection. Local community-based organizations are on the frontlines of implementing messaging having to translate textual grammars for the specific needs of their communities. Textual grammars create the parameters of subject formation within the discourses of HIV prevention as local communities must meet the messaging produced in order to receive resources. Thus, textual grammars are central to accounting and triage.

1.3.3 HIV/AIDS Prevention: Landscapes

The third part of the assemblage of my empirical studies are HIV prevention landscapes, where community-based organizations and black LGBTQIA communities interact with one another through specific cultural and structural contexts to access HIV interventions. My use of landscapes comes from the work of Sauer (2008/1935) who establishes landscape as a cultural relationship between the environment and people's experiences. Landscape necessitates a consideration of the ways place, with its social, cultural and political inputs, impact people's experience their environments. For example, Atlanta is known, in part, as being a place of black cultural production, which as an environment, intersects with the HIV/AIDS epidemic to create a unique set of social and political topographies that black LGBTQIA communities must navigate. In line with Gillian Rose's (1993) scholarship on masculinity and landscapes, in terms of epistemic expression, I propose a bottom up understanding of Atlanta as a HIV prevention

landscape from the standpoint of black LGBTQIA communities. HIV Prevention landscapes bring black LGBTQIA communities into a set of circumstances that must be navigated in order to receive resources and minimize risk. These barriers are found in the black queer Atlanta based landscapes of the club, the bed, the house, and the yard where spaces of potential HIV infection can require self-vigilance.

1.3.4 *HIV/AIDS Prevention: Risk*

The final part of the assemblage that brings together my empirical focus is the ways in which risk structures the black LGBTQIA communities' relationship to HIV prevention. Risk connects the intersections of race, gender and sexuality to potential harms. Adkins (2001) in their work on surveillance and risk points to the production of HIV-negative populations as at risk which allows for an overreach of public health intervention. For example, HIV testing is recommended for populations at risk of infection. Yet, it's not clear if a population is formed through sexual identity or sexual behavior. The proliferation of HIV prevention messaging around know your HIV status and get tested doesn't distinguish between identity or sex behavior. Therefore, risks are applied to anyone with a degree of connection to identity or behavior, which expands who is in need of an HIV intervention.

Additionally, risk is a space of potentiality where individuals and groups of people must act in accordance to their own understanding of the risk they carry. Beck (1992) points to the individualization of risk as a form of self-reflexivity as state-governments absolve themselves in their role in creating conditions that harm populations. Risk is reflexive in

that it confronts the limitations of governments to protect citizens and that to intervene on individual lies doesn't address the structural harm that is being perpetuated in the first place. Giddens and Beck (1994) state that risk is, in part, "the recognition of the unpredictability of threats [which] necessitates self-reflection on the foundations of social cohesion and the examination of prevailing conventions and foundations of rationality" (8). However, this reflection is afforded for those that are granted inclusion into the protection of the state, for those who are outside they must engage a social structure that lacks resources. For example, Sangaramoorthy (2012) in their work on the spaces of HIV intervention highlight that participants need to be aware of their HIV viral load in order to receive resources from HIV lay health professionals and HIV prevention staff. In Atlanta these are the subjectivities of a "good" at-risk subject who is aware of their risk and is responsible for others risk. The performance of risk extends to all parts of life, as black LGBTQIA communities come to see themselves as risk.

1.4 Critical Health Geography

My research on the ways in which HIV/AIDS prevention operates through statistical knowledge, textual grammars, HIV prevention landscapes and risk provide an empirical focus that I situate within Critical Health Geography. With Critical Health Geography, I consider the role of place as HIV prevention strategies are implemented in landscapes where communities must negotiate access through social, political and cultural forces. It is within the constraints of HIV prevention landscapes that I articulate accounting and triage as analytics to understand how biological citizenship, as the embodiment of biopolitics and sovereignty, align with racialization practices to produce uneven

landscapes for black LGBTQIA communities. It is from this standpoint that enter the field of Critical Health Geography.

Critical Health Geography is a subfield within Geography that uses feminist, black studies and queer approaches to studying biological/physical relations, socio-cultural, political economy, and critical standpoints in health. Critical health builds from a genealogy of inquiry within geography that stems from research on the urban global crisis at the end of the 1960s (Harvey 1973). Harvey (1973) is pinned as a focal point of departure for critical inquiry in geography but others (Massey 1977; Wilson 1977; Bunge 1973) where engaging in social justice, activism and research that was critical of power relations. The urban riots of North America and Europe propel two approaches to critical geography that are foundational today. The first, social justice became a measure for the ways research should be conducted. Whether through formal activism (Blomley 2009), using feminist approaches (Nagar et al 2002) or through the scholarly writing practice (Mitchell 2004), critical geography considers the role of scholarship in everyday struggle. The second, is that geography is made through contestation between those in power and those who are alters those power positions. This builds from the work of Harvey (1973), who after witnessing the racialized urban riots in Baltimore, MD centralizes class strife as the basis of urban change. Epistemically, Harvey's witnessing of the riots resulted in him moving away from liberal economic theory to Marxist political economy which prioritized grounded materialist approach. This brought Harvey to critique research as having a revolutionary or counterrevolutionary stance. Although binary thinking has been pulled apart – as it should – by feminist geographers (Massey 1994), Harvey's dualism

illustrates political commitments that researchers should have. Theory should reflect a “social relationship [...] actualized in the real world” (1973 125). As such, contestation as a driver of spatial processes is crucial for critical geography. Spatial production isn’t the result of power alone, but it is power in struggle that produces outcomes. Therefore, antiblackness is the result of contested freedoms and the spatial production of black communities in opposition to antiblack forces. These two approaches, social justice and contestation of space, reflect the need to show how place and political commitments have the ability to illuminate how HIV interventions are a sight of struggle between top down approaches to HIV prevention and black LGBTQIA communities who want community driven approaches. As such, the goal for my work is to continue the tradition of bring critical geography into health geography, which has been an ongoing project of health and medical geographers who sought to provincialize the subfield.

Critical Health geography underwent a cultural turn and took place as a central concept to health. Instead of place being seen as passive to health processes, place was viewed as “operational living construct which matters” (Kearns and Moon 2002 609). Place became the site from which to understand how localities and landscapes, as a reflection of culture, define health experiences. Additionally, the cultural turn brought social theory to health geography in place of quantitative approaches to understand how health and geography impact health outcomes. My work intervenes within Health Geography in particular the silences around the domestic persistence of the HIV/AIDS epidemic in the United States South.

Critical Health Geography takes on the global production of the HIV/AIDS epidemic (Craddock 2000; Brown, Craddock, Ingram 2012; Sparke 2016). Scholars were interested in the role that NGOs had in development and the HIV/AIDS epidemic (Kalofonos 2010), others were concerned with global governance regimes of pharmaceuticals (Biehl 2007), and some highlighted how the global turn reflected larger colonialization practices through the distribution of HIV/AIDS resources (Cooyadia and Hadingham 2005). Overall, scholarship was interested in the ways the crisis of the HIV/AIDS epidemic was globalized. Cheng, Juhasz, and Shahani (2020) in addressing the global turn of the epidemic consider how our notion of crisis impacts the knowledge production of the HIV/AIDS epidemic. They point to how crisis is informed through space and time in what they term “a time out of time” (viii). Crisis substantiates a spatial temporal order that is out of sync with the normal rhythms of everyday life. In the pre-antiretroviral era, crisis thrusts people living HIV/AIDS out of their everyday rhythms as a lack of societal response and death disrupt livelihoods. Hence, what is crisis for some is a non-crisis for others. Black LGBTQIA communities’ relationship to the epidemic operate in different time and space orders. The proliferation of the “hidden epidemic” – as a reoccurring loop - reminds those who care to pay attention that black LGBTQIA communities are in an underrecognized crisis. The proliferation of the “hidden epidemic” for black LGBTQIA communities highlights the limitations of crisis in that it only matters for some. I use crisis to situate how black LGBTQIA communities are hidden with the HIV/AIDS epidemic in a middle ground of a not quite yet and a not fully hidden place.

My dissertation approaches the “hidden epidemic” as a crisis between the visibility and invisibility of the HIV/AIDS epidemic in black gender and sexual minority communities. Visibility is premised on variations in the ways space and time interact to illuminate the burden that black LGBTQIA communities face. I take a critical health approach that uncovers narratives that haven’t been told within scholarship. I do this through understanding the role of HIV interventions in producing the “hidden epidemic.” I start with the life of Fabian Bridges and his relationship to the HIV/AIDS epidemic as a narrative that illuminates how the “hidden epidemic” functions for black LGBTQIA communities.

1.5 Fabian Bridges

To illustrate the ways in which the “hidden epidemic” is articulated at the intersections of race, gender and sexuality, I consider the case of Fabian Calvin Bridges. Bridges’ story much like the hidden narratives of black LGBTQIA communities during the HIV/AIDS epidemic falls into obscurity. However, for moment, Bridges was an example of the risk and danger that were placed onto to HIV positive persons in the early days of the HIV/AIDS epidemic. This is similar to Linda Taylor who was dubbed the Welfare Queen by the Regan administration (Kohler-Hausmann 2007). Taylor became the representative of negative images and stereotypes that viewed black women as pariahs gaming the social welfare system. Similarly, I situate Bridges’ story as illuminative of the ways negative discourses about the HIV/AIDS epidemic were attached to low-income black LGBTQIA communities who were not afforded the same sympathy as their white counterparts.

In 1986, the PBS program Frontline hosted a panel titled *AIDS: A National Inquiry* to humanize the AIDS epidemic and to understand its social impact (Frontline 1986) With the high-profile death of Rock Hudson in the previous year, the general public gets a first-hand account of the life of someone who is living with AIDS. Bridges, a 30-year-old gay man, is profiled as a special interest story of someone living with AIDS. However, before the start of Bridges' segment, Frontline host Judy Woodruff, cautions viewers that what they are about to witness is shocking and "not the typical story of someone living with AIDS and is rare" (Frontlines 1986).

Bridges' story begins at the Jefferson Davis Hospital's AIDS ward in Houston, Texas. Bridges was openly gay and worked for the City of Houston. Like many, he was unaware he had AIDS until he became sick with AIDS-related symptoms that bedridden him for three months in the AIDS ward. Eventually, Bridges' symptoms subsided, and he left the AIDS ward. However, he lost his job. Through the efforts of the hospital, Bridges received a one-way ticket to be with his family in Indianapolis, Indiana. Upon arriving to his sister's place in Indianapolis, he wasn't permitted to stay due to his AIDS status, with his brother in law remarking that he didn't want his child to catch the disease. Homeless and without work, Bridges steals a bicycle and is incarcerated within the Marvin County jail system. He was open about his AIDS status and was placed into an isolation cell. The prosecutors drop the misdemeanor bike theft charge against Bridges; however, the judge is concern with Bridges exposing other people to the AIDS virus. Upon his release, the court system fundraises money and pays for him to live with his parents in

Cleveland, Ohio. When Bridges arrives home, his family doesn't permit him to stay with them, so he is homeless again but receives help from the Red Cross who give him a hotel room stating they don't have accommodations for people living with AIDS. It is during this period that Bridges engages in infrequent sex work to make ends meet and to have a connection with others. To this, the narrator of the Frontline episode crew states that Bridges "is no longer just a victim" (Frontline 1986). The PBS crew is faced with an ethical dilemma around whether or not to inform public health authorities of Bridges' sexual transactions. Citing the crisis of the AIDS epidemic, the PBS crew informs the Cleveland public health department of Bridges' actions. The city debates how to handle Bridges' case, while national news picks up on Bridges' transgressions as a story of an AIDS patient gone wrong (Time Magazine 1985). When asked why he continues to have sex with his status, Bridges replies, "I'm just to the point where I just don't give a damn" (Frontline 1986). Cleveland public health authorities attempt to have Bridges arrested on solicitation of sex, but Bridges, with the help of social security disability funds, leaves Cleveland back to Houston, Texas. At this point in the film, the PBS crew asks the local Cleveland gay community what they felt about Bridges to which local leader Buck Harris states that people were actively looking for him and if they found him then he would have a lynch mob ready to take him out into the street for a beating.

In Houston, Bridges is found in and out of homelessness. PBS, on the condition that he doesn't have sex with anyone, gives him money so that he can sleep in a motel and not in the bathhouses. Bridges goes to Jefferson David Houston for a checkup where he is informed that the City of Houston bans him from having sex. The city's framing was that

Bridges had an obligation not to spread the disease. Additionally, the City of Houston creates a legal framework for his incarceration, in case Bridges is found having sex. Bridges is profiled on local Houston news which pushes the city of Houston to act. In response, the City of Houston gives him the choice of entering himself into the psychiatric ward at Ben Taub Hospital or going to jail for loitering. In response local gay community activist Ray Hill intervenes to shield Bridges from increased scrutiny. Ray Hill is able to get him out of the psychiatric ward under his protection. A few weeks later, Bridges is back in the hospital where he dies from AIDS-related complications.

Bridges' story highlights a key intersection between queer of color theory and biological citizenship as he is denied access to belonging, care and kinship. Bridges faces punitive and disciplinary systems of social interaction, from state institutions, local gay communities, and his own family. The cities of Houston and Cleveland create a punitive apparatus in order to surveil and punish Bridges for the risk of a potential sexual act. Bridges is never caught in the act of sex but his ability to do so creates an anticipatory punitive logic among public health authorities who limit his freedoms, which reproduces antiblack barriers. Bridges is spurned from the local gay community as his presence would evoke violence. His exclusion from the local Cleveland LGBT community on the grounds of being sexually promiscuous and AIDS-positive creates a model subject position for the local gay community. This is a subject position that is willing to police those who are deemed to be outside of this model subject position. Additionally, the use of lynch mob language to police Bridges, highlights the racialized logics of the local Cleveland gay community as they mimic the antiblack stance of their white

contemporaries who have committed lynch mob violence in the name of white supremacy. Finally, Bridges is denied kinship with his family as his AIDS status and life as an openly gay man causes him to be homeless without connection to biological family.

These intersections inform a material and discursive reality for Bridges and shows that the awkward acceptance that white gay men had during the epidemic with their straight brothers, wasn't extended to black LGBTQIA communities. I argue that these intersections in Bridges' place-based experiences speak to the limitation of public health and health care systems to intervene positively in lives lived at the intersections of a number of different oppressions. Bridges isn't afforded the ability to seek redress from his positive AIDS diagnosis and instead faces a number of exclusions. I argue that this exclusion points to an accounting and triage logic that speaks to a punitive or carceral logic that undergirds the "hidden epidemic." The basis of inclusion is prised on the ability to articulate a number of prescribed subject positions that are tied to prefigured expectations of those who are HIV or AIDS positive. What Bridges' story demonstrates is the ways race and HIV converge to limit one's relationship to citizenship – inclusion based on rights or recognition - which is how antiblackness functions through subject formation in the post-antiretroviral era.

1.6 Dissertation Outline

To make and evidence the arguments I have outlined above, the dissertation has 6 chapters. They trace my argument on how the "hidden epidemic" is reproduced through the production HIV prevention for black LGBTQIA communities in Atlanta, GA. In

Chapter 2, I introduce my methods for undertaking a historical study as I create an archive that is able to move in and between geographic scales and public health intervention spaces. In this chapter, I read against dominant archives in order to produce a case study that is able to understand how black LGBTQ communities' factor into knowledge production and biological citizenship. Chapter 3 introduces my theatrical framework around biological citizenship, Black feminist thought, and Queer of Color critique to show how limitations in biological thinking and citizenship claims impact how black LGBTQIA communities are understood in scholarship. I argue that a focus on black accounting as a practice of understanding what isn't account for, creates a conceptual space to understand how black LGBTQIA communities engage in biological citizenship claims. Chapter 4 examines the role of HIV interventions in producing accountings strategies for black gender and sexual communities in the interventions design. In this chapter, I show that HIV intervention carry their own racialization practices that render black LGBTQIA communities to the HIV prevention spaces. Chapter 5 is my second empirical study on the role of triage in shaping health care access to HIV prevention for black LGBTQIA communities in Atlanta, Georgia. Here, I focus on the role community-based organizations in challenging the limitations of HIV prevention landscapes. Finally, Chapter 6 speaks to the futurity of health care and the HIV/AIDS epidemic for black LGBTQIA communities.

Chapter 2 Methodology

2.1 Introduction

In this chapter, I outline a methodological approach using archival and ethnographic methods to understand the ways in which the “hidden epidemic” is reproduced through HIV prevention strategies. I draw from scholarship on the archive (Stoler 2002, Lowe 2015, Derrida 1996, McKittrick 2016, Hartman 1992, 2019, Spivak 1985) to understand how narratives are central to the proliferation of antiblackness. In line with this scholarship, I use the Foucauldian concept of genealogy to trace a non-linear approach to understand how antiblackness and racism as products of the past are found in the present (Foucault 1978). I am interested in how this particular form of genealogy is central to antiblackness and racism. Understanding how genealogy carries antiblackness requires developing a diverse archive of documents to research against the grain of dominant narratives in order to disrupt their promotion of discourses and material action. My archival approach is informed through participant observations, textual readings, and semi-structured interviews with Atlanta-based organizations and public health officials. My archive centers the material collections at universities, government archives, and community-based organizations that I cohere to understand how contingencies shape the “hidden epidemic” and HIV prevention strategies in Atlanta. In addition to the archive, I employ the case study as a method. The case study builds across a number of qualitative methodologies – ethnographies, institutional studies, and qualitative analysis – and follows the directive of research questions as the driver of methods. This is in line with Susan J Elliott’s (1999) formulation that the question shall determine the method in order to delink common methodological assumptions that may hinder a researcher’s ability to

answer research questions. Elliott references health geography's turn to cultural studies and the need of scholars to abandon a strict adherence to quantitative methods. Instead, she calls for health geographers to be flexible given that research questions may need qualitative methods to answer. Given my research on the "hidden epidemic" and HIV prevention, I use a number of qualitative approaches to build my case study. Finally, I conclude this chapter with a discussion of political commitments to research and how not to produce epistemic violence as a researcher.

2.2 Archiving the "Hidden Epidemic"

My research begins with the 2015 statistic that half of all gay and bisexual black men will be HIV positive in their lifetime (Hess et al 2017). As someone who is bisexual and black, I found the statistic to be alarming, however, I was increasingly shocked to see mainstream media address the HIV/AIDS epidemic as if it was new. It seemed that black men who have sex with men (BMSM) and black transgender/gender non-conforming folks had become the bears of the "new" HIV/AIDS epidemic. The "hidden epidemic" became a common phrase to highlight the fact that black men who had sex with men had the highest rates of infection in the world. Moreover, that the "hidden epidemic" had an epicenter in the United States South. I went to Atlanta due to its emergence as the new epicenter of the HIV/AIDS epidemic and the feasibility of having departmental connections at Georgia State University. What I found in preliminary research was that Atlanta had a rich history of LGBTQ activism, in particular, a long history of response to the HIV/AIDS epidemic. During my initial fieldwork in Atlanta, it became clear that people were well aware of the HIV/AIDS epidemic. Therefore, I questioned if the

“hidden epidemic” was really hidden as the general public seemed to be aware of the realities of the epidemic. It was apparent that the “hidden epidemic” was a conceptual tool to understand the failures of response to the HIV/AIDS epidemic. The “hidden epidemic” is less about knowledge of an actually existing health problem and it has more to do with a lack of social and political response. Hence, Atlanta is an especially illuminating place to understand this dynamic. In order to excavate what was hidden as a representation of response to the HIV/AIDS epidemic in Atlanta, it was necessary to see how the past was woven into the present which, I argue, is central to why the “hidden epidemic” persists. The archive as both a set of discourses and documentation that is central to understanding the “hidden epidemic.”

My research views the archive as a material representation of the ways in which history is documented and produced. As Foucault argued, the archive is less about the facts that are recorded and instead is suggestive of systems that govern how knowledge is made (Foucault 1970). Ann Stoler (2002) remarks that the archive “registers a rethinking of the materiality and imaginary of collections and what kinds of truth-claims lie in documentation” (94). What comprises the collection and truth claims made from it depends on those who hold power over the making of the archive. The archive, as a collection of artifacts, provides insights into how legacies of colonial and antiblack violence find their footing in the present. Lisa Lowe (2015) notes that “the archive that mediates the imperatives of the state subsumes colonial violence within a narrative of modern reason and processes” (2). In Atlanta, the archive built from HIV/AIDS statistics, HIV prevention media, local news stories and state driven reports center on

high rates of infection in black MSM communities and the lack of reprieve from the impact of the virus. Therefore, the task at hand is not to disassemble, but rather to read against the archive. Lowe (2015) points to this practice as “devising other ways of reading so that we might understand the processes through which the forgetting of violent encounter is naturalized, both by the archive, and in the subsequent narrative histories” (2-3).

Hartman (1997) provides insights on how to read against the archive. She calls for “brushing history against the grain” which “requires excavations at the margins of monumental history in order that the ruins of the dismembered past be retrieved, turning to forms of knowledge and practice not generally considered legitimate objects of historical inquiry or appropriate or adequate sources for history making and attending to the cultivated silence, exclusions, relations of violence and domination that engender the official accounts” (11). Reading against the archive shows how another archive can be constructed from the lives of those at the margins of space and how subjectivities are developed through these counter archives. Objects of historical inquiry are the documents placed into archives that cohere antiblack and colonial practices. Reading against accounting in the form of statistics, reports, memos, and newsletters about the HIV/AIDS epidemic requires another set of materials that speak back to the dominant archives. With regard to my project and focus on Atlanta, HIV prevention, and black LGBTQIA communities, the task is to show how there is another set of archives that are produced alongside the normative accountings of the HIV/AIDS epidemic which reside in the “hidden epidemic”. Through reading the archive from the experiences of people living at

risk of HIV, we are able to create a different archive that speaks to another historiography of the HIV/AIDS, in particular, the ways in which it relates to the city of Atlanta and black LGBTQIA communities in the United States Southeast.

I use the concept of the “hidden epidemic” to build a counter archive that is premised on an alternative narrative. My research takes the Foucauldian concept of genealogy to understand how the past is central to understanding how historically legacies of antiblackness are found in the present (Foucault 1970). Foucault, in his search for history of the present, offers genealogy as a way to develop a method to understand “descents and emergences” that produce a set of conditions where history isn’t thought of as a linear trajectory but is instead fragments (Foucault 1991). Foucault writes that “the search for descent is not the erecting of foundations: on contrary, it disturbs what was previously thought immobile; its fragments what thought unified; its shows the heterogeneity of what was imagined consistent with itself” (Foucault 1991 82). Genealogy is not a search for origins but a mining of contingencies (Garland 2014). Lisa Lowe (2015) elaborates that “by genealogy, I mean that my analysis does to accept given categories and concepts as fixed or constant, but rather takes as its work the inquiry into how those categories became established as a given and with what effects” (3). Similarly, Michelle Wright (2015) provides an application of genealogy through her writing on blackness as a formation that is outside of linear space and time. She calls for blackness to be a “when and where” rather than something that builds from black people in linear succession overtime. This is due to black people having multiple competing notions of selfhood that make it difficult to pin down a coherent body. My use of genealogy is to show how the

“hidden” nature of the epidemic is to erase from history black LGBTQIA response to the HIV/AIDS epidemic. My analysis takes dominant narratives of the HIV/AIDS epidemic in particular how white gay men become the primary bears and shows how this conceals how black LGBTQIA communities are central to this process. To understand how these continue to persist requires tracing a number of disparate locations with no single point of origin or convergence. My use of the archive helps develop an alternative history to black people and their relationship to health. The Black Health Tradition is important to developing a counter archival method to understand black LGBTQIA communities’ role in the epidemic.

The Black Health Tradition is a critical historiography that demonstrates the ways in which perceptions of health are mediated through black people (Roberts 2011, Washington 2008, Skloot 2010, McBride 1992, Nelson 2011, Geary 2014). This tradition traces the centrality of black people to the development of modern health and highlights how to read against dominant archives by looking for absences within larger historical narratives. For example, it was black people in urban environments that provided the material resources for the emergence of teaching hospitals and medical schools. It was from public hospitals providing services to low income racialized communities that experimental tests with little to no consent was performed, which allowed for larger health advancements. It was from here that Henrietta Lacks, a black domestic worker from Baltimore, had her bodily material used to advance cancer treatments at John Hopkins (Skloot 2010). Without her consent, the cells were taken from her that provided the foundation for cancer research globally. The dominant archives that center our

understanding of cancer research assumes that black populations are a non-factor in their production. Yet, the Black Health Tradition shows that Lacks' bodily material is central to it. Developing a counter archive through the experiences of black people uncovers how black people are central to health. Through the lens of the Black Health Tradition, the "hidden epidemic" is part of a long trajectory of racialization practices impacting black communities' relationship to HIV/AIDS epidemic. In order to illustrate this, I employ methods that unravels the archive and "hidden epidemic" in the HIV/AIDS epidemic and HIV prevention.

2.3 Reading Across the Archive: The Role of Case Studies

My research on HIV prevention and the "hidden epidemic" uses the case study as a method. My use of the case study makes explicit the number of different methods that my research employs to answer my research questions. The case study emerges as a necessary research methodology and allows the researcher to adapt to changes within fieldwork (Becker 1970). The case study allows for the application of the researcher's subjective judgements to the data collected. What informs my case study are institutional documents of HIV interventions, interviews with community-based organizations and the Centers for Disease Control, and participant observation. My research applies the case study method to understand how to assemble and read across archives that I develop to understand the "hidden epidemic".

2.3.1 Archival Research

I conducted archival research in Atlanta on the HIV/AIDS epidemic and HIV prevention strategies in the city. The material collected consisted of Centers for Disease Control reports, memos, funding allocations, local HIV prevalence data, and other documents that addressed black LGBTQIA communities and the epidemic. I collected secondary data from the State of GA reports and promotion materials. This data consists of internal memos, reports, programming materials, as well as city government conversations and considerations on the epidemic. Additionally, I collected material from local organizations on program outcomes, program materials, outreach records, and other grantee requirements that allowed community-based organizations to be on the forefront of response to the HIV/AIDS epidemic. I compiled an archive of Atlanta-based responses to the HIV/AIDS epidemic from 1990 to our current time on community-based organizations, government response, and community members. The final location of archival documentation comes from community members who have formal and informal archives in order to document their response and relationship to the HIV/AIDS epidemic. Archives within this group showed how community members responded to the HIV/AIDS epidemic as residents living in the United States Southeast. With this archive, I was able to collect data on three Atlanta based community organizations at the forefront of response to the epidemic. As part of this work, I attended meetings where organizations were laying the framework to develop a history of their response to the epidemic through oral histories and other memory placemaking practices. Together, federal, state, university and local communities archives amount to an assemblage of a diverse collection of data and demonstrates the vast transfer of HIV/AIDS related

knowledges to different scales of HIV prevention and how these scales speak back to the larger production of the “hidden epidemic.”

To analyze these assembled archives, I compiled over 800 data entries that I coded using NVivo thematically. Themes included: HIV Prevention, Atlanta based black LGBTQIA communities, the City of Atlanta and HIV, and racialized response to the epidemic. With the data collected, I performed a textual analysis to understand how the theme codes work with one another to produce a history of response to the HIV/AIDS epidemic. The textual analysis provided the foundation for the discourse analysis, which uses social theory to show how documents carry discourses about black LGBTQIA communities. The ways in which these communities are written about and how they form the basis of understanding around the epidemic is the focus of the analysis.

2.3.2 Participant Observation

I conducted participant observations for 12 months over 2 years in Atlanta, GA. My participant observation involved documented and undocumented accountings of social processes around HIV prevention. I make the distinction between documented and undocumented to mark a line between observations that I considered as part of my research and other more casual engagements that allowed me to build the relationships necessary for future research. Given the historical nature of my research, I used documented and undocumented participant observations to understand how to collect and read the archive I was developing for research. I attended City council meetings, community-based organizations meetings, meetings with executive directors of

organizations, and CDC sponsored outreach activities throughout the City of Atlanta. As part of my participant observation, I took part in the local black LGBTQIA scene, in particular black queer culture and social production. Participating in these events allowed me to understand how black queer life came together in Atlanta, while also building relationships with individuals who work in HIV/AIDS advocacy. It also allowed me to observe the transformation of space from a mainstream bar/club/warehouse during the day to a space of black queer cultural engagement that was necessary for black queer communities to come together. This spoke to the lack of dedicated black queer space but also highlighted the efforts of individuals to transform space into their own image and need. These spaces allowed me to see the ways in which the HIV/AIDS epidemic was navigated through a space of empowerment at the intersections of being black and queer.

In addition to black queer space transformations, there was the spaces of black led community-based organizations that provide HIV interventions and other HIV-related care to the local community. In these spaces, I was not allowed to make audio recordings, but I did compile exhaustive fieldnotes about my experiences. I would be given a tour and introduction to the organization's programs and/or campaigns. It was within these spaces where I witnessed the clinical mandate of HIV prevention taking on many different forms as organizations sought to meet the need of HIV prevention funding. The clinical mandate took the form of testing as organizations met the testing needs of funders. Organizations had a dedicated space for HIV prevention interventions which would be a communal space for people in need to have access to health care resources and relax. These spaces of relaxation function as an unofficial site of harm reduction

where people could have a reprieve from whatever they were facing in the world. This could mean people getting air conditioning for a few hours, black queer teens having a place to go after school or providing outpatient testing services for free.

The transformation of mainstream spaces to spaces of intervention, or expanding space to do harm reduction, are examples of queer worldmaking. While I explore queer worldmaking in chapter 5 in more detail, I want to highlight the way in which these spaces created alternative forms of community connection. Space making can serve the purpose of survival, meeting the needs of participants, or it can be a place to model alternative forms of practice, or it can be both. It is within these spaces where the local black LGBTQIA community engaged the HIV/AIDS epidemic. This is where HIV/AIDS organizations and the black LGBTQIA community come together and build community.

2.3.3 Semi Structured Interviews

I conducted 10 semi-structured interviews with members of community-based organizations, black LGBTQIA community members, public health officials and residents who have been impacted by the HIV/AIDS epidemic in Atlanta. Overall, I conducted 10 interviews in Atlanta. The low number of interviews reflects the challenges I faced establishing trusting relationships with community members. The interviews I was able to conduct were from organizations who were accustomed to working with researchers. I also found it difficult to talk with community-based organizations that had urgent demands that were outside of the scope of my research. My research often raised questions beyond the scope of the experience of participants, most of whom were not

involved in, or especially familiar with the way in which public health responses were crafted and therefore there was not a lot of insight to be gained from interviews.

For the interviews I did conduct, my questions were often casual and conversational, aimed at establishing connections with community members and organizations for continued research and to provide people the opportunity to speak to their experiences. I asked questions that encouraged participants to situate themselves within the relationships they have to organizations and to HIV/AIDS advocacy. I thematically coded the interviews focusing on race, gender and sexuality along with advocacy to the epidemic, which allowed me to situate their experiences within the “hidden epidemic”.

2.4 Standpoint and Research commitments

I take seriously my research commitments as I work on issues that involve the black LGBTQIA community in Atlanta, GA. I came to this study wanting to understand how the legacies of slavery and heteropatriarchy found its way into the lives of people I care about. As I became more versed in slavery’s afterlife and its connection with sexuality, I found a gap within Geography literature that dealt with these connections as they relate to health outcomes. To address this gap, I engage black feminist studies and black queer studies with geographical literature in order to deepen scholarship around race, gender and sexuality. In 2017, Atlanta emerged as a new epicenter of the HIV/AIDS epidemic and like many researchers and journalists, I went to Atlanta to see if there was a story to be told. Although I am a part of the black queer community and I am from the South, I didn’t want to be a parachute researcher who dropped into a local context to study

something and then just leave (Harris 2018). I wanted to do some form of “engaged scholarship” – participatory action research, community engaged research - where my research questions would align with problems that people were facing. Engaged scholarship tends to be ethnographic utilizing participant observation, textual readings of documents, semi-structured interviews, and community engagement in order to arrive at a set of questions. However, during preliminary research trips, I came to the conclusion that my ability to conduct such research was limited. Without research funds to conduct fulltime research that would allow for an extended stay in Atlanta, I wasn’t able to build the necessary connections for a deeper engagement with the Atlanta HIV/AIDS community. To address this, I turned to a historical focus with regard to the data I collected, and I relied on building friendships and connections with groups that I would eventually do work with, in the future. This approach allowed me to make connections with the Center for Disease and Control and community-based organizations who have had a long history addressing the epidemic in Atlanta.

The “hidden epidemic” is a research standpoint to make clear that the object of analysis isn’t black LGBTQIA communities but an abstraction that allows us to understand the legacies of slavery and heteropatriarchy in society. Additionally, the “hidden epidemic” provides a method to engage in what José Esteban Muñoz (2000) calls “identity in difference” which “understands the structuring role of difference as the underlying concept in a group’s mapping of collective identity” (67). Identity in difference speaks to a point of affiliation I have with my research and myself as a black queer person. My struggles aren’t the same, but I share a common bond with other black queers. Being a

black queer from the South afford me an opportunity to speak with communities about common struggles that made access to health care difficult. Yet, the question of “who speaks for whom?” is different given my own experiences. Instead, the question becomes “who is allowed to speak?” (Kobayashi 1994) As a graduate student researcher, I have a certain amount of societal privilege which amounts to a power relationship. In order to address this, I engage a situated solidarity with black queers in the South (Nagar 2014). As a situated solidarity, one’s inclusion to an identity group, needs to be structured to make power dynamics transparent. Central to this is that my group inclusion is fluid rather than fixed and that my position engages a number of power position that if not addressed can cross over into an unequal power exchange.

The “hidden epidemic” makes clear my research commitments as I uncover narratives that place black people at the center of the HIV/AIDS epidemic. As such, my research design is about creating transparency between my political commitments, community group identity, and academic research. I do this through being mindful of the power and positionality I have with regard to the data I collect and the stories I tell from the data. Part of this work is refusing to share certain narratives. Audra Simpson (2014) calls this “ethnographic refusal” where participants refusal to share certain elements of this experiences. which speaks to a refusal to engage in research and its representation in the normative subject positions prescribed by the nation and state. Ethnographic refusal limits narratives that produce epistemic violence by refusing certain information. As such, my work engages refusal in the stories told about black LGBTQIA communities and their relationship to the HIV/AIDS epidemic.

Table 2.1 Summary of Research Activities

Method	Item	Number	Hours
Semi-Structured Interviews	Members of community-based organizations, local LGBTQIA community, Centers for Disease Control Staff	10	10
Participant Observation	Community Events	15	45+
	Community based Organizations	6	12
	CDC Outreach events	5	10
	State/County/City Meetings	2	6
Archival Research	Emory University	600+	120
	Georgia State University	250+	80
	Kennesaw State University	5	20
	National Archives	8	40
	The Atlanta Center	15	40

Chapter 3

Literature Review

3.1 Introduction

In order to develop a theoretical approach to the “hidden epidemic,” I bring together scholarship on knowledge production, race, gender and sexuality. I take the “hidden epidemic” as my starting point in order to situate the ways in which its production is normalized at the intersections of race and sexuality. Theorizing the “hidden epidemic” demonstrates how individuals and groups of people are included or excluded as HIV/AIDS subjects. To understand how black LGBTQIA communities are included and excluded, I focus on the theoretical concept of biological citizenship. Biological citizenship addresses how groups impacted through biological harms emerge as a political body for rights and recognition. For example, biological citizenship was central to People Living With HIV/AIDS (PLWHA) activism and advocacy for an adequate response to the AIDS crisis.

The second part of this chapter will provide a critical engagement with the “hidden epidemic” through the lens of Black Feminist Thought and Queer of Color Critique. First, I focus my reading of Black Feminist Thought and Queer of Color Critique with theories on subject formation for minoritized people. Black Feminist Thought has been central to understanding how black women’s lived experiences, which have been relegated to the margins or backgrounds of spaces, are standpoints to understand large structural forces like capitalism, antiblackness, or patriarchy. Additionally, Queer of Color Critique’s focus on counter publics and worldmaking shows the limitations of citizenship claims and how marginalized people make meaning under systems of oppression. Second, I

place critical health scholarship in conversation with Queer of Color Critique to situate *health* as a key foundation to Queer of Color Critique and Queer Studies. I do this through a consideration of how subjects are made through notions of health and how health is a site of transgression against normative depictions of race, gender and sexuality. Central to this is showing how health is produced through race as it is expressed through sexuality. Finally, I show the ways in which a focus on the “hidden epidemic” and antiblackness can inform a critical health geography approach.

3.2 The “Hidden Epidemic”: A Theoretical Engagement

The concept of the “hidden epidemic” speaks to a lack of recognition and response to individual and population health concerns (Eng and Bulter 1997; DeLancey 2005; Kalia 2002). Scholarship using the “hidden epidemic” as an analytical concept point to undervalued health considerations. For example, Steinberg and Schnall (2000) highlight how there is a “hidden epidemic” of psychological disassociation where larger numbers of people “check out” in order to navigate spaces. Similarly, Parish et al (2003) points to a “hidden epidemic” in the prevalence of chlamydia among sexually active people in China. While much of the literature using the frame of the “hidden epidemic” speaks to unaddressed health concerns, the concept “hidden epidemic” itself has not been robustly theorized. Although the “hidden epidemic” doesn’t have a theoretical body of scholarship, social theorists have addressed the hidden nature of social phenomena in describing systems of power and how social phenomena comes into knowledge systems (Hartman 2019; McKittrick 2006; Sedgwick 1990; Lorde 1984). This scholarship has focused on the hidden nature of social phenomena with respect to the distribution of

power (Foucault 1975; Povinelli 2011) or unknown evidence (Hartman 2008; Hong 2008; McKittrick and Woods 2006), which creates an approach that outlines a theoretical engagement with the “hidden epidemic.” In order to develop a more robust understanding of the “hidden epidemic,” I turn to scholarship that addresses the hidden or unknown as an object of knowledge.

My approach to the unknown takes the “hidden epidemic” as a set of events and a lack of documentation that limit black LGBTQIA communities’ relationship to biological citizenship claims. Scholarship on the unknown or the hidden point to the role of smaller or less discernable occurrences that shape the emergence of an event. An event can be described as a process where things that people can say happened and that have an objective quality (Povinelli 2011). Yet, the hidden or unknown are processes that are mundane and never make it to the status of an event. Scholars have pointed to the black box of hidden knowledge production (Latour 1987; Macintyre Ellaway and Cummins 2002), creation of classification schemes (Hacking 1986; Foucault 1970), or anticipatory logics premised on unknown risk (Anderson 2010; Aradau and van Munster 2012), as examples of processes that identify the unknown or hidden as having a quality that is, in fact, central to the emergence of events in systems of power. Elizabeth Povinelli (2011), for example, describes events as “things that we can say happened such that they have a certain object being, then a quasi-events never quite achieve the status of having occurred or taken place” (13). Quasi-events never “rise to the status of an event” but they are key to how power is normalized as an event (Coleman and Stuesse 2016). As such, quasi-events routinize the way in which people experience processes like disavowal and

abjection in everyday life that “do not rise to the level of an explicit crisis” (Povinelli, Colman and Yusoff 2017). The term “quasi event” gives language to the way in which power is routine and normalized into everyday life. And yet, quasi-events can become “events” in and of themselves.

Scholarship on the role of technologies in knowledge production provides insights to into processes and factors that cohere the hidden or unknown into particular use (Latour 1987; Hacking 1990). This research has been central to social science studies of science scholarship which shows how seemingly routine social practices are technologies that take an unknown quality and give it a formation. This scholarship focuses on everyday technologies such as statistics (Woodward 2009), accounting (Poovey 1998) and other enumeration techniques to show how processes of rationalization render legible that which would otherwise be unknown. Scholars have focused on the ways in which these techniques shape how individuals and populations are governed (Leszczynski 2016), providing key insights into how the unknown materializes into that which becomes described or calculated as “risk.” Scholarship on the concept of “risk” highlights the ways in which individuals and institutions respond to potential threats that are environmental or man-made. These responses can entail a reflexivity amongst social bodies (Giddens and Beck 1994), anticipatory logics (Anderson 2010), or the emergence of a new security apparatus (Braun 2007).

Black Feminist scholarship takes a different approach to addressing the unknown. Concerned with the way in which black people live in the face of antiblack violence,

Black Feminists are concerned with understanding how subjected black people make meaning in spaces of antiblackness, even as these practices are hidden. Working with the unknown, scholars pry apart black subjectivity formations despite antiblack violence. This scholarship has brought a focus on the hidden aspects of black life through the concepts; intramural (Spillers 2003; Snorton 2017; Iton 2008), fugitivity (Moten 2008), fungibility (King 2017; Hartman 1996), or the demonic (McKittrick 2006; Wynter 1990) to show how there is a hidden quality to black life that demonstrates how antiblack violence is, in part, a response to black people's expressions of freedom. The hidden quality builds from an understanding that there is a distinction between the body and flesh for black people. It is through the flesh – often viewed through phenotype – where discourses and narratives cohere to create the body that is amendable to antiblack violence. The actions on the flesh produce the body, however, the body is also imprinted with other relationships given that there are a number of different forces that act on the flesh. As such, the body holds a number of subject positions. Moten (2003) highlights this through the declaration that “blackness is the testament to the fact that objects can and do resist” (1). Therefore, through blackness, black people take on a hidden quality at the intersections of anti-black violence and other subject positions including their own subjectivities. If antiblackness forms a totalizing knowledge of black people, then the unknown provides a conceptual strategy to understand how black people occupy different subject positions and subjectivities that challenge antiblack systems of knowledge production (Hong 2008).

Furthering the development of the unknown, as a strategy to limit the totalizing weight of antiblack violence, has been archival research uncovering black history. Archives like the Lesbian Her Story Archive, Mobile Homecoming, or Sweet Tea Oral Histories provide an excavation of black life under oppressive conditions. Through this empirical work tracing an alternative history, the limitations of knowledge within systems of antiblackness come forth. The unknown with regard to racial and ethnic minority communities starts to emerge as scholars and activists bring together stories that share hidden narratives of black life, which show how black life persist under antiblack violence. This has encouraged a new generation of scholarship with attention paid to the epistemic positions that black people engage under systems of antiblack violence.

Additionally, there is an emerging body of scholarship aimed at uncovering black LGBTQIA communities relationship to the HIV/AIDS epidemic today through black queer cultural expressions, histories of HIV/AIDS harm reduction strategies and community formations under conditions of ill health and poverty (Johnson 2016; Bailey et al 2019; Cheng, Juhasz, and Shahani 2020). The resurgence of scholarship on the HIV/AIDS epidemics calls for an approach to understand how the unknown – as represent through the “hidden epidemic” – is produced through the intersections of race and sexuality. Bailey (2013) has been at the forefront of this research through his work on black queer cultural expression, in particular black sexual practices, which has been central to understanding how the HIV/AIDS epidemic is not being addressed from the standpoint of black LGBTQIA communities. By focusing on race and sexuality, we can see how racial difference is produced through articulations of sexuality.

In order to understand the ways in which race and sexuality intersect and reproduce the “hidden epidemic,” I focus on biological citizenship and how Black Feminist Thought and Queer of Color Critique bear on the body of scholarship. If biological citizenship speaks to how marginalized groups come together to seek rights and resources under health crises, then Black Feminist Thought and Queer of Color Critique demonstrates how biological citizenship is limited for black LGBTQIA communities. Biological citizenship provides an avenue to understand how the HIV/AIDS epidemic, biological harms and citizenship claims converge to make a health crisis legible for some groups at the expense of black LGBTQIA communities. Consequently, what is assumed to be the easy registers of subject embodiment for white gender and sexual minorities, who are HIV positive or at-risk, falls flat for black LGBTQIA communities. On one hand, the “hidden epidemic” describes a renewed focus on the HIV/AIDS epidemic and its impact on black LGBTQIA communities. On the other hand, the “hidden epidemic” speaks to what is hidden is a normative part of everyday life. This illuminates how biological citizenship is naturalized through the “hidden epidemic” as it is assumed to incorporate everyone who is at risk. To develop this, I turn to biological citizenship as a body of literature that expresses the limitations of rights and recognition for black LGBTQIA communities.

3.3 Biological Citizenship

Roderick Ferguson in *Aberrations in Black* (2002) notes that “epistemology is an economy of information privileged and information excluded, and that subject formation

arise out of this economy” (ix). Knowledge production underpins the “hidden epidemic” as knowledge produced about certain groups functions to include and exclude who has access to HIV/AIDS resources. In this section, I consider the ways in which communities at-risk of HIV infection emerge to gain rights and recognition from states, public health departments and other governing bodies. I argue that biological citizenship structures the way that black LGBTQIA communities are engaged and the ways HIV/AIDS resources are distributed.

Adriana Petryna (2002) develops biomedical citizenship as a concept to describe the ways in which previously marginalized or underrecognized groups of people emerge worthy of recognition due to human and non-human risk that have been placed onto them. Exposure to environmental or man-made risks becomes the basis of subject formation for groups of people who were previously excluded but due to their advocacy emerge as a body deserving of recognition. Petryna (2002) describes biological citizenship “as a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it” (6). Therefore, biological citizenship considers how the injured body becomes the basis for understanding citizenship claims. For example, the Black Panther’s sickle cell-anemia testing program functioned to illuminate the black communities’ risk to sickle cell while also advocating for an expansion of health care resources for low income black communities (Nelson 2011). The failure of governments to protect marginalized people create opportunities for new political formations, as people previously excluded, come together to advocate for themselves. Additionally,

Rose and Novas (2003) demonstrates the ways biological citizenship “encompasses all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species” (2). Citizenship projects are how groups of people come together to seek rights and recognition as a body deserving of a government’s protection. Therefore, biological citizenship highlights a transformation of social bonds formally based in blood or phenotype to new group formations based in molecular understandings of the human body. The two approaches to biological citizenship – biological harms or biological advancement – consider how biology is wielded to citizenship projects.

What constitutes the “biological” in biological citizenship relies on advances in biomedical science as bodies are increasingly understood at scales below and beyond the surface of the body. Clarke et al (2003) points to “biomedicalization as a shift from enhanced control over external nature to the harnessing and transformation of internal nature (i.e., biological processes of human and nonhuman life forms), often transforming ‘life itself’” (164). Through biomedicalization, individuals move away from group connections based in surface level considerations – race and gender – and instead consider belonging based on molecular considerations found within genes, cell counts or DNA. The focus on the biological, has led to new group formations through biomedical capital accumulation strategies (Rajan 2011), risk and surveillance (Krupar and Ehlers 2017), the transformation of bodies and identifies (Rainbow 2007), and knowledge production (Clarke et al 2003). Hence, a new set of criteria emerges where people come

together to make citizenship claims for rights based on; biological risks (Petryna 2002 2004), biovalue (Waldby 2002), biosociality (Gibbon and Novas 2007), or life itself (Rose 2007; Rose and Novas 2005). Therefore, Scholarship on biological citizenship has been diverse as scholars have sought to understand the current and future implications of individuals and populations who seek recognition as a political, economic and social group through biological innovations.

Rose and Novas (2005) examine of the ways in which changes in biology constitute new understandings of social formations which births a new set of political considerations. Rose (2007) extends Foucault's (1976;1978) concept of biopolitics as a system that promotes life affirming strategies for populations to consider how biological understandings of cells and genes have become the basis of promoting life. Previous biopolitical interventions took place through surface level understandings of race, gender, citizenship, ability or sexuality which formed the basis of inclusion. However, with changes in how humans come to understand themselves at the genetic and cellular level, new ways to intervene, preserve life and understand populations take place at the molecular level. Rose and Novas (2005) contend that old forms of biological difference are not left alone but that new biological understanding are harnessed alongside older forms. Therefore, with technological advances that further group connection at the cellular level, new forms of group formation with different moral justifications emerge as people seek rights and recognition. However, Rose and Novas' (2005) reliance on biological innovation and its role in flattening previous forms of racial and gender

difference misrepresents how group formations takes place for people that are already marginalized in society.

The role of difference in shaping the ways in which people come together to advocate for biological citizenship claims is missing from Rose and Novas' (2005) elaboration on the subject (Fassin 2009; Kearns and Reid Henry 2009). Rose (2007) situates biological citizenship to be an outgrowth of older subjectification practices that are then cast aside as new group formations emerge through relationships to biological harms or biological innovations. Rose (2007) maintains, "I use the term biological citizenship descriptively, to encompass all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individual, as men and women, as families and linages, as communities, as populations and races, and as a species" (132). Yet, my reading of the above quote reveals a lack of clarity within Rose's thinking on the way social difference is altered through changes in what constitutes new group formation through biological innovation. Therefore, what is not accounted for are the ways in which existing systems of social valuation through the intersections of race, gender and sexuality mediate people's relationships to new citizenship group formations. Furthermore, I conceive that what is considered to be biological depends on how society values life. A consideration of life brings racialization and racism to biological citizenship as these structures exist to devalue certain forms of life in order to promote the existence of others. Therefore, biological citizenship must consider how understandings of life is understood in order to see the ways in which groups are able to form for rights and recognition.

Didier Fassin (2009) considers biological citizenship as a transformation of biopower to bio legitimacy as difference accompanies experiences of people engaged in biological citizenship rights and recognition movements. Fassin departs from the material expression of biopower as a structure of life and death and instead circles back to the “meaning and value” that a consideration of life and death gives. The stakes in considering meaning and value in relation to biopower’s focus on individual and population disciplinary strategies, that take death as its ultimate expression, demonstrates how biological citizenship needs to be seen through valuations between life *and* death, not solely death. Fassin writes, “if politics is about issues and not just games, life is such an issue, maybe the most crucial one; and if we take seriously the proposed shift, it is clear that bio legitimacy and bio-inequality tell us much about the meaning and value we attach to life as such and to lives concretely” (49). With Fassin, biological citizenship considers valuations of life through racism and heteronormativity which pin racialized groups of people to hierarchies of difference, rather than a biological citizenship where people emerge from spaces of non-representation into political light due to biological harms. Similarly, Health Geographers (Kearns and Reid Henry 2009) agree with Fassin’s formulation and criticize Rose’s egalitarian view of biological citizenship which, in their estimate, discounts the role that the state and capital are the primary drivers of developing biological technologies. Instead, they call for a focus away from the individualizing tendencies within Rose’s work and point to a consideration of the lives that people live as they engage with new biological understandings of group formation developed through governance and capital accumulation strategies.

Biological citizenship as it is currently constructed continues to allude the subject positions of racialized black LGBTQIA communities. With scrutiny placed on biological considerations of biological citizenship it is important to analyze the other half, citizenship. A focus on citizenship demonstrates how race is articulated through sexuality and how this connection informs group formations for citizenship claims.

3.4 Biological Citizenship, Black Feminist Thought and Queer of Color Critique

This section explores the ways in which citizenship is limited for black LGBTQIA communities. Biological Citizenship is understood as a set of inclusion practices that is premised on stable subject positions that emerge due to biological innovation or biological harms. Taking race through its association with gender and sexuality highlights how biological citizenship is limited for black LGBTQIA communities as the criteria for inclusion is limited. Therefore, the “hidden epidemic” in relationship to biological citizenship can be conceptualized as a symbolic barrier that limits the claims black LGBTQIA communities can make towards rights or redress.

3.4.1 Black Feminist Thought and Citizenship

I argue that citizenship is a politics of emergence. Traditional forms of citizenship projects promote citizens as bearers of natural rights that are protected through birth. As long as one meets the criteria for inclusion, they have an inherent right “to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in society” (Marshall 1950). However, the equal extension of rights,

as it relates to state inclusion and protections, is limited for race, gender and sexual minorities. For race, gender and sexual minorities, rights and protections vary along the lines of social difference. Although birthright extend citizenship to race, gender and sexual minorities, the deployment of rights and recognitions were unequal. Therefore, groups in addition to birthrights must emerge through struggle for the equal claims to rights and recognition. With regards to biological citizenship, citizenship claims are brought forth via connections to biological harms or biological innovation which creates new grounds of social membership. Central to biological and minoritarian citizenship claims are groups making themselves legible to governments that extend rights and recognition. Therefore, Foucault's use of governmentality shows the ways groups seeking rights and recognition must make themselves legible to power.

Governmentality describes the relationship between state power and non-state actor's ability to govern themselves. Iton (2008) referencing governmentality states that "Foucault asked us to conceive of a set of relationships, discourses, and projects that might bind together state and nonstate actors, the political narrowly defined and the person, in the interpellation of subjects and the organization and management of the people" (132). Through governmentality, there is an emergence of a set of relationships where individuals and populations govern themselves. Foucault (1991) pins this transition, in part, on the development of the natural sciences and the ways in which humans became an object of study that could be disciplined. Central to this are humans understanding themselves to be biologically governable which creates a scientific justification for human differentiation. Therefore, citizenship claims under biological

citizenship take the emergence of new scientific understandings of the human body as the basis to understand belonging, which is coproduced alongside already existing, yet to be realized, social relationships based in difference. Similarly, Roberts (2011) contends that “human beings are not divided into races in the biological sense of the term. But that we are divided into races in the political sense” (5). Therefore, the emergence of new citizenship forms based in biological harms or innovations, must consider already existing social and political relationships that make access to rights and recognition difficult, especially for groups of people impacted by intersectional forms of race, gender and sexual difference.

Black Feminist scholarship highlights limitations of citizenship for black communities given the historical legacy of slavery which creates an instability in how black communities are able to seek rights and recognition (Hartman 1997; Collins 2000; Alexander 2006; Sharpe 2016; King 2019). The historical legacy of slavery articulates black people’s relationship to citizenship as limited given that enslaved people did not have ownership over themselves. Citizenship is fluid in terms of who is given legal status and also how people are perceived to come together as a group seeking and recognition. Central to individual’s coming together to advocate for rights is the ability to have individual autonomy over one’s self. The subjection of enslaved black people afforded to their owner’s citizenship rights as they were property of someone else. Consequently, as formerly enslaved people were emancipated, the citizenship rights extended were increasingly articulated through one’s ability to have property, in particular, the exercise of one’s ownership of property. For newly freed black people, this meant having property

over themselves as wage laborers or in patriarchal marriages which were premised on individual autonomy in decisions. However, access to individual autonomy, as a measure of one's access to ownership over themselves, becomes the site from which black people are denied access to themselves as legacies of slavery, in the form of antiblackness, continually limit individual expression of autonomy. Hartman (1997) notes that "the individual, denuded in the harsh light of scrutiny, reveals a subject tethered by various orders of constraints and obscured by the figure of the self-possessed, for lurking behind the disembodied and self-possessed individual is the fleshy substance of the embodied and the encumbered – that is, the castigated particularity of the universal" (123). Therefore, individualism, as one's ability to have property over oneself as the basis of citizenship rights and recognition, is constantly disrupted for black communities.

The ways in which black communities come together to advocate for citizenship rights and recognition is vexed through antiblack technologies that limit individual autonomy and expression. Patricia Hill Collins (1980) highlights how controlling images in discourses about black women limit their ability to articulate ownership over themselves. Others demonstrate the way black women are materially hidden from view as a way to enact unequal social reproductive practices. As such, the invisibility of black women is crucial for maintaining social inequalities. Additionally, Alexander (2005) highlights how the demands of citizenship require a "sacrifice of consent" where in exchange for rights and recognition, those included must also take part in extending imperial logics of the state. Similar to Foucault's (1994) understanding on how governmentality manages populations, Alexander's view of citizenship as an exchange between populations and

state's imperialism that centers a value system that black communities are placed out of, given that they are often the objects of state aggression. As people who have limited capacity to exercise individualism in the form of ownership of themselves, consent isn't afford given that black people don't have the ability to consent. Therefore, without the ability to consent in exchange for rights and recognition, black communities seeking redress are limited. With regard to biological citizenship, the ability for new group formations to emerge through new understandings of biological citizenship must consider the ways in which legacies of race and gender intersect with them.

3.4.2 *Queer of Color Critique*

Queer of color critique allows us to see the ways in which notions of citizenship intertwine with antiblackness at the intersections of race *and* sexuality. José Estaban Muñoz (1999) and Roderick Ferguson (2004) establish queer of color critique from the political projects of Black Feminist Thought and Third World Women of Color Feminism. Queer of color critique demonstrates how “racist practices articulates itself generally as gender and sexual regulation, and that gender and sexual differences variate racial formations. This articulation, moreover, accounts for the social formations that compose liberal capitalism” (Ferguson 2004 3). Therefore, the relationship between race and sexuality provide a window to understand the way in which citizenship is limited for black LGBTQIA communities. For example, HIV/AIDS criminalization laws that regulate the type of sexual acts one can commit have unequally policed black queer people. Through the regulation of sexual acts, which are enacted on black queer communities, what emerges are a set of preferred sexual acts that carry little or no stigma.

Lamble (2013) highlights that sexual citizenship as a “reconfiguration of sexual politics, where citizenship norms and practices are increasingly infused with a chillingly and death logic” (2). Sexual citizenship are state granted rights and protections that are extended to sexual minorities through a particular set of demands. Demands around sexual expression, adoption, and protections from violence create expectations that sexual minorities must occupy in order to receive rights and recognition. However, black queer cultural and social expressions are outside of this narrow view of citizenship.

Importantly, social and political cost of inclusion for queer communities are investments in US imperialism or incarceration. Therefore, through queer investments in punishment, citizenship rights take place for some LGBTQIA members at the expense of others. Thus, black sexuality and its criminalization allows us to speak to homonormativity, which substantiates an ideal subject formation to be afforded rights and recognition (Puar 2007; Duggan 2012). Citizenship is premised on homonormative assumptions that are continually denied to black LGBTQIA communities.

Additionally, queer of color critique’s focus on the nation-state shows the way in which rights-based guarantees, which form the basis of citizenship claims, are limited for black LGBTQIA communities. Bassichis and Spade (2014) describe how the fight for gay marriage often took on the language of racial strife defined through the civil rights movements and how this analogy proliferated antiblackness within the gay marriage movement. This led to a lack of recognition around racism within the gay marriage movement. Any attempt to bring in race was shot down by organizers. This has the effect of promoting “whiteness as progressive whereas blackness [was aligned] with death and

pathology” (195). Additionally, citizenship claims are mediated through a sexual exceptionalism, which Puar (2007) uses to develop the concept of homonationalism. Homonationalism describes processes that bring homosexuality into United States exceptionalism and is mobilized in favor of US imperialism. Therefore, citizenship is bound with sexual exceptionalism as privilege sexualities are afforded the rights and protections of the state. For black LGBTQIA communities, citizenship rights of certain sexualities are produced through racial difference, in particular racial formations and racialization practices. Therefore, articulations of citizenship are tied to the lives of black LGBTQIA communities who regardless of sexual currency have to still contend with racialized landscapes. It is important to recognize the materialist’s application of queer of color critique as black LGBTQIA communities provide the basis from which to theorize and understand the ways in which race and sexuality produce everyday relationships. Therefore, many theorists take race, gender and sexuality to be different, but they work together to situate the HIV/AIDS epidemic and how the nation state promotes those who are worthy of its’ rights and protections.

At the intersections of race, gender and sexuality are considerations of home and belonging for black LGBTQIA communities. Manalansan (2005) through a queer of color critique lens speaks to how homosexuality creates barriers for queers of color who seek temporary homes in public space. Utilizing Ferguson’s (2004) concept of the “ideologies of discreteness,” Manalansan speaks of how white gays mobilize concepts of home to gentrify parts of cities that are central to queers of color. Ideologies of discreteness speaks to the physical acts of pushing queers of color out of social space and

also excluding them from the imaginary of who should be occupying those spaces.

Through the concept of ideologies of discreteness, citizenship becomes something that is foreclosed through the literal denial of access and also from an imaginary that figures black LGBTQIA communities incapable of accessing those subject positions. As such, belonging is more than a self-identity, it indexes a limitation that is mediated through structures of power, which limit access to citizenship claims.

3.5 Racial Formations and Health

This section works with critical health scholarship to consider the ways in which health is central to Black Feminist Thought and Queer of Color Critique. Critical health scholarship has studied the ways perceptions and responses to health impact the lives of women and LGBTQIA communities. However, there has been little engagement with the political and theoretical bodies of Black Feminist Thought and Queer of Color scholarship. Bringing Critical Health, Black Feminist and Queer of Color scholarship together provides an engagement with the ways in which that black people are central to subject making process associated with health outcomes. Critical health scholars have shown that health is much less a state of being and more a reflection of difference, as moral judgements accompany perceptions of health. Metzl and Kirkland (2010) trace the social and political impacts of health, as health is used as a tool of biological determination that glosses over difference in the name of science. Here, health is mobilized to naturalize difference in the name of biology, which has the effect of normalizing the impact of antiblack violence and premature death that black communities face. For racialized communities, health becomes a tool, under this view, to naturalize

racial difference as biology and at the expense of those who are bearing the burden of health outcomes. Extending this is Krupar and Ehlers (2016) who point out that “the targeting of specific bodies or spaces extracts them from broader relations of structural racism and customizes medical resources in ways that objectify race or racialized space as that which should be secured against” (12). Health’s impact on race naturalizes the very conditions that produce adverse health conditions in the first place. What is taken together as health -moral judgments, a lack of illness, or a state of feeling – becomes part of racialized logics. Therefore, race based medicine shows the ways in which racialization practices accompany the application of health. For Ehlers and Hinkson (2017) race-based medicine “operates in and through a web of debt and indebtedness” (ix). Debt speaks to the relationship between accounting for black communities and the triages that structure their relationships. Debt allows for differential access to health care as the structures that underpin society are never fully addressed. As such, debt highlights the way health is mobilized through race to further normalize and deepen racial inequalities.

DuBois’ (1903) consideration of the racial line between white and black health outcomes in Philadelphia makes health a site from which to understand racialization and health practices. Race scholars such as Omi and Winant (1994), Goldberg (2002), Melamed (2011), and Gilmore (2002) demonstrate that Dubois’s (1903) use of the color line is demarcated through knowledges about both white and black populations. Racialization illuminates that “racial knowledges are materially produced discourses that both constitute and are determined by the historically specific material circumstances and

geohistorical conditions for which they offer comprehension and sense making” (Melamed 2011 12). It is through racial knowledges that hierarchies of difference emerge where racialized bodies are placed into systems of value and meaning making. Racialization practices “displace and disguising differential value making within world ordering system of [difference as it] as it reefs and ensures a baseline for social possibility and legitimate violence” (12). This definition is in line with Gilmore’s (2002) contention that racism is “a practice of abstraction, a death dealing displacement of difference into hierarchies” (17), which situates racialization as a practice that promotes racism and the valuation of racial difference as normal. Health becomes a site to understand the ways in which racialization and racism place black communities into racialized systems of value.

I use racialization within the Black Health Tradition. The Black Health Tradition builds from the work of Adam Geary (2014) who coheres the term in order to speak to the foundational relationship black communities have to health in particular the HIV/AIDS epidemic. Using a materialists approach, Geary pins our understandings of health and disease as part of larger systems of domination, in particular, antiblack violence. Health is not just an isolated standpoint from which one is deemed sick; it is a site that is produced in and through black communities’ relationship to the world. The Black Health Tradition speaks to health as an object of knowledge for black communities in that it animates how the legacies of slavery and other forms of racial valuation are present today. Also, the Black Health Tradition operates as the site from which a critique against health emerges from the activism of black communities in response to their health conditions. Geary

notes that “the Black Health Tradition is not simply a manner of knowing. It has been a wing of a broader project of black liberation, a response to the resistance of antiblackness itself” (128). This is eloquently taken up through the scholarship of Alondra Nelson (2012) in their scholarship on the Black Panthers health programs and their health advocacy for adequate health resources. Here the Panthers mobilizations around sickle cell anemia as a “hidden epidemic” within the black communities seeks redress for larger problems like health care access. The Black Health Tradition are a set of critiques on the very nature of racialization practices as they relate to health. The racialization practices outlined above are foundational to the Black Health Tradition and situates the ways health is mobilized with already existing racial logics. It is through the Black Health Tradition that one is able to leverage a critique and expansion of biological citizenship.

3.6 Place, Race, Sexuality and Biological Citizenship – Conclusion

Biological citizenship needs to consider race as it is articulated through sexuality. As Black Feminist and Queer of Color Scholars have shown, subject formation is premised on being legible which obscures groups that challenge prefigured subject positions. Race articulated through sexuality demonstrates that some gender and sexual minorities receive rights and recognition at the expense of others. However, these sexual subject positions which create new citizenship bodies, limits a deeper engagement in the ways black LGTQIA communities come together as a stable formation to seek rights and recognition for health harms. How black LGTQIA communities cohere under systems of antiblack are central to how biological harms or innovation is mobilized for health access. The Black Health Tradition intervenes as a body of critical scholarship to centralize the

experiences of black communities in the United States as drivers of health care advocacy, reform and public health intervention and health knowledge production. Therefore, I place the “hidden epidemic” within the Black Health Tradition in order to show the ways in which black LGBTQIA communities are central through their response to the HIV/AIDS epidemic.

The “hidden epidemic’s” relationship to race and sexuality provides a necessary intervention around biological citizenship’s focus on new group formations emerging. Biological citizenship speaks to the ways communities come together through shared risks for rights and recognition. Additionally, biological citizenship uncritically takes on the technoscientific telos of human evolution which is premised on the hopes that technology can bring a different unity in society. A unity that is egalitarian and utopic in that it moves away from previous forms of difference. Therefore, biological citizenship with regard to race can’t fully capture how biology is harnessed without an explicit focus on race. The “hidden epidemic” troubles the deployment of biological citizenship as racialized communities are left out of state inclusion strategies based on a shared relationship to the HIV/AIDS epidemic. Therefore, to address this requires a retracing the history of the HIV/AIDS epidemic and connecting how the intersections of race, gender and sexuality impact the way society comes to understand HIV/AIDS advocacy. Therefore, questions of biology, race, sexuality and citizenship as it relates to race, gender and sexuality are needed to understand limits in biological citizenship for people within the HIV/AIDS epidemic. For example, this focus will elaborate the ways in which

the HIV/AIDS epidemic failed to recognize black LGBTQIA communities as a key risk group until later in the epidemic (Moseby 2017).

Additionally, VK Nguyen (2010) highlights that biological citizenship is contingent on large stable institutions that are able to meet the needs of people seeking rights and recognition. Nguyen calls for a view of biological citizenship that is thin as full resources and actions are limited for people living with HIV/AIDS in cash-strapped countries. Biological citizenship is contingent on place and the resources available to populations. As such, place is central to biological citizenship as it is limited for black LGBTQIA communities. Therefore, we must view difference within populations through the resources available locally. The “hidden epidemic” highlights the role of place in impacting biological citizenship claims. Finally, this requires an approach that situates the HIV/AIDS epidemic in place as a way to understand the ways black LGBTQIA communities respond to harms.

Therefore, place, race and sexuality become a site from which to understand the ways in which the “hidden epidemic” is produced as a limitation in biological citizenship for black LGBTQIA communities. The task isn’t to valorize place but to show that biological citizenship is part of antiblack violence. In order to situate place in my research, I take accounting and triage as an object of study to understand the ways in which black LGBTQIA communities are documented and the ways they navigate adverse health outcomes in response to the HIV/AIDS epidemic.

Chapter 4

All the Queers are White, All the Bottoms are Black, But Some of Us are Brave: HIV/AIDS, Blackness and Accounting in HIV Interventions.

4.1 Introduction

In this chapter, I consider the ways in which the production of HIV interventions function as an accounting practice that situates black LGBTQIA communities within the differential value systems of race, gender and sexuality. I use the concept of “accounting” to highlight the way in which marginalized communities are made legible via systems of knowledge production. These knowledges form the basis of black LGBTQIA communities’ inclusion and redress within the HIV/AIDS epidemic. This legibility is central to the making of *biological citizenship*, a process in which biological deviation becomes the basis of citizenship claims. I use the concept of *critical accounting* to make sense of the way in which the legibility of black LGBTQIA communities impacts the types of biological citizenship claims that can be made. I show the ways in which this unfolds specifically in the process of designing, marketing, and implementing HIV interventions. I engage social science studies of statistics and biopolitics scholarship to explore the ways accounting within HIV interventions subsumes racial hierarchies and discourses.

To understand the ways in which accounting practices intersect with the interlocking systems of race, gender and sexual difference in HIV interventions, I develop a *black accounting* framework. In conversation with Hortense Spillers’ (1986) theory of fungibility alongside the Black Health Tradition (Geary 2012, McBride 1992, Roberts

2006, and Washington 2016), I place critical accounting literature in conversation with the production of HIV interventions to understand the ways race, gender and sexual difference are produced and reproduced through prevention strategies. I argue that the production of HIV interventions produces specific understandings of race as it articulates with sexuality. This production is then mapped onto marginalized communities in HIV intervention spaces. Therefore, antiblackness shapes the black LGBTQIA community's relationship to the HIV/AIDS epidemic and as a result, HIV interventions lack an understanding of how black communities advocate for protections and rights. This limits how black LGBTQIA communities are understood within the scientific production of HIV interventions. Therefore, accounting practices are key to understanding black response to the epidemic in the midst of antiblack HIV interventions. Black response to the epidemic is found in social interactions that are not accounted for in – and stand outside of – dominant accounting processes. To understand black response during the epidemic, I develop a black accounting framework to inspect HIV interventions. Therefore, I am able to conceptualize how black LGBTQIA communities are documented, or accounted for, in HIV interventions. I mobilize the conceptual resources of black feminist scholarship to interpret HIV interventions as an accounting strategy that produces and reproduces antiblack discourses. This expands critical accounting scholarship and speaks to the necessity of considering the complex experiences of black LGBTQIA people in order provide effective HIV interventions in those communities.

4.1.1 Setting the Scene

In 1996, the introduction of antiretrovirals - drugs to combat HIV from turning into AIDS - gave people living with HIV/AIDS (PLWHA) a reprieve from what many were calling a modern-day plague (France 1999, Shilts 1987, Sullivan 1996). Antiretrovirals turned a positive HIV diagnosis from a certain death to a condition that could be managed. This had radical implications for the HIV/AIDS epidemic as antiretrovirals, combined with lower rates of HIV infection, reduced the overall spread of new HIV infections. However, while the general public witnessed a reduction in rates of infection, black and other racialized men who have sex with men (MSM) were seeing increases. One study placed a 125% increase in new infections in black (MSM) communities from 1996 to 2000 (CDC 2002). From 1996 to 2002, black men who have sex with men (MSM) under the age of 25 were 9 times more likely to have an HIV positive diagnosis than their white counterparts (Millet 2006). The high rates of infection in black gender and sexual minority communities, post antiretrovirals, can be contributed to the concept of biological citizenship where the reduced rates of infection in white gay communities diminished the impact and response to the HIV/AIDS epidemic in black gender and sexual minorities communities. For black LGBTQIA communities, the intersection of being both black and lesbian, bisexual or gay highlights created a number of barriers that communities needed to navigate or what Cathy J Cohen (1999) describes as a secondary marginalization.

Secondary marginalization illuminates the ways in which black LGBTQIA communities face racial discrimination in LGBTQ communities and discrimination in their own race-

based communities, which create barriers to biological citizenship claims of rights and recognition. As a subpopulation within the black community, black LGBTQIA communities are expected to fall in line with those who carry their primary racial identity. This creates a hierarchy within the black community where gender and sexual minorities are stigmatized in order to support the larger black community at the expense of their own needs. Politically, this allows for the promotion of racial elites, like the black political class, who benefit from the marginalization of folks within their own communities in order to gain cultural capital. When faced with discrimination on multiple fronts, black LGBTQIA communities were often absent on a number of social, economic, and political fronts with regard to the HIV/AIDS epidemic. Their concerns were hidden due to internal community homophobia and the outward racism of the mainstream gay community that created barriers to black LGBTQIA communities' political advocacy. Therefore, secondary marginalization demonstrates the ways internal and outward expressions of homophobia and racism creates additional barriers that black LGBTQIA communities must navigate within the HIV/AIDS epidemic.

To address these barriers, the Centers for Disease Control (CDC) focused HIV prevention efforts on bringing racial and ethnic minority communities into HIV interventions, as a tool to provide resources. Instead of relying on black LGBTQIA communities to mimic the biological citizenship actions of (white) gay men, the CDC sought to incorporate black LGBTQIA communities into the production of HIV prevention, in particular HIV interventions. By bring black LGBTQIA communities into HIV prevention interventions,

the CDC sought to bring health care access, education, and interventions to black LGBTQIA communities.

4.1.2 The Push Towards Interventions

In 1999, The Centers for Disease Control (CDC) in consultation with the Institute of Medicine (IOM) published *No Time to Lose: Getting More from HIV Prevention* to address increasing rates of HIV infections among racial and ethnic minority communities (IOM 1999). The report highlights that in the post-antiretroviral era “advances in treating AIDS have helped fasten a growing sense of complacency in many sectors of both the government and the general public” (IOM 1999 1). The use of complacency highlights how black LGBTQIA communities were understood in the post-antiretroviral era as lacking sexual behavior changes due to the introduction of antiretrovirals, which made a HIV diagnosis not important among black men who have sex with men (BMSM) (Adimora and Schoenbach 2002). Additionally, the use of complacency highlights black LGBTQIA communities’ inability to produce the previous generation’s response to the HIV/AIDS epidemic. The previous generation’s advocacy and activism creates a certain level of public engagement that wasn’t matched in the post-antiretroviral era (Moseby 2016; Cohen 1999). Without a perceived adequate response through sexual behavior change or activism, the CDC used complacency as an optic to promote interventions in marginalized communities that addressed race (black and Latinx), class (below the poverty line), gender (gender nonconforming and transgender) and geography (US South and Rural areas). However, the CDC noted that there were limits in their promotion of HIV prevention strategies as a high number of HIV interventions were focused on “gay

white men in major metropolitan areas” (IOM 1999 2). How to intervene within racialized, non-urban, low income communities gave birth to the production of CDC/IOM’s *No Time to Lose*. As a central document of the CDCs response to the HIV/AIDS epidemic in ‘post-antiretroviral’ era, *No Time to Lose* outlines changes in HIV prevention, in particular interventions, which are seen key to addressing the complacency laid out by the CDC. The report establishes costs, targeted interventions and knowledge translation as central the development and distribution of HIV prevention strategies

4.1.3 Costs

Prior to the introduction of antiretrovirals, HIV prevention funding was distributed evenly matching the distribution of AIDS infection rates nationally. HIV prevention was housed under the Centers for Disease Control, while the Health Resources and Services Administration (HRSA) provides health care resources for People Living With HIV/AIDS (PLWHA). HRSA handles disability care, social security, and other care-related issues for PLWHA, who needed long-term care options prior to death. The introduction of antiretrovirals changed the need for end of life care. PLWHA, who were formerly under end of life care structures, need treatment and prevention due to people living longer lives. Therefore, the CDC felt PLWHA living longer created more opportunities to infect more people (IOM 1999). Hence, HIV prevention transitioned from focusing on exclusively HIV negative populations to addressing in both HIV positive and negative populations, which increased the overall costs of HIV prevention.

The cost of addressing both PLWHA and HIV-negative populations through HIV prevention was more than the standard Federal spending allotted for HIV prevention. Hence, HIV prevention spending domestically is flat with between 700 to 780 million dollars per year allocated during the 2000s (CDC 2020). Overall, Federal Spending on the HIV/AIDS epidemic increased 3 times from 11 billion to 34 billion for the 2000s (KFF 2020). The CDC estimates that the lifetime treatment cost for PLWHA will be 16.6 billion dollars, if the current level of HIV positive individuals stabilized for the whole of the epidemic (CDC 2012). For example, the cost of providing treatments for someone HIV-positive in 1996 - the year of antiretrovirals – was \$20,300 and in 1998 these costs were \$18,300 respectively as drug cost went down (Bozzette et al 1998). Additionally, the prevention cost for HIV-negative individuals was similar. According to Farnham et al (2010), the cost of HIV prevention at the turn of the century found that the lifetime cost of HIV prevention would be \$129.9 billion. The \$129.9 billion cost compared to the cost of treating PLWHA of 16.6 billion with flat domestic funding for HIV prevention forced the CDC to address both PLWHA and HIV-negative populations simultaneously with cost effective strategies. To standardize HIV cost, the CDC prioritized intervention that addressed both HIV- positive and negative populations. Therefore, the CDC restructured their approach to the HIV/AIDS epidemic through a prioritization of targeted HIV interventions.

4.1.4 Targeted Interventions

In order to stabilize the cost and provide treatments for risk groups comprised of PLWHA and HIV negative populations, the CDC prioritized ‘targeted interventions [that] combine

scientifically proven, cost-effective, and scale interventions to the right populations in the right geographic area” (NHPC 2012 1). Therefore, interventions will have a target risk group, dedicated delivery spaces for the intervention, and follow up to see if sexual behavior hanged over a period of time. The types of sexual behaviors that interventions changed were the use of condoms, number of sexual partners, drug use and other sexual related activities. Yet, behavioral HIV interventions alone weren’t enough. The CDC in the report *No Time to Lose* wanted interventions to provide services for populations who lack traditional access to health care. There was a growing sense that other prevention services where needed, in particular mental health and substance abuse services, which allowed for more access to HIV interventions. Interventions would serve as a site of care for PLWHA and those at-risk in informal settings. Therefore, targeted interventions change sexual behavior and brought people into health care by providing clinical case management and other social service resources. For example, the Pre-Prophylactic Exposure program, (known as PrEP), is a system for the delivery of the pill Truvada which stops HIV transmission. People receiving PrEP must see a health care professional every three months to ensure there are engaging in a healthy lifestyle, remain HIV-negative and take Truvada daily. With PrEP, HIV interventions expand health care for participants who may not have access.

Additionally, targeted interventions brought HIV prevention further into the lives of people at-risk and living with HIV/AIDS. To be included into the HIV interventions, a target population composed of a risk group through self-identification was required. Identity – as a reflection of self-identification and geography – informs the basis of

inclusion for target populations (risk groups) rather than sexual activity and extends what Clarke et al (2003) have called the biomedicalization of HIV prevention.

Biomedicalization refers to the process where social, economic and political relationships outside of HIV/AIDS is brought into the purview of the HIV/AIDS epidemic. Clarke et al (2003) points to biomedicalization as the “increasingly complex, multi-sited, multidirectional, processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of highly and increasingly technoscientific biomedicine” (163). The focus on “bio” in biomedicalization highlights how biology in the form of blood, cells, genetics, and tissue is used as technology to bring medical discourse and action into new spaces. For example, the insistence of addressing both HIV positive and HIV negative populations through sexual networks in HIV interventions brings black LGBTQIA communities, regardless of sexual activity, into biomedicalization as membership to a sexual network becomes the basis of inclusion. Therefore, targeted interventions focus on the spaces that PLWHA and HIV negative populations come together, which expands biomedicalization into their personal lives. For example, we see the further encroachment of biomedicalization in the use of GPS to create hotspot maps of new HIV infections (Thorpe et al 2011). Or the use of GPS to trace sexual and social networks among black gay men in New York City (Duncan et al 2018). Furthermore, the social and spatial lives of those HIV positive and at-risk of HIV intervention become key sites for targeted interventions.

4.1.5 HIV Prevention Knowledge Translation

To facilitate the development and diffusion of targeted interventions, the CDC created a structure bring intervention science to community-based organizations, who are on the front lines of delivering interventions to at-risk communities. This was part of a larger effort to transition to evidence-based medicine, in which the efficacy of the intervention would be evaluated to treat specific groups (Lambert 2006 and 2009; Lyles 2006; Holmes et al 2006). Evidence based medicine is a technique of scientific rationalization that aims to quantify treatment outcomes in order to evaluate their effectiveness. Part of the quantitative revolution in the post-cold war US academy, evidence-based medicine applied statistical methods to social science questions and thus changed the standards of what “counts” as evidence. For example, *No Time to Lose* calls for an evidence-based medicine approach that uses randomize control trials to evaluate a HIV intervention’s effectiveness in stopping the spread of the virus. Evidence based medicine centralizes a set of quantitative tools to evaluate the outcomes of a study, and in doing so, creates a hierarchy of evidence. In the case of HIV interventions, this means that if a particular intervention proved effective using a particular kind of evidence, then that intervention would be scaled-up and distributed to community-based organizations for implementation.

The Prevention Research Synthesis (PRS) team - a division within the CDC’s HIV Prevention Unit – use evidence-based strategies to select HIV interventions. The PRS team creates a criterion for the selection of interventions based on HIV/AIDS risk population, evaluation of outcome, population size and the use of a behavioral sexual

strategy (CDC 2006). In describing how the studies are conducted, Lyles et al. (2006) writes: “decision makers and program planner must consider the entire body of scientific evidence regarding interventions to identify and support the most effective and efficient HIV prevention strategies” (22). The PRS group prioritizes the use of randomized control trials and systematic reviews to compile and compare HIV interventions with one another. For HIV prevention, the use of systematic reviews and randomized control trials established a structure of evidence in which the validity of the intervention itself is measured according to the evidence used in the research and design of the intervention. The idea is that this ensures that the intervention has undergone rigorous scientific testing, and that the efficacy and effectiveness of the intervention is reliable. Interventions that meet the PRS selection criteria are sent to the Replicating Effective Programs Project, which makes the intervention suitable for implementation by community-based organizations. The last stage of designing an intervention falls to the Diffusion of Effective Behavioral Interventions Project, which disseminates interventions to community-based organizations. These organizations adapt the intervention for local contexts. Overall, to be implemented, HIV interventions must be able to be replicated, disseminated, and translated to a range of communities and organizations (Dworkin et al 2008). To support the knowledge transfer of interventions to community-based organizations, the CDC created regional HIV Prevention Training Centers to build capacity for CBOs to deliver clinical interventions, provide training and support, education development contractors, volunteers and evaluation consultants (Collins et al 2006). The goal of this program is to enable community-based organizations to have the capacity to implement cutting edge HIV prevention science so that target populations will

receive the best HIV prevention interventions available. Moreover, by providing a way to measure and assess the relationship between cost of implementation and behavioral change, EBMs are also a way to assess the cost effectiveness of an intervention. Costs are calculated as a ratio between the cost of implementation divided by the number of HIV transmissions stopped. Thus, the overall impact of interventions is to create a selection criterion in which only a narrow set of interventions are considered effective on the basis of the criteria imposed (Lyles et. al. 2006).

4.1.6 Lack of Interventions in the Black Community

As the use of target interventions increased, the CDC recommended that community-based organizations (CBOs) use approved interventions that met the CDC standard for cost effectiveness and impact (CDC 2003). Problems arose, however, when CBOs serving black LGBTQIA communities found that the interventions being delivered did not meet the needs of their constituents. In 2004, the CDC offered 11 interventions for community-based organizations to deliver, but only two were specifically designed for black men who have sex with men (BMSM). The majority of interventions were targeted at white gay men and heterosexual couples. The slow roll out of targeted interventions for black LGBTQIA communities concerned many CBOs. Organizations using CDC interventions had problems adapting them to meet their needs. Feedback from CBOs emphasize a lack of community input in the creation of interventions and indicated that their relationship to the CDC felt top-down (Owczarzak and Dickson-Gomez 2011). CBOs commented that interventions were too specific for the particular needs of their communities and that the interventions limited their own ability to adapt interventions

(Collin et al 2006). Crucially, CBOs also claimed that the effectiveness of the interventions offered could not be standardized across risk groups because various populations had different needs. To address this, the CDC helped organizations adapt to interventions, or allowed organizations to develop homegrown interventions (Collins and Sapiano 2016). The CDC also adopted CBOs feedback and eventually made more interventions available, bringing the total interventions to 22. Although CBOs were funded to implement interventions, there has been little understanding of how organizations adapted them or their impact on the epidemic (Dworkin et al 2008). However, in 2010, increased use of HIV interventions took place due to the Obama Administration's National HIV/AIDS strategy, which provided more funding and resources for the development of interventions, this brought the total number of interventions from 22 to over 70.

In the early 2000s, the limited number of interventions for black LGBTQIA communities and community-based organizations who had difficulty implementing HIV interventions presented a problem. The CDC was responding to the epidemic with little consideration of those most impacted by it. As Epstein (1996), Patton (1990), and Cohen (1999), argue, in the pre-antiretroviral era, People Living With HIV/AIDS (PLWHA) fought to be at the table as the CDC developed a response to the epidemic. In the post-antiretroviral era, as black LGBTQIA communities were most impacted by the disease, the CDC developed a top-down response without large-scale feedback from members of that group and without consideration of the ways interventions would impact internal group differences among communities in particular transgender and gender nonconforming

populations. Instead, evidence-based medicine supplanted grassroots approaches to developing HIV interventions. Therefore, this top-down approach raises the following question: If black LGBTQIA communities are not influencing HIV intervention, then how are black LGBTQIA communities brought into interventions?

My focus on HIV interventions are part of a larger body of scholarship that engages the development and implementation of HIV prevention efforts globally. Arguably, the HIV/AIDS epidemic is a catalyst for the emergence of the global health movement as an AID industry comprised of people living with HIV/AIDS, volunteers and experts creates an infrastructure of non-government organizations, pharmaceutical companies, and state interventions to bring HIV/AIDS prevention strategies and interventions to the Global South. It is through biomedical technologies like treatment as prevention and male circumcision where the AIDS industry finds a footing in the Global South. However, biomedical technologies find difficult contexts in which to operate given social, political and cultural contexts that present their implementation on populations in need. For example, the clinical efficacy of circumcision to combat HIV transmission among heterosexual couples in Africa found difficulty adapting to the cultural parameters of populations at risk of a positive HIV/AIDS diagnosis. Instead of adapting HIV interventions to local contexts with increased infrastructure, funding, and adaptation of HIV prevention technologies, biomedical intervention of male circumcision went unchanged. This diminished local, culturally specific, efforts to address the epidemic. Therefore, this reflects the broad AIDS industry's focus on philanthropy, capitalism and scientific research.

Scholars have pointed to the connection between the AIDS industry and the global health movement as comprising a series of failures within HIV research (Peterson et al 2015; Ngyuen 2015; Kingori and Sariola 2015). Failure, like my use of the “hidden epidemic”, is a conceptual tool to understand the ramifications of HIV prevention strategies that are less effective or does not produce their intended outcome. Failure can look like, the lack of efficacy of HIV interventions within communities, a lack of consideration of participants’ cultural values, or the lack of self-reflexivity among researchers. My interest in failure speaks to a specific context of HIV prevention as they fail to “translate between the fiction of the laboratory and the prose of every life” (Nguyen 2015 327). Therefore, HIV interventions are a tool that seek to close the gap between clinical efficacy of a particular HIV prevention strategy and the on the ground realities that limit uptake among participants. Crucial are the ways the CDC in their attempts to translate and promote HIV interventions in black LGBTQIA communities understand barriers to adaptation which are the result of intersectional forms of structural factors comprising race, gender and sexual difference, which undergirds barriers that HIV interventions seek to change (Carter and Flores 2019). Central to the CDC’s implementation of HIV interventions are accounting practices that translate structural barriers that black LGBTQIA communities experience into the intervention’s design. Hence, the CDC is increasingly reliant on accounting practices to close the gap between the clinical efficacy of the intervention and the realities of black LGBTQIA communities. Therefore, I argue that the “hidden epidemic” is produced through gaps in the CDCs proliferation of prevention strategies where accounting of black LGBTQIA relationship to the epidemic is situated between

HIV interventions and the social cultural and economic contexts that animate their relationship to the epidemic.

4.2 Politics of Accounting

HIV interventions are accounting strategies that make black LGBTQIA communities legible within the HIV/AIDS epidemic. As detailed in the previous section, HIV interventions are a key site of knowledge production in which the accounting of black LGBTQIA communities used to bring them into systems of care and prevention. Accounting signals the way in which HIV interventions, as a medical technology, substantiate knowledge about black LGBTQIA communities by bringing their lived experiences into the interventions design. HIV interventions account for certain parts of black LGBTQIA communities while also limiting how the black LGBTQIA community *account* for themselves in relation to the epidemic. In this section, I provide a genealogy of accounting, not from a singular origin of emergence but from a number of practices that coalesce to configure my use of accounting (Foucault 1978). I use genealogy to situate *contingency* as the driver of accounting processes (Garland 2014). This is crucial for understanding the ways black LGBTQIA communities relate to the HIV/AIDS epidemic which is done through accounting's blurring of the subject/object divide. This division is central to the production of antiblackness within HIV preventions and interventions.

The etymological roots of accounting stem from the Latin *ac*-prefix meaning; to count or to reckon. "To count" highlights the way that accounting is used as a technology of

standardization in which an object is rationalized through enumeration (such as arithmetic, numbers, or statistics). “To count” highlights the proliferation of quantification practices that use numbers to represent and constitute everyday life. Political economic scholarship has illustrated the role of numbers in everyday life with a particular focus on the ways in which the economic realm constitutes reality (Porter 1995, Poovey 1998, Rose 1991, Miller and O’leary 1997, Hacking 1996). Economic processes like financialization (Toscano 2008, Martin 2002,) accumulation (McDonough 2011) and value (Foley 1982) impact individual bodies (Joseph 2016), groups of people (Gray 2002) and governance strategies (Tickell and Peck 1992, Jessop 2003). The way that accounting can translate the economic into everyday life points to its promise as a technology that can translate the qualitative into the quantifiable. At the level of the individual body, Miranda Joseph (2016) highlights how the economic logic of credit and debt forces individuals into a debt relationship. The mechanisms that produce the debt relationship can be economic, however, as Joseph argues, this is not the only site from which debt functions. For example, women in patriarchal systems can engage in a debt relationship if their partners are the primary income earners. This creates a debt relationship as women have a social reproductive debt within the home that must be paid for in exchange for the material gains of the breadwinner. Additionally, accounting for women and their relationship to economic processes can be located in debt-forming technologies, like credit scores. In this case, bad credit for women operates to reproduce gendered narratives of women lacking financial literacy, while also creating accumulation strategies that take money from women in the form of payday loans or check cashing sites. Debt functions to limit full participation within a social or economic

system, while in effect also advancing capitalist processes. As an accounting practice, Joseph argues, debt renders individual bodies for capital gain *and* reinforces the valuation of heteropatriarchy and racialized systems of difference. Accounting at the level of the individual body, then, can be understood to signal the intersection of social reproduction and capital accumulation strategies.

Echoing Joseph at a different scale, Miller and O'Leary (1992) approach the relationship between accounting and the management of workers through the accounting technology of standard budgets and costs. Standard budgets and costs operate as a tool to incorporate disparate economic inputs like raw materials and fixed costs together to better understand the whole production process and subsume workers as economic inputs rather than a group of individual bodies. Accounting for economic inputs extends the reach of production cost to areas like labor, which allow workers to become an object of production. Miller and O'Leary situate standard budget and costs is a technology that renders workers visible to their inefficiencies within the labor process, as workers are scrutinize for their production output on the assembly line. Therefore, worker's bodies are brought into a cost regime where productivity in the form of output can be measured through workers individual movements on the assembly line. As a tool of accounting, standard budgets and costs have a social impact where labor costs are inflated through cost speculation which is then mapped onto labor representation. A fixed number of workers on the floor could diminish the potential for organizing as accounting practices seeking lower labor cost creates less workers on the assembly line. Finally, standard budgets and cost, as an accounting technology, brings the worker in to the scientific

management strategy of Taylorism. The life of Taylorism as scholars have pointed to, extends beyond the workplace and comes to represent aspects of everyday life, for example, the deskilling of homework in order to facilitate social welfare care structures (Merkle and Riley 1980, Deacon 1985).

Finally, accounting facilitates the economic realm's encroachment into everyday life, as state's aim to standardize populations alongside the emergence of capitalism. Ian Hacking (1990) calls the enumeration techniques of states in the 1700s through census and other population demographics, an avalanche of printed numbers where statistics emerge as a tool to enumerate all that was under the purview of nation-states. During this period, the contours of state formation follow a series of rationalizations where populations under a particular territory are brought under the purview of their governance. James C. Scott (1999) speaks to this process of accounting as a narrowing of vision that makes "the phenomenon at the center of the field of vision legible and hence more susceptible to careful measurement and calculation" (17). For Scott and scholars of state governing strategies (see for example Jessop 2003; Rose 1990), the use of accounting - numbers, mathematization, measurement, counting, and calculation, and in particular statistics – makes that which is accounted legible to state governance practices. State accounting practices transform everyday life into knowable entities for capital accumulation through taxation, federal funding distribution, and the distribution of loans for mortgages.

My use of accounting is concerned with the way governance practices allow those in power to wield control over groups of people. It is through the process of making measurable objects out of living subjects at the scale of the individual and the population that allows accounting to be understood as a process of abstraction. My use of accounting is concerned with how documentation processes that translate everyday life into measurable entities. This translation is premised on the assumption that knowledge of individuals can be scaled up to population level concerns. With respect to HIV interventions, interventions are made to be generalizable but between individuals and populations around behavioral risks. I argue, accounting is the practice of smoothing out barriers between individuals and populations to create a whole body of knowledge about a risk group. The second dimension of the definition of accounting, to reckon, elaborates on this point.

4.2.1 Individual and Population

Scholarship on accounting provides a pathway to understand the ways in which technologies aimed at individual bodies come to represent populations and how technologies to understand populations impact individual bodies. I use Foucault's (2008/1976; 2003/1978) theory of biopower to explain the relationship between individual and population knowledge. Foucault's use of biopower is central to his explanation of how nation-states reorient their relationship to sovereignty in the late 17th century. Prior to this period, sovereignty was defined as *juridical*, where a state's ability to exercise power over life was through deciding who lives and those who die under the state's discretion. Under this system, power was exercised through the ability to "take life

or let live” (Foucault 1976 136). Biopower points to how sovereign power changes “to foster life or disallow it to the point of death” (138). Foucault pins this transformation from “take life or let live” to “foster life or disallow it” through the emergence of two different poles that allowed for the articulation of power; *the disciplines: anatomo-politics of the human body* and *regulatory: the biopolitics of a population* (139). The disciplines point to institutions that develop to understand and manage individual bodies whereas, regulatory knowledge production took place at the level of populations in the form of tools to understand and prolong the life of a population.

Although these two poles emerge as separate, over time they combine to produce technologies of power. Rose (2007) highlights the distinction between individual and population concerns as the relationship between “discipline and regulation - between strategies that the management of individual bodies and those focus on the collective body of the population (53).” Overtime, biopower comes to be the distinction between individuals and populations which then bear on individuals and populations. Following this line of thinking, accounting strategies in the form of numbers, statistics and enumeration bring individual and populations together. This develops through taking humans as real objects of knowledge which meant that what is understood at one pole could speak to the other pole. Therefore, providing life for the individual necessitated a baseline understanding that human beings were a biological species where knowledge about humans could be categories to represent a population. Berlant (2007) elaborates that biopower is the process of “making individuals into normative social units” (665). In Foucault’s estimate, this allows for the production of a number of disciplinary strategies

where dispositif of power and knowledge could emerge. Foucault (1976;1978) uses the term dispositif to show how life itself is used as the disciplinary tool. A litany for life not only informs how people may or may not act but also situates how individuals and populations will be intervened on at scales between the fostering or disallow of life to the point of death.

Biopower's accounting for individuals and populations transforms the way in which sovereignty acts on populations as it moves to a general politics of society (Adams 2017). The politics of society speaks to the way sovereign power acts on behalf of its populations. This, in Foucault's theorizations, is where racism emerges not between individuals in a population but as a population comes to represent the whole. According to Foucault "[a] battle that has to be waged not between races, but by a race that is portrayed as the one true race, the race that holds power and is entitled to define the norm, and against those who deviate from that norm, against those who pose a threat to the biological heritage" (Foucault 2003 137). Foucault points to state racisms as the ultimate expression of biopower as states come to protect that which they have promoted through the accounting process of biopower. In order to substantiate these accounting practices, states engage in racism as a way to bring those outside of the population into the logics of the state or disavow them to the point of death. The individual body is connected to the biopolitics of a population through the institutionalization of knowledge. What we understand as "racism" manifest when individual knowledge extends past the boundaries of populations beyond the nation/state. Racism, then, enables movement between sovereign territories as the logic of one group is incorporated into another.

Foucault's thinking on biopower illustrates two points that are useful for my deployment of the concept of accounting. First, accounting enables subjects to be made into objects. Individuals who have their own subjective qualities can be made into objects through accounting. Similarly, through population level accounting strategies, groups of people can be made into objects. Both of these practices come together to produce a new type of power that is at once disciplinary and expansive. Second, the objectification of people within a territory allows those who do the accounting to extend beyond the geographies of their sovereign rule. In order to demonstrate the vitality of a population - a core premise of biopower - states must incorporate and disavow other places in order to justify the internal biopower practices within their own territories. Foucault (1976;1978) identifies the Nazi regime as the ultimate expression of biopower. Its proliferation gives accounting both material and imagined spatial properties in so far as accounting at the individual body extends beyond geographic scales. Central to my understanding of accounting is the way that individual knowledge produced from bodies through institutional practices are made to be generalizable to the whole of populations and that they are grafted on to entirely different groups. In this sense, accounting is an epistemology that moves in and between geographic scales.

4.2.2 Problems

There are limitations to Foucault's use of biopower with regard to the role of subjectification and his use of racism. Without clear material and discursive examples, scholars' gesture to a lack of clarity as to what Foucault meant through his use of

sovereignty and its connection to biopower. Giorgio Agamben (1998) provides the most sustained debate on the subject. He argues that sovereignty is fundamentally about life and that Foucault's description of biopower does not consider the role of law. For Agamben, Foucault fails to address how juridical-institutional power is exercised within biopolitical models of power, which has the effect of disarticulating how subjects are included within sovereignty regimes, juridical knowledge or biopolitics. This lack of clarity prompts Agamben to consider when biopolitical regimes and juridical power are suspended, which forces a consideration of bodies that are excluded from life. Similarly, Mbembe (2003) considers under what conditions "is the right to kill, to allow to live, or to expose to death exercised? (13)" For Mbembe, one's relationship to death becomes the basis of subject formation and not the life affirming strategies of Foucault's biopower. Therefore, I build from this consideration of death to understand the ways in which subjects are made through systems of domination. Didier Fassin (2009) calls for biopolitics to consider "itself not merely a politics of population but is about life and more specifically about inequalities in life which we could call bio-inequalities" (49). For Fassin, biopolitics is more than just governing populations. It also creates unequal distributions of governance. Biopolitical subjects are differentiated into hierarchies of power which creates ideal subjects for individuals and populations. The ability to differentiate individuals and populations into categories is central to the proliferation of state racism. Thus, my use of accounting elaborates the ways in which internal systems of difference that place value on populations at the expense of others are brought to outside to populations beyond a state jurisdiction. By bring biopolitical systems of differentiation to new population, the social, political and economic systems that support biopolitics

within a government are legitimized. For example, slavery and settler colonialism legitimize biopolitical practices within the colonizing state. Therefore, accounting of individuals and populations within a state must consider the external accounting of groups outside a state's borders.

I build from these considerations to examine the way in which individuals and populations outside of the privileges of the state inform biopower. Agamben (1998) offers the analytic of bare life as the transformation of basic life which provides a conceptual outside that informs biopolitical subject formations. Through an example of the walking dead subject formation of the *Muselmann*, who were Jewish concentration camp prisoners, Agamben argues that Jewish subjugation under the Nazi regime is biopolitics' ultimate expression as *Muselmann* come to represent individuals who have lost their will to live. However, Weheliye (2008) calls into question the role of race and racialization with respect to the word *Muselmann* as it is a translation of the word Muslim. Weheliye extends Agamben's use of *Muselmann* to consider the "techniques by which human beings are transformed into bare life" (328). Racism and racialization are key technologies in differentiating humans. Therefore, Foucault (1976;1978) and Agamben's (1998) choice to frame racism through ethnic division, eludes the "bio" in biopower, as the naturalization of racial categories through biology go unexamined in Agamben's and Foucault's work. Weheliye (2008) elaborates that "all modern racism is biological first because it maintains the believed natural inferiority of the targeted subjects and because racialization is instituted in the realm of human physiology as the sociogenic selection of one specific groups in the name of embodying all humanity" (60).

As colonizing states are exploring new lands beyond their own sovereign borders, the organizing force that create the human, sub-human and non-human are built from the biopolitical racism and racialization practices. Hence, biopower is a feedback-loop between knowledge gained at the individual and population level and knowledge brought based from processes of racism and racialization. Racism and racialization are central to biopower. Internal differentiation through racism and racialization along with its expression externally through colonial landscapes demonstrate the way in which accounting informs individuals and populations undertake social, economic or cultural subject positions.

I argue that HIV interventions are an accounting technology that differentiates black LGBTQIA communities at both the individual and population level. At their core, interventions act on individuals through changes in sexual behavior which maps onto population level discourses about black LGBTQIA communities. Therefore, it is important to demonstrate the way in which HIV interventions account for black LGBTQIA communities. I turn to accounting for blackness to provide an analytic to understand what exactly is being subsumed through HIV interventions. Hence, accounting for blackness operates illuminates to the connection between dominant narratives about black LGBTQIA communities and counter narratives that are produced by these communities through HIV interventions.

4.3 Accounting for Blackness

Accounting for blackness demonstrates the way in which black people are made malleable to antiblack violence. Accounting rationalizes black people into narrow subject positions from which knowledge and intervention can be enacted on them. For example, the slave ship's ledger is an accounting technology that renders stolen African people into object-commodities, as they enter the transatlantic slave trade. Accounting for blackness documents black life within systems of domination. Therefore, I take black people as objects of knowledge rather than a real object. The distinction between an object of knowledge and a real object builds from scholarship critical of Black Studies' institutionalization within the academy (Spillers 1994, Sexton 2011, Weheliye 2014). The demands of institutionalization produce black people as static where their cultural, social, and economic contributions are fully known to the academy. Scholars critical of the institutionalization of black life question the way in which disciplining black studies takes black people as real objects that link their experiences to post-enlightenment universalisms (Gilroy 1993, West 1993), the naturalization of race as a biological or cultural phenomenon (Park 1932, Myrdal 1944), or the introduction of whiteness as a racialized group who are similar to other racialized communities (Roediger 1992, Foley 1998). For Sexton (2011) viewing black people as real objects undermines scholarship that attempts to understand black subjection post-emancipation in the afterlife of slavery (Wilderson 2010, Hartman 1997, Sharpe 2009, Holland 2012). Weheliye (2015) elaborates that, "continuing to identify blackness as one of black studies' primary "objects of knowledge," with black people as real subjects rather than an "object of knowledge," accept too easily that blackness, and by extension race, is a given natural

and/or culture phenomenon as opposed to an aggregate of aggregates that must continuously re/produce black subjects as not-quite human” (24). Accordingly, Spillers (1994) highlights that the distinction between black people as real objects or objects of knowledge is important given that the former assumes that black people exists in already prefigured knowledge systems. Instead, she calls for black studies to take black people as an object of knowledge in order to introduce a “new set of demands” that allude the disciplining of the field (451). Therefore, taking black people as an object of knowledge addresses how accounting practices carry legacies of antiblackness and how antiblackness as is foundational to how black people are understood. For example, racialization - building from the work of Gilmore (2012) and Melamed (2011) - highlights the ways race enters populations into systems of valuation which, “materially produce discourses that both constitute and are determined by the historically specific material circumstances and geohistorical conditions for which they offer comprehension and sense making” (Melamed 2011 13). Therefore, accounting for blackness illuminates how value systems like racialization are found in dominant accounting practices. It is within dominant accounting practices that black people placed into racial hierarchies. Additionally, accounting for blackness understands how abstractions are foundational to how black people are understood as their subject positions in a system of domination is made to seem natural. Accounting for blackness allows us to understand the ways in which antiblackness proliferates in accounting practices and is made to seem normal.

To develop an accounting for blackness approach, I elaborate on the ways in which accounting makes black people malleable to antiblack violence. Scholarship on slavery

and its afterlife are foundational to demonstrate the ways black people through accounting practices are made malleable under antiblack violence. Katherine McKittrick (2013) situates the plantation as a historical spatial temporal geographic site of black dispossession that considers the ways in which black people are linked to the past, present and future of “post slave conceptualizations of geographic violence” (4). McKittrick points to the plantation as a space that structures normative geographies based in racial hierarchies. The plantation as an object of knowledge highlights “a conceptualization of time-space that tracks the plantation toward the prison and the impoverished and destroyed city sectors and, consequently, brings into sharp focus the ways the plantation is an ongoing locus of antiblack violence and death that can no longer analytically sustain this violence (2). The plantation extends beyond its spatial temporal origin in the antebellum period to provide a set of logics that inform spaces of antiblack violence. For McKittrick, the plantation is a central organizing force for dominant geographies – capitalism, racism, heteropatriarchy – and also points to how black people made meaning and life under these harsh conditions. McKittrick’s insistence that black people have their own set of relationships within the antiblack violence of dominant geographies demonstrates the limitations of antiblack violence. Hence, the limitations of antiblack violence point to the centrality of accounting for blackness as an analytic that uncovers black life strategies. However, the way black people emerge with their own subjective understandings within systems of antiblack violence is due to an issue with dominant accounting practices of black people. The plantation as a site of accounting is generative to understand this relationship as it is a process to make black people malleable for antiblack violence *and* create opportunities for expressions of black life.

Tiffany L King (2016) addresses the ways in which expressions of black life can be found within systems of antiblackness in her use of the term fungibility. Fungibility is built from the work of (Hartman 1997; Spillers 1987) and points to the capacity of blackness for “unfettered exchangeability and transformation within and beyond the form of the commodity” (2). Black people exist beyond what is prescribed for them given that they must alter in order to meet the needs of those who benefit from black people as objects. Fungibility attends to how black people are made malleable to meet the needs of material and imagined relationships in systems of antiblackness. During slavery, black people were made fungibility as commodities in what Spillers (1987) calls the “raw material” of being human. Therefore, fungibility is “a form of raw material and an expression of spatial expansion used for hu(man) ascendancy under conquest” (King 2016 5). Fungibility attends to how black people exist for the needs of racial hierarchies but also how their use extends beyond the space of antiblack articulation. King links black people to material and imagined spaces through an example of black people being depicted on maps as unknown marooned settlements while also simultaneously occupying plantations. Hence, fungibility expands spatial possibilities of antiblackness in the imagination of plantation settlers. Thus, black people under systems of antiblack violence have a material and imagined use that proliferates through space and time. McKittrick (2011) and King (2016) illustrate how black people are configured into whatever is needed of them which indirectly produces other forms of social relationship, in particular, the way black people’s spatial production extends beyond systems of antiblack violence. What allows black people to be fungible are accounting strategies that

alters black people but not the entirety of the black body or population. It is important to understand how the body and flesh work together to limit the dominant accounting strategies which also diminish the spatial production of black people.

Black Feminists' theorizations on the distinction between the body and flesh allow for accounting practices based in antiblack violence to be normalized (Spillers 2003, Hartman 1997, McKittrick 2006, Sharpe 2009). The distinction between the body and flesh demonstrates the way black people are made into objects through antiblack violence. Hortense Spillers (1987) defines the distinction between the body and flesh as central to the relationship between "captive and liberated subject positions". In that sense, before the "body" there is the "flesh," that zero degree of social conceptualization that does not escape concealment under the brush of discourse, or the reflexes of iconography" (67). The flesh is the point of racialization practices that transfers antiblack violence by cohering black skin to systems of domination. As such, the flesh is an actant for sociality and is the site from which "captive and liberated subject-positions" can be understood (67). Violence against the flesh renders the body – which has its own subjective qualities – mute. As long as the symbolic order of antiblackness focuses on the flesh then the productive capacities of the body are hard to understand. Therefore, my use of accounting for blackness understands how the flesh is acted on by systems of antiblackness and the ways in which there are other relationships to that go unaccounted for.

Accounting substantiates violence against black people but also limits what McKittrick (2011) calls “substantiations of black life.” Accounting for blackness finds its meaning with the facts of black life which are often unaccounted. At its core, accounting for blackness does not mean challenging normative accounting strategies. Doing this enters those who do into limited research, methodological and theoretical concerns where antiblackness is reproduced, or accounting fails to recover objects that are not enumerable (Hartman 2008). Accounting for blackness does not use the master’s tools to create different accounting practices (Lorde 1984). Instead, I argue that accounting for blackness creates spaces where black experiences can flourish before, during, and after antiblack accounting practices. Working to understand how black life exists in systems of antiblack violence is part of a mandate which geographers have attended to. Derickson (2017) in referencing earlier work on race and the discipline highlights Clyde Woods’ (2002) intervention on the limitations of academic production when a continual disavow of black life is part of research outcomes and considers what is needed is an “awareness of both what is foreclosed in our narrations of racialized violence and dispossession as well as vigilance about the ways white supremacy suffuses both our epistemological postures and the institutional spaces where knowledge is produced” (Derickson 2017 7). Therefore, accounting for blackness reconstructs dominant accounting practices to understand the ways black life could be substantiated. I frame accounting for blackness as a practice that considers the “impossibility of knowing” as an epistemic position that opens up a space to consider the role of what isn’t accounted for in the lives of black people. As an optic that speaks to what could be, accounting for blackness highlights what cannot be recovered as a productive site of knowledge production. Yet, experiences

of what isn't accounted for doesn't mean they lack impact. Through Lowe (2006) and Hartman (2008), addressing unaccounted for space and time creates a conditional space of "what could have been" (Hartman 2008 11). The "what could have been," of what is not accounted for, considers how the unaccounted creates a site to understand the limitations of antiblack violence as it moves through time and space. Therefore, what is not accounted for matters to show how black people are continually disavowed of connections they have to places. The difficulty is making sure not to recommit the epistemic violence that antiblackness carries. One way to approach the epistemic violence is to consider what is not accounted for in black people's spatial production.

4.3.1 Transition to Case Study

Accounting for blackness illuminates the ways in which HIV interventions operate with antiblack logics which naturalizes discourses about black LGBTQIA communities and hides how they shape interventions. The racialized production of epidemiological knowledge about black LGBTQIA communities' influence on HIV interventions. For example, black LGBTQIA communities susceptibility to the HIV/AIDS epidemic is understood through the epidemiological knowledge of small sexual networks (Millet et al 2006), stigma (Eaton et al 2015), lack of political movement (Cohen 1999), and other behavioral and social factors that limit the lack of uptake of HIV prevention strategies (Rintamaki 2006). Overtime, HIV interventions substantiate this knowledge and become part of the discourse about black LGBTQIA communities' relationship to the HIV/AIDS epidemic. Therefore, HIV/AIDS interventions take on racialization practices that impact black LGBTQIA communities in the intervention setting. Robinson and Moodie-Mills

(2015) remark that HIV prevention and interventions have not seriously considered the connection between race and the HIV epidemic especially as, “race intersects with poverty, gender, and sexuality among other factors [and] becomes the embodiment of a multifaceted social exclusion and the rationalization for massive health inequalities” (2). Accounting within HIV interventions reveals the naturalization of race without disarticulating it from the intervention’s focus of sexual behavioral. HIV interventions normalize race and racialization practices into the intervention’s design.

In order to see how accounting functions through HIV interventions, I will move to an analysis of HIV interventions to show how black LGBTQ communities are central to interventions as participants are central to the production of interventions. To do this, I will perform a systematic review and will conduct a content analysis to read across interventions for their impact and articulation of black LGBTQIA communities. I will end with a discussion on how accounting for blackness allows us to see black contributions when there isn’t an explicit consideration in the research.

4.4 Methods

In order to address accounting strategies for black LGBTQIA communities in HIV interventions, I conduct a methodological approach combining a systematic review of HIV interventions, archival research, content analysis and interviews with CDC HIV prevention staff. My choice in using the methods above are informed through Susan J Elliot’s (1999) recommendation that the research question should guide the method. The phrase “the question shall denote the method” highlights the need to apply, when

necessary, qualitative methods to health geography scholarship (Elliot 1999; Kearns 1993). The shift to qualitative approaches in health geography is in response to the demand of social and cultural perspectives that researchers were incorporating into scholarship. Therefore, questions that center my analysis for this chapter are; **How do HIV interventions articulate race? How do black gender and sexual minorities shape interventions?** To answer these questions, I replicate the CDC's own method for developing interventions through a systematic review. I use a systematic review to understand the social dimensions of the CDC's accounting within HIV interventions. I analyze the choices and decisions made in selecting interventions and how black gender and sexual minorities are represented. To inform my analysis, I draw from two interviews with the CDC Prevention Research Synthesis team who are tasked with developing systematic review criteria for evaluating interventions. Through interviews and my own critical systematic review, I conduct a latent content analysis on interventions that were made available for black LGBTQIA communities. Data from the latent content analysis will be analyzed through social theory in order to evaluate how interventions incorporate racialization practices. The social theory I use is Dorothy Roberts' (2008) theoretical foundation of race-based medicine. With race-based medicine, I create a taxonomy of racialization practices and how they intersect with gender and sexuality in HIV interventions.

4.4.1 Systematic review

My use of a systematic review is to study the ways in which HIV intervention's contextualize race, gender and sexuality through participants in the study. A systematic

review is the scientific synthesis of research results where controls and methods are developed to evaluate the study's outcomes. The goal of a systematic review is to compare outcomes with each other even though other variables in the study design may be different. Systematic reviews allow for the evaluation of techniques within a study's design as part of a larger methodology. As a method for critical inquiry, I replicate the CDC's own systematic review and the controls developed by the Prevention Research Synthesis (PRS) team who evaluate HIV interventions. The PRS team establishes a set of criteria to evaluate HIV interventions through intervention description, study design, implementation and analysis, strength of evidence, and fatal flaws in the study (Lyles 2006). What emerges are a set of controls that evaluate interventions for how participants are allocated in study arms, length of follow-up, and participant retention in interventions. The goal is to highlight the effectiveness of the intervention's research design in order to evaluate its impact on HIV risk populations.

In replicating this process, I searched key terms within social science and science databases with the key terms (intervention, HIV/AIDS, behavioral change, risk, and prevention) in four databases (MedLine, AIDSInfo, PSYInfo, Web of Science). My searches returned over 800 interventions that matched the key terms above. From here, I used the PRS team's inclusion and exclusion criteria and applied it to 800 interventions by reading abstracts. The inclusion and exclusion criteria as listed in Figure 1. From here, the included interventions went from 800 to 222. When I then applied the PRS team's final evaluative criteria my end results came to 79, which is similar to the PRS teams 72

HIV interventions.⁸ To evaluate the interventions collected, I apply a content analysis to understand the ways in which interventions are connected to one another through race, gender and sexuality.

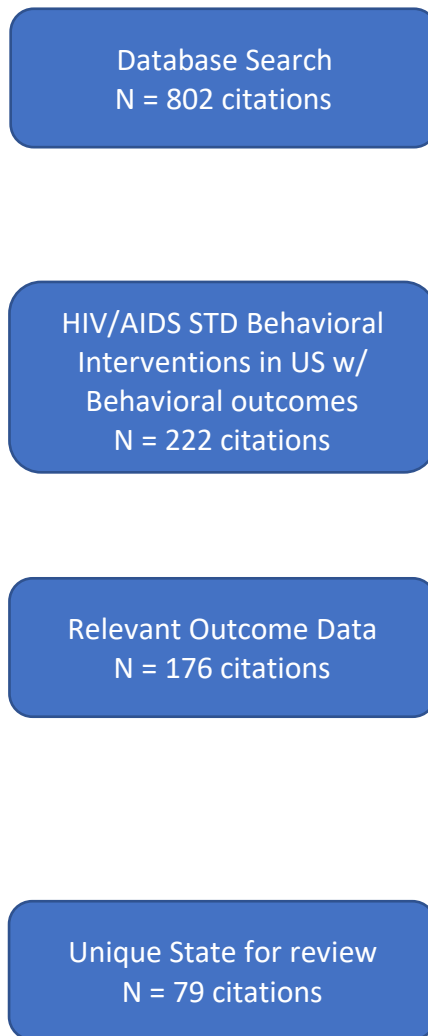


Figure 4.1

⁸ I replicated the CDC – PRS team’s original criteria for selecting interventions within taking an account of intervention that were discontinued overtime. This is why the interventions collected through the systematic review were different from the CDC’s own approach.

Summary of Content of HIV Interventions			
67 Interventions Analyzed	90% had at least One black Participant	38% had majority black participants	19% were made for the black community
6% were made for black MSM	4 Interventions for black MSM	54% of black Centered were in the South	38% of Majority black participants in the South

Table 4.1

Content Analysis of HIV Interventions with Roberts (2012) Race Based Medicine			
	Race Neutral	Race Conscious	Race Liberation
Race	Ignores Barriers	Race is Central	Reconsidered in research design
Racial	Naturalizes difference	Social determinant	Race is not static
Racism	Ignores systems of valuation	Individual autonomy	Structural Factor

Table 4.2

4.5 Accounting for Black LGBTQIA communities in HIV Interventions

4.5.1 Race Based Medicine: Race Neutral Interventions

Race neutral HIV interventions use colorblind race approaches to diminish the presence of black LGBTQIA communities in studies and the impact these communities have on intervention outcomes. Here, race is considered a non-factor or a salient determinant in the outcome of the intervention. Instead of addressing how race, gender and sexuality cohere to impact populations' relationships to risky sexual behaviors, the interventions appeal to universalist notions of disease risks, in particular that the intervention isn't hindered by social or cultural barriers. Therefore, HIV prevention specialists and community-based organizations are expected to adapt the intervention to the needs of their communities. Adaptation of interventions is premised on universal understandings of risk populations. Although studies may have majority black participants or least one black participant, race is not considered factor in the study. The lack of recognition of race within colorblind/race neutral interventions universalizes the study's outcomes across race or naturalizes race in the intervention.

Keep It Up! (Mustanski et. al 2018) is an online sexual behavioral intervention for youth that uses race to diminish the impact of racial difference. *Keep It Up!* uses an online platform to deliver HIV knowledge and sex education to increase safer sexual behavior practices. Participants in the study were ethnically and racially mixed with 63% being from underrepresented communities. Researchers found in the analysis of data that 18 to 24-year-old black men who have sex with men (BMSM) displayed the greatest change

within the intervention's outcome. Within the study, *racial* is used to compare racial and ethnic groups to one another. The intervention language is as follows;

“Keep it Up! (KIU) is an interactive online HIV prevention intervention tailored to racial/ethnically diverse, English speaking YMSM” (Mustanki et. al 2018).

The use of *racial* in the intervention elevates the outcome of the intervention as effective for all racial and ethnic minority groups in the study. However, the intervention doesn't consider how race and socioeconomic structures underpin participants access to intervention materials. Central to the intervention's design is internet access, which only 28% of participants were able to access in their home. Only 62% of black households have broadband internet (Smith 2014). The majority of participants came from Boys and Girls Clubs who were able to give youth participants access to the internet in an afterschool education setting. The interventions use of *racial* to highlight its universal appeal doesn't consider the social and political structures that contribute to the intervention's success. Additionally, the intervention does not consider what happens if participants are unable to access structures of learning that after school programs provide. The use of race dismisses difference between participants, in particular, socioeconomic structures that may impact the intervention's outcome.

Second, race neutral approaches normalize the impact of race in interventions. There is an acknowledgment of racial difference, but race is seen as part of a complex relationship that bears little weight on the intervention's outcome. The HIV intervention *Focus on the*

Future (Crosby et al 2009) is an intervention tailored for black male youth to increase consistent and correct condom use. The target population are black teens and young adults 15 to 23 years old who identify as men. The intervention setting is a health educator within a clinical setting who delivers the intervention to the target population. The context for the intervention is a peer to peer model for black young men that involves a lay health adviser, who is a non-technical staff within a clinical setting. It is through the non-technical staff where a relevant culturally appropriate intervention is delivered. However, the key intervention piece isn't the cultural connection between young black men and the lay health practitioner but that the delivery is from a neutral person devoid of any race, gender and socioeconomic background. The intervention states,

“The program [...] was based on a lay health adviser model. Evidence suggests that lay health advisors are instrumental in achieving interventions success among various populations of African Americans across a broad range of health behaviors. The essence of the model is that the most effect change agents are people who come from the community which the intervention program is intended. This goes beyond the concept of matching by race, age, and gender” (Crosby et al 2009 97).

Without elaborating on the ways in which race impacts the connection between a lay person health practitioner and participants, the intervention doesn't connect community or group formation to any racialization process. The intervention's target population is black young men. However, the study's outcomes are not premised on being black but that the participants come from a community that is reflected in the intervention's study

design. Race is made mute in the intervention in favor of the use of community as connection, which without an explicit elaboration links race with community. The impact is that risk is distributed to the entire community rather than specific groups internal to the community who are most in need of HIV interventions.

4.5.2 Race Conscious

Race conscious perspectives seek the inclusion of racial difference as a determining factor in the intervention's outcomes. With this approach, race is considered a determinizing force in healthcare straddling biological or cultural understandings of black identity and community formation. However, within HIV interventions these are health approaches that pathologize the black community as being devoid of normative structures that prevent the spread of the disease. We see this within the intervention, *Horizons for heterosexual African American Adolescent Females* (DiClemente et al 2009) who are seeking health care services. The intervention highlights that racial disparities do exist and that to overcome these barriers we need to develop culturally relevant interventions by African American health educators. However, the intervention indirectly connects black cultural production to individual risk factors. For example, the intervention takes on identity politics in order to naturalize race in the following quote,

“Given the marked racial disparity in STDs and HIV, there is a clear and compelling urgency to develop risk-reduction interventions for this population” (DiClemente et al 2009 1123).

Racial disparities are naturalized through their connection to STD/HIV infections. The word *racial* compares race and ethnic groups with one another and creates an adverse relationship where race is central to the intervention's outcomes. Race is taken as an actor in the distribution of HIV risks and it becomes a site from which to intervene on the HIV/AIDS epidemic. The use of race establishes a need to understand how race is defined either by cultural, biology or self-identification within the intervention's design.

The second use of race conscious is that it links race as a determinant to adverse health outcomes. The intervention Responsible, Empowered, Aware, Living Men (Real Men) is a group level skill building intervention that involves seven two-hour interventions with black fathers and their adolescent boys (Dilorio et al 2007). The goal of the intervention is to increase sexual abstinence. The intervention's goals are that,

“The intervention appeared to have an effect on delay of sexual intercourse, because adolescents whose fathers attended the HIV sessions had higher rates of abstinence throughout the follow-up period. The overwhelming majority of adolescents in the study were African American, and among male high school students, African Americans have the highest rates of sexual intercourses of all racial/ethnic groups” (Dilorio et al 2007 1084).

By focusing on black fathers, the intervention creates an equivalence between the sexual promiscuity of black children and father figures. This not only creates a limited view of sexual networks among black adolescents, but it also pins the lack of a patriarchal family

unit as a determinant. This produces a false narrative about black people and speaks to a respectability politics within the interventions. Additionally, central to this intervention is family stability within the study design and isn't considered a limiting factor in the intervention.

4.5.3 Race Liberation

Race liberation breaks from colorblind and race conscious perspectives to move beyond racial understandings based in phenotype or identity. Roberts (2008) in her development of race-based medicine points to race liberation as a strategy that understands that “race is a concept that was invented to legitimize racism, not a natural distinction among human beings that can produce racism if not handled properly” (Roberts 2008). Using a race liberation approach necessitates that gender and sexuality be liberated from their binary and normative positions. There are two ways that interventions did this. The first are interventions that recognize that race needs to be addressed in the intervention design. The second are interventions that allow for the emergence of multiple genders and sexualities in the target population.

My research considers Popular Opinion Leader which provides peer to peer interventions for gay men who frequent bars to be a race liberation approach (Kelly et al 1991). The intervention provides HIV knowledge and STD prevention resources to gay men who are stakeholders in their communities. The intervention is unique in that it is one of the first Southern based interventions delivered between the cities of Biloxi, Hattiesburg and Monroe, LA. Although not explicit, the intervention's geography in states with a higher

than average black population, necessitates a reckoning with the black community in the intervention that prompts a race liberation perspective. The intervention states that,

“New intervention components were developed to address the dual identity struggle of Black Men who have sex with men as men who are black and gay” (Kelly et al 1991 168).

The intervention doesn't provide an abolitionist perspective, but it does consider black men as a group who impact the study design. The focus on black men wasn't the original intent but as the intervention was being evaluate, it became clear to researchers that race and racism needed to be addressed in the intervention. The intervention isn't clear on how race or racism will be addressed but it does point to the intervention changing due to the experiences of participants in the study studu. The intervention listened to black participants and correctly changed the study's considerations.

The second race liberation approach takes place in an HIV intervention's attempts to liberate the normative categories of gender and sexuality. The intervention Many Men, Many Voices (3MV) (Wilton et al 2009) is an intervention that addresses racism at the intersection of being both black and queer. Here, the category of Gay includes bisexual participants and people unsure of their sexual orientation. The intervention consists of six - two-hour session at a retreat site, where participants are able to bond and form kinship. The intervention builds kinship through troubling what the heteronormative category of

men. The intervention's name Many Men literally means any self-identified man which allows for a wide view of self-identification. Language states,

“M3V is a small group intervention that addresses behavioral and social determinants and other factors influencing the HIV/STI risk and protective behaviors of Black MSM. These other factors include cultural social and religious norms, identity of Black MSM and their degree of connectedness to Black and gay communities, HIV/STI interactions, sexual relationship dynamics, and the social influences of racism and homophobia” (Wilton et al 2009 535).

This is the only intervention that has transgender men as part of the participant cohort. By troubling the population category of men, the intervention can approach all the ways that family, culture, and religious norms, along with racism and homophobia impact HIV risk behaviors and sexual relationship dynamics. In their approach what they establish is how communities are understood in the intervention, which is central to the interventions ability to intervene in diverse populations. The intervention becomes a site to understand how race, gender and sexuality come together to impact the intervention through a consideration of the ways in which black men occupy a number of different masculine registers which troubles the naturalization of race and its connection to an assumed gender category.

4.6 Discussion

My framing of the politics of accounting and accounting for blackness illuminates the ways in which HIV interventions embody racialization practices that are mapped onto black LGBTQIA communities. The race neutral approach describes HIV intervention's tendency to ignore barriers, naturalize difference and not consider how black LGBTQIA communities are placed into systems of difference. Therefore, the intervention's claim of universal use denies local contexts or specific barriers that impact the interventions outcome for the black LGBTQIA community. Additionally, these generalizations around the interventions use naturalize race, gender and sexual difference given that dummy variables or descriptive statistics are not factored into the intervention's outcome. If target populations and behavioral change are the focus of intervention, then the composition of the target population is necessary to consider. Therefore, what this does is ignore how systems of difference value black LGBTQIA communities within the intervention's design and implementation. With regard to race neutral practices in HIV interventions the "hidden epidemic" is reproduced through colorblind race approaches due to race and its system of valuation not being seen as a factor in the HIV/AIDS epidemic's proliferation.

Colorblind race approaches create a static view of race where black people are depicted as homogenous. This naturalizes black identity formation through biological determination or a dominant cultural expression. Although not explicit in their connection to biological determination, HIV interventions reproduce race as a natural condition of biological difference by centralizing race as a determinant of HIV risks. As a result, race

becomes inseparable from deviant sexual behaviors and rates of HIV infection. Additionally, black cultural expressions are mapped onto HIV risk. For example, black cultural practices like African American vernacular is stigmatized and seen as a barrier that needs to be incorporated into interventions in order to be meaningful to black populations. This makes race into a structural component of the intervention either through population, or the sexual behavior risk which pathologizes black participants in the intervention setting. Therefore, race is made into a determinant that structures one's relationship to the intervention or sexual behavioral change.

A problem that emerges is the relationship between risk at the individual and population level. For example, if a participant is considered a risk, it's not clear if the risk is from individual sexual behaviors, or if the risk is tied to population level behaviors. Stated another way, it is not clear if the intervention is for shared group identity or engaging in a particular sexual act. The intervention reflects that the participants in the study design rather than addressing racial barriers, access, translation and other cross-cultural differences in the adaptation of the intervention. This creates a static approach to understanding the composition of black populations which centers black gay men and black heterosexual couples as the target populations of interventions. Transgender or gender nonconforming individuals with a diversity of sexual preferences are left out of the intervention's design as the target population narrowly defines who is part of the population. With a race conscious perspective this differentiation within BMSM gets lost as interventions are tailor for black gay communities rather than black queer communities or other subgroups.

The race liberation approach considers a fundamental reconfiguration of the HIV intervention's study design. In the first example, Popular Opinion Leader (POL), it's apparent that black gay men in the intervention wanted to talk about race and racism. Instead of continuing the study as is, the intervention adapts to allow for the content of the behavioral intervention to incorporate the concerns of black participants. This moves black gay men from the margins of Southern gay clubs into the center as participants who have the ability to shape the HIV intervention's design. Additionally, a race liberation approach considers differences within black gender and sexual minority communities with attention paid to gender and sexuality. Central is understanding the diversity of gender and sexual experience and expressions within the black queer community. This creates a number of different relationships to the intervention, in particular how participants relate to sexual behavior. This diversity was adapted to consider how gender non-conforming and transgender men are part of men who have sex with men. Also, it challenges the categorical use of men who have sex with men to consider people who are unsure if they fit into the category. These considerations undo the static depictions of race through its articulation with gender and sexuality. By expanding what we consider to be black LGBTQIA communities through the numerous gender and sexual identities of participants, the intervention must expand their use of populations to include the diversity of research participants.

The three race-based medicine approaches show the ways in which racialization practices can be found within HIV interventions. This is important to consider given that the CDC

in their selection and distribution of HIV interventions were not mindful of the race-based discourses that they are promoting. The Prevention Research and Synthesis group conducts routine systematic reviews of HIV prevention intervention scholarship at the behest of the CDC, however, there is not a consideration of racialization practices. In an email correspondence with a representative from the Prevention Research Synthesis Team, I asked about the team's approach to addressing the impacts of the HIV/AIDS epidemic for low-income communities of color. Their response was that the "PRS has conducted several reviews on the populations (by risk groups and race/ethnicity) that are most affected by HIV to understand the disparities and needs/gaps (see the PRS publication list)" (personal correspondence). I took this to mean that the word race is disconnected from racism or racialization practices and was treated as a demographic factor that has its own set of associations with health outcomes. Following the research output of the PRS team, conversations around racism were never centralized. One potential reason for this is that the focus on evaluation of HIV intervention's study design rather than looking at the complexities of the study's participants, limits the uptake of race and racialization processes. This due to enforcing a mandate for the best evidence rather than a bottom up approach that incorporates those who are most impacted by the disease in decisions about what type of interventions to select. As such, what is reproduced through the CDC's selection of interventions makes black LGBTQIA communities into real objects that are placed alongside other inputs and variables of the HIV intervention's design. Therefore, the interventions narrow what we can and cannot know about participants within the interventions, many of which are from black LGBTQIA communities.

4.7 Conclusion

This chapter provides a textual analysis of HIV interventions to consider the ways in which racialization practices impact black LGBTQIA communities within the intervention's study design. Crucial are the ways critical race perspectives lack an explicit focus in interventions. However, regardless of an explicit focus on race, HIV intervention engage racialization practices. Therefore, HIV interventions offer a site to understand how the "hidden epidemic" is produced through unrealized racialization practices that are found in HIV interventions. Additionally, the technology of accounting provides a basis to understand how racialization practices are present, although they are not made explicit. This is due to black LGBTQIA communities impacting HIV interventions as they are accounted for as risk populations within the HIV/AIDS epidemic. For HIV interventions, accounting provides a structure to see how epidemiological and statistical discourses depict the way black LGBTQIA communities as disproportionately disadvantaged, which then maps onto interventions.

As statistical knowledge comes to understand the conditions of black LGBTQIA communities, HIV prevention orients itself to these populations in order to intervene on them. Yet, instead on intervening from the social and political position that black LGBTQIA communities occupy, HIV prevention intervenes through their own top-down logics. Therefore, the production of HIV interventions skips an opportunity to understand how racialization impact black LGBTQIA communities as they interact with interventions. As such, limitations within HIV interventions misappropriates the conditions that black LGBTQIA communities live in and thus reproduce them as hidden

within the production of interventions. In the next chapter, I show how the HIV/AIDS care continuum continuously reproduces the “hidden epidemic” through the concept of triage which structures how black LGBTQIA communities and community-based organizations connect to HIV prevention resources.

Chapter 5

Punitive Health: Triage and Queer Worldmaking in the Hidden Epidemic

5.1 Introduction

In 2015, the Centers for Disease Control (CDC) requested that the Fulton County Health Department return 8.7 million in HIV prevention funding (Burress 2015). The CDC's request comes after a 2012 change in HIV prevention that provided HIV prevention funds directly to local public health departments. Previously, HIV prevention funding was given to large state coalitions who distributed funds to local health departments and community-based organizations. However, this model did not distribute funds to locals most in need, but rather allocated funds equally to health departments and community-based organizations. To fix this, the CDC directly funded local health departments and community-based organizations with the greatest HIV prevention, care, and treatment needs. Under this new funding structure, the Fulton County Health Department received funds to provide HIV testing and getting more people into HIV/AIDS healthcare system. Yet, an internal audit of the health department revealed a lack of oversight and capacity to distribute funds. The audit found that the Fulton County Health Department was not building the necessary infrastructure to carry out funding requirements (Burress 2015). For example, less than half of the 20 million dollars granted was spent in the first year. The Fulton County Board of Commissioners, who oversee the health department, claimed that a lack of institutional capacity to deliver funding requirements and a weak relationship with community-based organizations were factors in the lack of spending. A report from The National Alliance of State and Territorial

AIDS Directors on HIV prevention and local capacity to deliver interventions found that the CDC's switch from funding a coalition-based system to individual health departments left local health departments with limited resources to deliver on funding agreements (NASTAD 2013). As a result, the Fulton County Health Department returned the funding to the CDC funding, resulting in the forced resignation of the director of the department and the passage of legislation to allow for emergency takeovers of county health departments in Georgia. Georgia House Representative Jan Jones commented that the changes were necessary given that "infectious disease do not respect county lines" and House Bill 885 provided the tools to create a better synergy between the state and county health systems (Kass 2016). Overall, the state decided not to take over the Fulton County Department of Health, however, HB 885 gave them the authority to do so.

In this chapter, I consider the ways in which the Fulton County Health Department's return of CDC funds illuminates the punitive aspects of HIV prevention landscapes which are central to state intervention into the HIV/AIDS epidemic. HIV prevention landscapes represent the social and political environments that black LGBTQIA communities must engage in order to access HIV prevention resources. Central to HIV prevention landscapes are the ways funding is distributed, top-down, from funders like the Centers for Disease Control to local public health departments, who then distribute resources to community-based organizations. I argue that HIV prevention landscapes are punitive in that they create barriers to access through their structure, which represents the health intervention concept of triage.

My use of triage elaborates the ways in which HIV prevention landscapes are premised on funding and prevention delivery models that are structured through the logics of crisis. Therefore, triage is fundamental to understand why the Fulton County Department of Health had difficulty delivering on funding requirements. In making this argument, I consider a larger body of material and imagined response to the HIV/AIDS epidemic that is premised on deficiency. It is deficiency and an assumed lack of resources that informs public health response to HIV prevention, care, and treatments. To develop the ways in which triage points to structural deficiencies within HIV prevention landscapes, I use examples from three local community-based organizations and their relationship to HIV prevention in Atlanta. I follow these organizations in order to demonstrate the ways that “triage” structures their relationship to funding, HIV interventions, and prevention.

Triage refers to the combination of social and political forces that create hierarchies of resource allocation based on the perceived need among people who must use these resources. Triage is enacted when there is a need for quick action with limited resources. Ideally, those with more need and whose lives can be saved by the intervention are the ideal subjects of triage. Therefore, triage reflects health care delivery decision making as limited resources force those in positions of power to allocate based on the needs of those who are worth saving. However, rather than triage signaling a new crisis within the HIV/AIDS epidemic, I argue that triage is ongoing and present given that HIV prevention resources have always been limited which operationalizes crisis as a response to the HIV/AIDS epidemic in the United States. For example, domestic HIV prevention funding has remained flat for the last 20 years, with an average 3% of Federal HIV/AIDS funding

marked for domestic prevention (KFF 2019). State and county health departments who allocate HIV prevention funds to local communities do so with limited funding, which brings triage thinking into the delivery of funds and resources. Additionally, community-based organizations who implement HIV prevention, care and treatment do so with limited resources. Therefore, organizations engage in triage in order to distribute funds within the organization. With varying degrees of capacity and resources, every role within HIV prevention landscapes operates under the logics of triage. Therefore, HIV prevention landscapes are built on a number of triages at different scales, as state, county, and local organizations make decisions on what to prioritize within communities that are in need of interventions.

Triage expands our understanding of health resource allocation and community engagement of health through landscapes in two ways. First, it highlights how health care in the United States is punitive. I understand health care to take a punitive logic through its connection with neoliberal restructuring of health care delivery and the lack of universal health care access. Under neoliberal and a lack of health care access, health care is purposefully distributed with a limited capacity in order to benefit capital accumulation practices in the form of managed care organizations and hospital networks (Robinson 2001). Not only has this led to an exorbitant increase in health care costs, it creates a system in which access to different care, treatment, and prevention options are limited. Second, “triage” invites us to consider the ways in which the intersections of cultural, social and political environments create landscapes that black LGBTQIA communities must navigate in order to access HIV prevention resources. I show how black LGBTQIA

communities shape landscapes through their response to limitations in HIV prevention resources. Therefore, HIV prevention landscapes are central to how black LGBTQIA communities navigate the triage of HIV prevention resources and how black queer communities create alternative health practices within landscapes.

In what follows, I analyze the ways in which community-based organizations respond to limitations in HIV prevention resources as they navigate HIV prevention landscapes in Atlanta, GA. Through the Queer of Color Critique lens of belonging and kinship, I am critical of how triage creates sites of antiblack violence and how black LGBTQIA communities must resist antiblack violence and shape the logic triage within HIV prevention landscapes. To make this argument, I use ethnographic and archival data from three community-based organizations in Atlanta, GA. I trace how their response to the HIV/AIDS epidemic provides a platform to understand how triage is navigated in HIV prevention landscapes. Through their histories and stories, I show how triage functions within HIV prevention landscapes as an outgrowth of a larger punitive health care system that has impacted how the United States engages in health care. I argue that the black LGBTQIA community's relationship to HIV prevention landscapes and triage are shaped by their own response and social actions. I conclude by focusing on one organization in particular, detailing the ways they challenge triage within HIV prevention landscapes.

5.2 Punitive redistribution, Punitive Health – Hospital Closures and Managed Health

In this section, I establish a “punitive health” approach through a consideration of universal health care, hospital closures and the rise of the managed care movement in the US. These considerations provide a set of contingencies to understand the ways that the social mandate of universal health care is met with capital accumulation strategies and punishment logics. As a result, health care is made individual and punitive rather than collective.

My use of “punitive health” can be attributed to Ruth Wilson Gilmore’s (1999) elaboration of rise of the prison industrial complex as a social fix to a crisis of capital accumulation and surplus labor populations in the 1960s and 1970s. In her analysis, this crisis led to a shift away from a military Keynesian redistribution of wealth to a post-Keynesian model that saw the retrenchment of government social services and the movement of capital accumulation away from inner cities. In the early 1970s, a social problem emerged where the stagflation of the 1970s, mass unemployment and militant radical activism created a social problem where people were challenging inner city degradation and capital’s retrenchment from urban centers to the suburbs. Gilmore (1999) points out that “no central, strategic plan emerged to employ the state’s capacities and absorb the national surpluses for finance capital, land or labor” (179). Therefore, instead of addressing the lack of urban capital investment, white flight, and inner cities with little resources, governments increased policing and punishment, which brought social movements into punitive incarceration structures. This marks a turn away from

government-sponsored, socially-driven support based in a redistribution of resources to a punitive logic to address social problems. Mass incarceration, in Gilmore's analysis, becomes a solution to deal with the social and economic problems of the time. For example, prison expansion provides another site for capital accumulation and a structure to subsume surplus labor and provide jobs to rural and suburban locations. Therefore, racial and ethnic minority communities find themselves under incarceration logics of jail, prison, parole or other conditional freedom practices.

With Gilmore's (1999) scholarship in mind, the move from a military Keynesian to a carceral Keynesian as a social fix to a labor surplus and the radicalization of racial and ethnic communities can also be applied to health. I situate a similar move within the relationship between hospital closures and the emergence of the managed health care movement. In elaborating this connection, I demonstrate the ways in which government retrenchment of resources alongside the encroachment of the private health care market generates a punitive health logic, which provides the foundation to understand forces that propel triage within HIV prevention landscapes.

5.2.1 Punitive Health

The passage of Medicare and Medicaid in 1985 marked the first large scale government health care reform legislation. Both emerged from social pressure to provide universal entitlements for the elderly and basic provisions for the poor. Medicare provides care for retirees, disabled workers. Medicaid provides health care to low income families and individuals. Medicare and Medicaid emerge due to the growing costs of medical care for

the elderly and their inability to pay (Loyd 2015), an ideal period of social expansion before racialized logics overtake national discourse of social redistribution (Brown 1996), and the government's attempts to control the cost of healthcare (Hossler 2011).

Additionally, as part of the passage of Medicaid and Medicare, companies were given tax incentives for providing employment-based health insurance. However, Medicare and Medicaid placed the social pressure for government sponsored health care into individuals and privatize corporations. Medicaid was structured in a way that its expansion could be limited through states, which were given the power to determine funding allocations based on a number of individual factors (income, family size, criminal past etc.). Additionally, the government with Medicare paid for care through individual vouchers that could be used within private medical systems (Loyd 2015).

With the government fronting health care costs, this decreased pressure on health care providers to provide care and placed scrutiny on the government to keep costs in check (Hossler 2011). There, the blame for rising health care costs was directed not at health *providers*, but on the government itself for matching increasing payment of Medicare. A problem emerges in which the private health care market increases costs, while the government is focusing on cutting cost. In considering of this dynamic, I take urban hospital closures during the 1960s and 1970s and the emergence of the managed care movement as a reflection of the relationship between government and private health care.

What this looks like is a relationship between a social mandate of health care along with capital accumulation strategies that results in the government taking health resources away from low-income communities of color and into health-based capital expansion in

rural and suburban areas. I argue this is the foundation of punitive health; government retrenchment alongside capital expansion of health care resources.

The social mandate to expand health care while cutting costs ultimately fall on hospitals to enact within health care markets. Hospital closures represent a move away from healthcare organized around care for the poor and instead increases share of private health care in health care markets. For example, between 1937 and 1977, in neighborhoods with over 76% black populations in the Midwest, nearly half of all hospitals that existed in 1937 closed by 1997 (Whiteis 1998). Additionally, between 1972 and 1978, nationally, 315 community hospitals closed (Sager 1983). Nationally, there was a sharp reduction in hospitals in major cities which fell in 52 major cities from 781 to 426, with a 46% drop in 1970 (Whiteis 1998). For comparison, in 1950 public hospitals accounted for a third of all hospital beds and by 1985 they accounted for one-seventh of all beds (Sager 1983). Reasons given for closures were a lack of public investment and the general increase in hospital spending. Researchers have found a link between the lack of Medicare reimbursement at inner city urban hospitals that caused hospital closures (Feyman et al 2016). Concurrently alongside hospital closures, the managed health care movement emerges to reduce health care cost and to provide better access to care.

Health care management organizations (HMOs) emerge as the vehicle through which new capital accumulation strategies are enacted. HMO enrollment increased 12% each year from 1970 to 1999, increasing from 3 million people to 89 million people (Markovich 2003). Additionally, the number of hospitals with at least one contract with

an HMO increased from 57 percent in 1990 to 68 percent in 1994 (Gage 1998). The move to managed care models were billed as a solution to address rising healthcare cost while also addressing the lack of health care in particular locations. This resulted in hospital mergers but also a 27% consolidation of hospitals in metropolitan statistical areas (Feyman et al 2016). Additionally, high health care cost were addressed through provider networks which created contracts with cheaper health care inputs and services in order to keep costs down. Therefore, the managed care movement reflects a socially produced product with non-profit and for-profit mechanisms at the helm.

Managed care is a reflection of the need to stabilize health care costs through the idea of choice. Ultimately, it was a short-term solution to the high costs of health care with a social individual mandate for health care access. Light (2006) shows that “managed care was selected as a marketing strategy to borrow the trust and respect implied in this clinical term, for how responsible physicians managed the care of patients with a complex disorder, in order to disguise what investors intended” (35). Therefore, the public buy in was leveraged on individual trusts of their preferred health care option, which was publicized to reduce costs, but ultimately increased profits in the end. Key to this was consolidating the number of health care providers through hospital and care facility merges. Robinson (2001) notes that “controlling health care costs behind the scenes is difficult even in the most propitious circumstances; it became volatile in the context of reports of excessive profits, bureaucratic hassle and exorbitant executive earning” (2623). The end of managed care comes from the tensions of dealing with limited health care resources and the social expectation to retain healthcare costs.

However, the impact of hospital closures is due to a comprise between social pressures and capital interests, which provides the foundation for punitive health care.

Thus, “punitive health care” speaks to the outgrowth of revanchist policies at the intersection of a lack of government support, private health care expansion, and health regulation at the expense of low-income communities of color in cities. Residents within cities must engage in a reduction of overall health care facilities and increased costs of care which leaves many without insurance or the ability to pay out of pocket health expenses. Without the ability to pay for care, barriers are placed to access, delivery and the amount of resources available which creates a punitive system when one seeks to engage in health care. This is central to the underutilization of healthcare among poor individual and groups of people who access healthcare within cities (LaVeist, Isaac, and Williams 2009). My use of punitive healthcare is to demonstrate the ways in which the social mandate of care is placed into individuals in the form of choice. It is through punitive health that I explain the ways in which HIV prevention becomes under resourced in Atlanta, GA. HIV prevention, like health care, has undergone a retrenchment of government support while there is a social mandate for those who are at-risk of infection, or infecting others, to seek out care. I argue that this leads to the triage of HIV prevention care in which limited funding, a lack of care options and social pressure to know your HIV-status and enter into care, create a number of barriers that black LGBTQIA communities must navigate.

5.2.2 Atlanta HIV Prevention Landscape and Care Continuum

In the Metro Atlanta area, the black population is 32% of the population but suffers from disproportionate rates of infection. Within Atlanta, there are over 36,000 people living with HIV (AIDSVu 2017). Among this population, 70% are black, 6% are latinx and 18% are white (AIDSVu 2017). Further, 80% of those who are HIV positive self-identify as men. Additionally, Atlanta accounts for over half of HIV/AIDS related deaths in Georgia. Black men are 5 times and black women are 15 times more likely than their white counterparts to have a positive HIV diagnosis when compared to their white counterparts (AIDSVu 2017). For Latinx communities this number is 1.4 times for men and 4.4 times for women. Finally, the numbers for new diagnosis from 2013-2017 were 73% black, 8% Latinx and 14% White (AIDSVu 2017).

The strategy to address disproportionate rates of infection follows the Obama Administration's 2010 National HIV/AIDS strategy which centers getting people tested and linked into care structures (White House 2010). The goal is to get individuals with first time HIV diagnosis into treatment and care within three months. Comparatively, in Atlanta, 17% of those who are newly diagnosed with HIV within 3 months have transitioned to AIDS (AIDSVu 2017). Therefore, linkage to care and the care continuum is necessary to stopping the onset of AIDS and the spread of HIV. Care involves first time visits, retention into care, and being virally suppressed. Additionally, as part of the national HIV/AIDS strategy, the goal is to have 90% of people to know their status, 90% in care and 90% virally suppressed before 2020. Atlanta's county, Fulton County is still a way off from the 2020 goals of the Obama administration. In 2013, within Fulton County

76% of people who were newly diagnosed with HIV were linked to care. Among existing people living with HIV/AIDS 59% had any care, 46% were retained in care, and 42% were virally suppressed (Fulton County 2015). For the State of Georgia, 66% of new HIV cases received any form of care, 51% were retained in care, and 52% were virally suppressed. Finally, in Atlanta, there are over 20 + AIDS-service organizations providing HIV prevention, treatment and care services (Fulton County 2017).

I argue that punitive health logics explain the disproportionate rates of HIV infection among Atlanta residents and their access to care. This lack of health care comes in the form of HIV prevention, care and treatment services. Carter and Flores (2019) note that “the current HIV prevention and care landscape is heavily driven by individual-level clinical and biomedical approaches that have shown progress in reducing HIV diagnoses but yield less than results in reducing the HIV racial disparities for Black MSM in the South” (331). Therefore, punitive health in HIV prevention landscapes in Atlanta have two central components; the first is access to prevention and care resources. The second are social, political and economic considerations that exasperate health disparities. It is within HIV prevention landscapes that communities in need of resources must interact with their environment in order to access those services. Therefore, HIV prevention landscapes are a decentralized response by state, local health departments, and community-based organizations. Additionally, HIV prevention landscapes involve formal and informal organization, and community members who do care work outside of a formal intervention settings. Therefore, my research on HIV prevention landscapes in Atlanta, GA highlights how triage shapes not only access to interventions but how social,

political and cultural deficiencies can be found at all levels of HIV prevention. As such, there are a number of different actors who engage in HIV prevention activities, but the care continuum remains unchanged.

To reiterate, the punitive health logics of HIV prevention are structured at the intersections of a lack of services and resources and individual responsibility that is tied to access to prevention, care, and treatment. What this does for HIV prevention is require that people seek out care rather than care coming to them. HIV prevention care and treatments are available, but the key is getting people into to care *and* keeping them within care.

Triage provides a site to understand this particular HIV prevention landscape. Through top-down delivery of care from federal to state to communities, racialization practices inform health care systems that are then mapped onto HIV prevention delivery. The end result is a paradoxical HIV resource delivery system that limits the number of providers giving services and those who have access. In order to understand this dynamic, I turn to queer of color scholarship around counterpublics and health geography literatures on landscapes to understand the ways in which the outcomes of triage limit access to health access but also create opportunities for activism. This framework offers a view of triage that isn't all encompassing and points to how communities navigate the landscape. In so doing, I demonstrate that these landscapes, shaped through HIV resources, are not fully determinate and that organization or people can limitations in resources. This framework helps illuminate the limits of HIV prevention landscapes as black LGBTQIA

communities and organizations navigate these landscapes. I am particularly interested in how queer worldmaking impacts our understanding of triage and how HIV prevention landscapes are constructed in Atlanta, GA.

5.3 Triage

In its colloquial use, triage is a method for prioritizing those who will receive care immediately and those who will have to wait for care. It is an approach to distributing scarce health care resources which creates a social order of decision-making empowering those with power to make decisions for others through the implementation of the triage (Iserson and Moskop 2007). Triage originates on the military battlefield, where wounded soldiers were evaluated based on severity of injury and their ability to survive to determine who could return to the battlefield as soon as possible. Over time, with the development of hospitals and advances in medicine, triage is standard within emergency departments, hospital admissions, larger scale incidents like multicar highway pileups and disaster. Triage informs a central technology of health care delivery and access for those who need critical care. However, triage not only establishes the distribution of health resources but, I argue, it speaks to how society values life.

I frame triage as a reflection of social judgments and values through the body of scholarship on sovereignty (Agamben 2005; Agnew 2005; Ong 2006). My use of sovereignty seeks to build on considerations of the state of exception (Agamben 2005) and biopower (Foucault 1978) to consider how sovereignty is made routine and natural for marginalized populations. Agamben (2005) in his work on the state of exception, is

not concerned with the exception to law but how the state of exception denies people from having access to life afforded by the law. He is interested in a space outside of the law between bare life and citizenship. He contends this is missing from Foucault's (1978) elaboration on the subject due to Foucault being concerned with sovereignty as the distinction between life and death with life being central to sovereign power. Foucault states the sovereignty "is not the right to put people to death or to grant them life nor is it the right to allow people to life or to leave them to die. It is the right to take life or let live" (Berlant 2007: Foucault 1978). However, the distinction between sovereignty in Agamben's and Foucault's work is a question of; what is the quality of life for people who exists in-between life and death? Therefore, the state of exception gives a spatial temporal order in the space between Foucault's "take life or let live." Therefore, I want to expand from the spatial temporal order of the state of exception to consider how triage is an expression of sovereignty.⁹

I take sovereignty as it is articulated through the concept of the state of exception as an expansive formulation. The state of exception demonstrates, according to Agamben's logic, how the exception is in fact the rule. However, the use of the state of exception speaks to an abnormal legal order that sits adjacent to a normative relationship where full citizenship exists. I develop a different order built with Gilmore (2002), Ong (2006), Weheliye (2008) and Nguyen (2010) to consider the state of exception as the law, not the

⁹ Scholar's critical on Agamben's use of bare life as the ultimate subjective expression of the state of exception have brought in considerations of slavery, settler colonial, and colonialism to show how Agamben's camp is a central feature of a racialized modernity (Moregensen 2011; Ziarek 2008; Sharpe 2012).

exception to the law. Weheliye (2008) through a reading of Gilmore (2002) describes that the inclusionary process of the state of exception on groups of people are nothing more than the everyday articulations of racialization and racism. Weheliye (2008) notes that “in the end, we do well to recall that racism, whether in the colony, the concentration camp, the plantation, the prison, or in Guantanamo Bay exhibits no dire need for a legal state of exception, although it has a hard time it when offered as a fringe benefit” (70). Sovereignty isn’t found in the choice of who dies but the natural order of a world build on racialized difference, which produces hierarchies and exclusions. Therefore, I configure triage not as the exception to a normative order of resources but the fundamental logics within HIV prevention and the HIV/AIDS epidemic. Hence, triage, as a state of exception, is the normal logics of the health care delivery system.

Triage, as I understand it, reflects and enacts the routine orders of biological citizenship. For example, HIV/AIDS activism is built through the narrative of (white) gay men and their political activism as the right way to produce an adequate response to the epidemic. It was this political formation that allowed people living with HIV/AIDS to come together as a body to seek redress from private health care companies and the federal government. However, due to the racially uneven landscapes of the HIV/AIDS epidemic, black individuals and populations are limited in engaging in the same types of biological citizenship as their white counterparts. Therefore, triage illuminates how the HIV epidemic, in particular prevention, is structured to elevate particular subject positions over other relationships. VK Nguyen (2010) points to a therapeutic sovereignty that highlights how under differentiated forms of access to HIV resources, people must adapt

to selected subjectivities. Taking HIV drug treatment therapies in West Africa as a case study, Nguyen finds that HIV positive people must meet ideal narratives that Western NGOs set forth in order to gain access to drugs. Here biological citizenship is premised on one's ability to enact different subject positions. Instead of a biological citizenship premised on individual and group collective action, Nguyen points to a type of citizenship that emerges when "large, stable institutions that can grant access to life-saving therapies are absent" (109). Therefore, if limited resources highlight variations in how individuals and populations engage biological citizenship, then the ongoing logic of triage means that there are differentiated forms of citizenship for black gender and sexual minorities. I argue that HIV prevention landscapes are the sites from which forms of triage are enacted and where community-based organizations and the LGBTQIA community must interact to access resources.

Triage is a conceptual tool to understand the ways in which the relationship between HIV prevention resources and the communities who access them are held together under the logic of a state of exception grounded in deficiencies. In showing the ways in which triage is foundational to HIV prevention landscapes, I illustrate the way health landscapes are produced through the experiences of individuals and populations as they interact with the environment with regard to health. Here, I engage critical geography literature on landscapes and demonstrate how they exist at the intersections of power and the experiences of people who seek them out. I then highlight the limitations of triage and the ways it can create a counter public that is central to queer world making within HIV prevention landscapes. I focus on Queer of Color Critique's use of worldmaking which

allows for a contextualization of the ways queer futurity navigates the enactments of triage.

5.3.1 Triage and HIV Prevention landscapes

I situate triage within HIV prevention landscapes to trace the ways in which ongoing practices of exception within the HIV/AIDS epidemic are built from the interrelation between health environments and black LGBTQIA communities. As a foundational term in geography, landscapes center the relationship between humans and their subjective relationship to the environment. The human and environment relationship comes from the work of Sauer (1925) and his concern around anthropocentric changes to the land as the basis of understanding geography as a discipline. Their concerns emerge from debates about how to make Geography into a science by challenging claims that environmental determination in the form of a pure unaltered nature is needed to make Geography an objective science (Hartshorne 1939). These early bodies of scholarship on landscapes produce two different strands of thinking within geography that can align with current considerations around qualitative and quantitative research methodologies (Barnes 2001), liberal economics and political economics (Harvey 1973) and a positivist scientific understanding of the environment compared to anthropocentric relationships (Robbins 2011). However, my concern is with the anthropogenic relationship between humans and the environment, which together co-produces our understandings of landscapes.

My use of landscape approaches the human and environmental relationship through the concept that health environments are *unsettling*. Doreen Massey (2006) highlights the

need to unsettle landscapes given that they are perceived to be a stable construct that allows for a seamless interaction between the environment and people's perceptions of the environment. Massey notes that with landscapes "the emphasis is on constant movement, the ineditability and inexorability of processes (rather than entity); on flow rather than territory" (40). Landscapes act as representations of a foundation or something fixed that people can have stable interactions with. Yet, what isn't considered is how the object of representation, a hill or mountain, is part of a larger system of disciplinary structures that allow for the environment to be of human use. For example, Stone Mountain's development as a large piece of quartz outside of Atlanta was part of a geological event that has been reimagined for the use of white supremacy politics (Kruse 2013). Here, nature is used to legitimize antiracism, however this alludes other uses that may have been present for indigenous populations to the area. Key to Massey's (2006) use of unsettling are that the stabilities found between a place and nature are fluid and dependent on systems of knowledge production in place. Therefore, I bring instability and fluidity to landscapes as this is part of how health landscapes are experienced.

Health geographers have been attentive to the role of landscapes in shaping the relationships between individuals, populations, and health. Scholars have generally focused on inequality and the ways in which landscapes, as part of place, produce adverse health outcomes for people (Craddock 1995; Brown and Duncan 2002). In contrast, health geography scholarship has sought to understand how landscapes promote healing or good health (Kearns 1993; Gesler 1993). Scholars use the concept therapeutic landscapes to draw attention to how places have health enabling processes. Therapeutic

landscapes consider the ways place is central to health promotion beyond biomedical treatments and practices. Central to this work has been demonstrating the ways in which social and political understandings of health are reestablished through the healing properties of landscapes. Scholarship on therapeutic landscapes has paid attention to environment therapeutic properties like hot springs (Gesler 1993), neighborhoods (Finlay et al. 2015) and love (Wylie 2009). Scholarship on therapeutic landscapes focuses on place as a historical, political and social formation that converges with the environment to mediate health experiences (Kearns and Moon 2002). Inherent in the body of literature above is that landscapes are produced through a setting or place that generates a positive therapeutic experience. However, scholars have been critical of the universalizing nature of therapeutic landscapes, showing that it is differentiated based on individual experience (Andrews and Holmes 2007), and that it may produce risk or even harms (Milligan 2007). Regardless of the outcome of experiences, I want to consider how landscapes are produced through the social, physical and symbolic understandings of environments, which impacts how health outcomes are experienced.

My use of landscapes attends to the ways in which dominant *and* therapeutic landscapes structure black LGBTQIA communities' relationship to HIV prevention. Therefore, triage draws attention to the reality that HIV prevention does provide necessary interventions while also having barriers that make access difficult. This intersection brings forth the ways in which environments have a multitude of different qualities that communities seeking health outcomes must negotiate.

5.3.2 *Queer of Color Critique and Triage*

On one hand HIV prevention landscapes describe the ways in which environments are constructed and on the other landscapes consider the ways people navigate these environments. I take both considerations of HIV prevention landscape and place them in conversation with queer of color critique in particular its use of queer counterpublics and worldmaking as strategies to navigate limitations in HIV/AIDS prevention. My use of queer counterpublic comes from Berlant and Warner's (1998) who trace the use of counterpublic from Nancy Fraser's (1990) *subaltern counterpublics* to demonstrate the ways minority populations emerge to resist majoritarian domination. Fraser states that "subaltern counterpublics signal that they are parallel discursive arenas where members of subordinated social groups invent and circulate counter discourses, which in turn permit them to formulate oppositional interpretations of their identities, interests, and needs" (67). However, Warner (2002) takes aim at Fraser's formulation of counterpublics around a question of clarity as it relates to how a person is situated in a counterpublic. Warner notes that "a counterpublic maintains at some level, conscious or not, an awareness of its subordinate status. The cultural horizon against which it marks itself off is not just a general or wider public, but a dominant one" (86). Additionally, Berlant and Warner's (1998) use of queer world making follows that "by queer culture we mean a world-making project, where "world" like "public," differs from community or group because it necessarily includes more people that can be identified, more spaces than can be mapped beyond a few reference points, modes of feeling that can be learned rather than experience as a birthright" (558). Therefore, membership into a counterpublic is understood through a continual subordination to dominant social forces. Queer

counterpublics takes abjection, stigma, taboo, and otherness as sites that inform one's connection to the world. Queer Counterpublics form through culture expressions across a varying degree of landscapes (Moon 2006). What emerges are queer worldmaking practices where queer counterpublic engage in performances that "have the ability to establish alternate views of the world. These alternative vistas are more than simply views or perspectives; they are oppositional ideologies that function as critiques of oppressive regimes of "truth" that subjugate minoritarian people" (Muñoz 1999 195). Muñoz elaborates on queer counterpublics practices has taking heteronormative sexuality and gender expression and transforming them into raw materials for new uses. Therefore, I take both Muñoz (1999) and Berlant and Warner's (1998) definitions together to create an approach to queer worldmaking as an outgrowth of a queer counterpublic that's fundamentally spatial and cuts against normative heteronormative and homonormative, gender and sexual, expressions in landscapes. Central to both approaches consider the ways a public is defined and how this public extends beyond geography and cuts across social identities. For example, queer identity as a public is expansive and just doesn't encompass gender and sexuality but a political stance that is transgressive to dominant normative power (Cohen 1997). Therefore, I consider queer worldmaking through process that are able to transform geographic scales of domination. If particular, I am interested in the use of disidentification to achieve this aim.

Disidentification provides one way to understand how individual and population emerge into a counterpublic. Muñoz (1999) builds from Althusser (1970) and Pêcheux (1982) to situate disidentification as a relationship between subject formation and dominant

ideology where individuals and populations oppose and work against dominant ideology. Key is how the interpellation of subject formation, within an apparatus, is addressed rather than a non- engagement. Queer of color points to how subject formations for queer subjects' interest with race. Much like racism being a foundation to the emergence of capital as proliferated through notions of racial capital, queer of color critique takes race as a central feature of how queerness is understood and articulated. Therefore, Muñoz's (1999) use of the term tactical misrecognition is key to understandings the ways disidentification utilizes race, gender or sexuality to extend beyond preformed subject positions as they are attached to social, political and economic categories. Therefore, "disidentification permits the subject of ideology to contest the interpellations of the dominant ideology" (Muñoz 1999 168). "To disidentify is to read oneself and one's own life narrative in a moment, object, or subject that is not culturally coded to "connect" with the disidentifying subjects. It is not to pick and choose what one takes out of an identification" (Muñoz 1999 12). This latter point is crucial as it recognizes the seriousness of dominant forms of oppression that operate to produce individual or group subject formations. Muñoz uses performance to show how ideologies are challenged and how they map onto representations and subject formations. For example, black LGBTQIA communities engage in a triage system of HIV prevention and perform a tactical misrecognition of that in order to get their needs met, while also promoting the world that they want. For organizations, this may mean performing the limiting demands of funding through workplaces in order to translation that recognition – in the form of funding – into black ballroom spaces (Bailey 2014). Or, this tactical misrecognition of

the HIV/AIDS virus where queens as “mothers” tell their children that they can be sexually active as long as there are safe.

Similarly, Ferguson (2004) articulates disidentifications as a method to address and disarticulate from a historical materialism which he scrutinizes for taking class struggle over other social relationship. “Disidentifying with historical materialism means determining the silences and ideologies that reside within critical terrains, silences and ideologies that equate representations with reality” (5). Ferguson’s use of disidentification as a method to point to silences around race, gender and sexuality within historical materialism. From both Ferguson (2004) and Munoz (1999), disidentification is a method of investigating limitations in dominant forms of power that produce subject formation. Therefore, disidentification articulates material practices that queer communities engage with in order to create a counterpublic. This provides one way to understand the ways in which group affiliation can take place and a new world can be built from dominate strategies. Therefore, triage allows us to understand how power functions within HIV prevention and disidentification creates a methodological tool to look for how power within HIV prevention silences race, gender and sexuality.

Queer worldmaking through disidentification as I have mobilized them here provide a lens to understand the ways in which triage functions within HIV prevention landscapes and how communities counter and create new worlds from misuses of power in HIV prevention. I take disidentification of HIV prevention landscapes materially through the actions of black LGBTQIA communities in two ways. First, through the transformation

of space. With uneven geographical development in the South, in particular, the emergence of new south gentrification there is a lack of dedicated black queer space. However, through strategic partnerships with sympathetic establishments, black queer communities are able to repurpose normative spaces and make them amendable for black LGBTQIA communities. With regard to HIV prevention, CBOs and community members create a number of informal spaces in parking lots, shopping centers and community centers to develop HIV-related care through spaces that are transformed for different uses. Second, HIV-related risk, which inform which behaviors HIV prevention interventions intervene on, are transformed into spaces of empowerment, where risk becomes the basis for community connection and inclusion around social, political and cultural expressions. For example, instead of limiting sexual acts, political education about sexual acts as a way to understand how stereotypes limit people's ability to fully understand their sexual risks. Therefore, risks are transformed in order to produce community connections and other forms of intimacies.

I argue that response to limitations in HIV prevention in Atlanta, GA can be understood through the queer worldmaking strategies of black LGBTQIA communities as these disidentify from the logics of triage and resource strapped HIV prevention landscapes. Through the program activities of three organizations and their membership who are part of black LGBTQIA communities, we can see not only how triage structures their relationship to HIV prevention recourses but how through their practices these limitations are challenged through a counterpublic based in their relationship to HIV prevention

landscapes. To challenge an HIV prevention landscape, is to engage in a specific type of queer worldmaking.

5.4 Three Community Based Organization in Atlanta GA

In what follows, I provide narratives of three community-based organizations who provide HIV prevention services to black LGBTQIA communities in Atlanta. The narratives situate the organizations within the HIV prevention landscape and addresses a number of events that highlight the unpredictability of HIV prevention. Therefore, I consider organizational histories that intersect with the unpredictability of the HIV prevention landscape with regard to funding, homegrown HIV intervention programs, and refusal of certain types of HIV funding. The three organizational profiles suggest that the logics of triage, in terms of distributing HIV/AIDS resources, is dependent on funders, community-based organizations and the black LGBTQIA community. Yet, community-based organizations' relationship to funders are only one part of their social engagement and doesn't define how they participant in co-producing a counterpublic in response to the unpredictability of HIV/AIDS prevention landscapes. It is through community-based organizations and community members coming together through community empowerment, self-love, and personal narrative that allows for HIV prevention landscapes to be challenged and transformed to the needs of black LGBTQIA communities.

The organizations profiled have a long-term engagement with HIV/AIDS activism and advocacy in Atlanta. The first organization AID Atlanta formed in 1982 as a fundraiser for the Gay Men's Health Crisis in New York City to provide monetary resources. AID

Atlanta provides HIV prevention care and treatment services for people living with HIV/AIDS in Atlanta's Midtown neighborhood, which is Atlanta's first gay neighborhood (AID Atlanta Archive; Remembering AIDS Archive). The second organization profiled is Sister Love. Sister Love was one of the first HIV/AIDS community based organizations to support black women in the United States (Remembering AIDS Archive). Founded in 1991, Sister Love formed in response to the demands of black women who wanted HIV/AIDS education. The Counter Narrative Organization, founded in 2014, centers the principle of black men loving other black men in order to address the HIV/AIDS epidemic. This is done through a narrative driven intervention strategy that centers black gay and bisexual communities and their concerns into HIV prevention. This provides a platform for black gender and sexual minorities to have belonging, home, kinship within HIV prevention landscapes.

The organizational profiles demonstrate the ways in which HIV prevention landscapes are navigated and challenged. These organizations have different relationships to the HIV prevention landscape around operation budgets, target populations, missions and programs delivered. Therefore, this section considers their changing relationship to the black LGBTQ communities and HIV prevention in line with changes in funding, interventions, and discourses of the epidemic. In what follows, I will provide a short profile of each organization and their relationship to the HIV prevention landscape.

5.4.1 AID Atlanta

AID Atlanta, arguably, has been the focal point of organizational advocacy and response to the HIV/AIDS epidemic in Atlanta. AID Atlanta receives a large share of HIV prevention funding in Atlanta and has one of the largest program budgets in the US Southeast to address the epidemic (Staples 2017). AID Atlanta has an operating budget of 7.6 million with 100 staff members. Given AID Atlanta's long history within the epidemic, it has provided fiscal support to smaller organizations looking to address the HIV/AIDS epidemic within underserved populations. With 2.5 million people in the Atlanta metro area, AID Atlanta provides health care to a number of populations.

In 2017, AID Atlanta's relationship to the CDC and HIV funding changed when the CDC decline funding for AID Atlanta's prevention program for young men of color who have sex with men. The funding in question was the PS17-1704 program announcement which provided funding to reduce new infections, increase access to care, and promote health equity among young men of color who have sex with men or young transgender communities of color. PS17-1704 provided 50 million dollars in HIV prevention funding to 30 cities. For this funding cycle, only two organizations sought funding from the Atlanta metro service area. Previously, from 2011 to 2016, AID Atlanta received CDC funding for a similar grant (AID Atlanta v. HRSA 2018). However, for the 2017 funding cycle, AID Atlanta was denied funding. In what would be a \$350,000 decline of their operational budget in the organization and the closing of the HIV prevention program, AID Atlanta protested the CDC for not funding them for the grant cycle and insisted that their relationship to the CDC and the HIV/AIDS epidemic necessitated the funds. The

CDC stated that AID Atlanta came in second in the evaluation of proposals. Yet, the key contention from AID Atlanta was that in email correspondence with the CDC, the CDC claimed they were exemplary in their approach to HIV prevention. AID Atlanta felt this was enough to justify the continuation of funding.

The CDC's removal of funding had two impacts that illustrates how triage and HIV prevention landscapes function. First is that the CDC, under the discourse of a lack of resources, disrupts what AID Atlanta assumes to be an informal agreement of continued funding for prevention services. This expectation emerges from AID Atlanta's ongoing funding relationship with the CDC. Although this grant was 5% of the organization's budget, the funding denial challenges this assumed agreement which AID Atlanta feels is the result of a lack of transparency. The second impact is that the removal of funding allows more organizations to enter the HIV prevention landscape and thus more competition from other grantees.

5.4.2 Sister Love

The second organization Sister Love was born out of AID Atlanta through a HIV/AIDS hotline for black women in the Atlanta metro area. Sister Love is one of the first organizations nationally to address black women and the HIV/AIDS epidemic. Although black women make up about 6% of the population, they are close to half of all new infections for women (CDC 2019). The disproportionate rate of HIV infection among black women make Sister Love's intervention "Healthy Love" central to addressing disparities among black women in in the Atlanta Metro area. "Healthy Love" is a group

centered HIV intervention where sexual education and HIV testing are given to social groups of women in the Atlanta metro area. Social groups, for example, are college women, professional women, low income black women, HIV positive women and other social formations. The intervention is tailored for black women according to their own social relationships to risk. This addresses the diversity of black women from different socioeconomic risks and it highlights how HIV risks can mean different things for different populations. The risk of a positive HIV diagnosis is for all black women and not those perceived to be low income, undereducated, or the working poor. In an interview, with a member of the organization in referencing the “Healthy Love” intervention, the goal of the intervention is to “access your risk and to make you aware that you were at risk” (interview conducted). Therefore, Sister Love through the “Healthy Love” intervention points out that everyone is potentially at risk under the HIV/AIDS epidemic. The goal is to make sure that everyone, in particular, black women know the potential risk that they carry. Therefore, Sister Love had the CDC evaluate their intervention for its effectiveness. “Healthy Love” was found to be effective in changing sexual behaviors related to the spread of the HIV/AIDS epidemic (Dixon Diallo 2010). As such, the CDC incorporated the “Healthy Love” intervention for dissemination nationally for other organizations to adapt to their communities. However, this changes in 2012 when the CDC deems “Healthy Love” to not be a priority intervention. The “Healthy Love” intervention would not be made available anymore from the CDC.

The CDC’s rationale for de-prioritizing the “Healthy love” intervention was that black women were not a target risk group for HIV infection. In 2012, black women were

deemed not to be a key risk group within the black community for HIV infection.

Although Sister Love doesn't receive direct funding from the CDC for "Healthy Love", they continue to provide the intervention to groups of people and organizations in order to raise awareness. As a keystone intervention for their organization, "Healthy Love" still continues to be requested from groups with the core elements of the intervention staying the same, while other aspects of the intervention are changed for whatever groups need of it.

5.4.3 Counter Narrative Organization

The third organization is the Counter Narrative Organization (CNO) who takes the Joseph Beam quote "black men loving black men is the revolutionary act" as a model for programming and advocacy (Beam 1986). The CNO builds power among black gay men in solidarity with other social and racial justice movements. Central to the CNO is that storytelling is critical to social change and by amplifying the voices of black gay men, the public narrative of black men can change. This builds from the revolutionary cultural renaissance of black gay cultural production who came together during the HIV/AIDS epidemic for change (Beam 1986; Hemphill [1991]2007; Riggs 1989). The goal is to center black gay men as a group with a particular experience that has the power for change. Key initiatives have been the black gay vote, harm reduction strategies around methamphetamine use, PrEP advocacy and access, peer support, and various arts and culture programming. Part of the culture work is providing opinion pieces to local newspapers and artistic expression in order to challenged dominate narratives. Additionally, the Revolutionary Health YouTube series works to provide up to date

health and scientific information about the lives of black gay communities. It is within here that we see how people navigate healthcare access among the changing HIV prevention landscapes. What the Revolutionary Health YouTube series does is provide a play by play resource for black gay men seeking resources and access to information. What Revolutionary health provides as an approach to health that meets the fallout that black gay men face in cities like Atlanta. This is a program that isn't funded through direct CDC lines and instead reflects the needs of the community first without the input of funding. The model of providing a service without consideration of funding makes sure that the funding collected meets the needs of those seeking the funding rather than organizations adapting funding to the needs of groups. With topics like racism and health, the program provides the necessary relationships. The need for this came out of organizations needs to move out of strict HIV/AIDS formations that were defined by the Centers for Disease Control.

The organization brings narratives from black men who have sex with men to bear on the numbers that surround the HIV/AIDS epidemic. In an interview with the founder, he states that "people are reduced down to a number and only people can see the number" (interview). The push for a narrative approach personalizes the impact of the programing being delivered and moves away from the number driven case management model of HIV prevention, which is premised on numbers served, numbers engaged and making sure evaluation meets the goals of the workplan. The CNO seeks to change how value is created within the epidemic away from numbers in favor of connections with people and organizations that share the same core values. The interviewee calls this "sustainability

without sacrificing integrity” which produces a differed consideration of how HIV prevention landscapes should be developed. In our conversation, the interviewee speaks to a different kind of HIV prevention landscape that isn’t driven by testing and large organizations who are able to deliver services. Instead they call for a more expansive space where access to interventions are built directly into the culture of being black and gay in Atlanta. Part of this is developing networks with a diverse number of organizations in a number of different advocacy platforms. The CNO provides a platform for education and support that allows for black sexuality to flourish in a way that isn’t stigmatized.

The three organizational narratives highlight relationships that are central to triage and HIV prevention landscapes in Atlanta, GA. The first is *funding* as crisis. AID Atlanta’s relationship to the CDC under limited funding meant that without a firm justification, they lost access to funding. Although, the impact of a CDC decision isn’t as devastating as it would be for a smaller organization, the CDC’s decision challenged the assumed privilege that AID Atlanta felt they had especially in outreaching to communities who were in need. The second is *adaptation* without long term support. Sister Love’s key stone intervention “Healthy Love” loss of support from the CDC points to the limitations of adaptation within HIV prevention landscapes. Sister Love underwent the difficult task of bring their intervention to the standards that the CDC set forth in order to make it legible to the CDC. Sister Love shows that homegrown interventions can meet the standards of the CDC. Yet, the CDC’s decision to de-prioritize the “Healthy Love” intervention demonstrates how adaptation is contingent on the needs of top-down understandings of risk groups. The third is a *disidentification* of HIV prevention. The

Counter Narrative Organization engages in a structure that is outside of formal HIV prevention landscapes. The triage is real, but its impact is dispersed with the Counter Narrative Organization as they take an approach that is through their own vision and not the vision of other people. This shows how triage in the formal sense creates a limited engagement in other ways for people engaging the epidemic.

The first two narratives AID Atlanta and Sister love highlight the limitation of HIV prevention for organizations but also shows how landscapes under the logics of triage produce a crisis of funding and show how adaptation is contingent on particular focuses that elude community-based organizations in Atlanta. There are many more relationships that inform my use of triage, but I point to these two in order to show how funding and allocation create a space to disidentify from. These points are developed in the next two sections as I show how the work of the Counter Narrative Organization provide a space disidentify and create new worlds. This necessitates undertaking triage as metaphor to see how it can be disidentified from HIV prevention landscapes and transformed.

5.5 Triage as Metaphor for HIV Prevention Landscapes

My engagement with health geography is through the use of narrative and metaphor to demonstrate limitations in health systems. The use of metaphor allows for connections to be made between empirical research and theory. Metaphors highlight the extent to which a word or idea carries beyond its literal application. Sontag's (1978) *Illness as a Metaphor* points to how systems of oppression are mapped onto the diseases itself. For example, AIDS has the ability to shorten people's lives, but the weight of meaning that

the word carries is mapped onto groups of people. Someone at risk or who is HIV positive is transformed and brought into structures of difference through their relationship to HIV/AIDS. The use of metaphor in health geography allows for what we know about health to be spatialized. Health as a metaphor elaborates on how place conditions and impacts people's lives. Therefore, metaphor is crucial to see how medicalization practices are structured through power and difference. This allows us to bridge the gap between nature, society and health (Shepard-Hughes 1992), political ecology and health (Jackson and Neely 2015). Kearns (1997) elaborates that what the use of metaphor does "is strive to reclaim health as a quality rather than a commodity – something less medicalized and more connected to everyday life experience" (271). Therefore, metaphor allows for a conceptualization of HIV prevention landscapes beyond access and shows how resources are mediated through social and political concerns.

Additionally, triage as a metaphor considers how HIV prevention landscapes extend into the lives of black LGBTQIA communities. Similarly, Foucault (1975) in *Birth of the Clinic* uses space as a metaphor to demonstrate that the "space of configuration of the disease and the space of location of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time ..." (3). Space as a metaphor denotes the ways in which disease is correlated with the body. As bodies are advanced with innovations in scientific knowledge, new spaces of the body take on discourses and other forms of meaning. What this does is create a "configuration" of disease where discourses and other form of meaning can be attached to bodies. Therefore, it is from these spatial meanings of the body that organizations like Counter Narrative

Organization have the opportunity to disidentify from. Key to this process is taking what has been constituted through violence and transforming it into something that black MSM can use. For example, the Counter Narrative Organization challenges stigma in HIV prevention through questioning how risk is mapped onto group affiliation rather than sexual activities. Therefore, it is the social space of black sexuality that is used to discuss other relationships between black men and their relationship to risk. It is from this perspective that I want to consider how the Counter Narrative Organization disidentifies from HIV prevention landscapes and create new meanings.

5.6 Discussion and Conclusion

The Counter Narrative Organization draws from the Joseph Beam quote that “black men loving black men is the revolutionary act of the 1980s” (Beam 1986). This line is found in Beam’s poem “brother to brother” which is situated in the anthology *In the Life: A Black Gay Anthology*. I take *In the Life* as the title of my dissertation as a metaphor to highlight the struggles that black LGBTQIA communities face, in particular, people who are in need of HIV prevention, care and treatments. Similarly, The Counter Narrative Organization takes black men loving black men as a guide for a praxis that centers black gay men and their concerns through the practice of love. This praxis challenges individuality driven HIV Prevention strategies and instead calls for a collective understanding of how to intervene. Additionally, it is a recognition that institutional change is only as good as the health care support that black MSM have. Therefore, the Counter Narrative Organization seeks to transform dominant approaches to HIV prevention landscapes through a practice of disidentifying from HIV Prevention.

Disidentification within the Counter Narrative Organization (CNO) takes on two approaches. The first approach delinks the relationship between HIV prevention as a source of stigma. CNO recognizes that in the delivery of HIV prevention and care that these are sources of stigma. Sangaramoorthy (2012) work on numerical subjectivity among HIV positive Haitian populations in Miami, illustrates that there are certain performative aspects related to knowing one's status and being able to articulate their status that creates potential barriers for those who are unable to do so. What these do according to Tim'm T. West (2015) is "point the finger at black gay and bisexual male behaviors that have long been proven to be no riskier than our white counterparts. [...]" Then black men become responsible for their own dying" (Aaron 2016). Therefore, prevention spaces that require a confessional as part of entry into the space, can reproduce stigma for those who are unable to fit the required subject positions. The second approach is to disidentify from who is the ideal subject of HIV prevention to center those who are at risk. This is a position where the risk of HIV infection is understood through communities rather than the top down production of epidemiological knowledge production. Instead of statistics determining where risk is distributed, risk is factored into the existence of being black and queer. Therefore, the space of risk is ongoing regardless of home, belonging, or kinship. This is due to the fact that health maybe interrupted at any time in these spaces and that risk is foundational to how one relates to the world.

Both HIV prevention's relationship to stigma and risk are addressed through an acceptance of being black gay or bisexual, while also addressing the ways that stigma and

risk influence one's understanding of their relationship to HIV prevention. CNO does this through a critical engagement with HIV prevention, care, treatment, and research from the perspective of community driven understandings. As part of this process, HIV prevention is subsumed through the lens of organizations that are then distributed back to community members. There is an understanding that HIV prevention is needed in order to stop the epidemic but what this looks like is contingent on base level access. For example, understanding that stigma and risk are connected to stable housing has led to a number of collaborations with housing justice groups in Atlanta. Part of the work with housing justice groups is to show that the stigma and risk can't be contributed to individual behavior but that is found in housing especially, when that housing is tied to federal or state dollars for marginalized people. Additionally, another process is producing HIV prevention education at the intersection of black gay and queer life which is often absent from HIV prevention, care, and treatments. Through online media platforms, the CNO takes on topics that are in the periphery of HIV stigma and risk and places themselves into the center. They have taken on topics like self-care in particular how to be vulnerability. Therefore, what this cultural production does is provide a space to take on stigma and risk and transform it through a deeper connection to being black and queer.

The contributions of the Counter Narrative Organization maybe banal when compared to the totalizing weight of the HIV/AIDS epidemic. However, their relationship to the HIV/AIDS epidemic and HIV prevention necessitates a critical reflection on how communities navigate limitations in public health interventions. Crucially, triage

structures how decisions are made about health resource allocations under a premise that resources are always lacking to begin with. As such, decisions are made every day that impact health care resource allocations and the delivery of services. What makes this especially difficult is a system of punitive health that highlights the structural retrenchment of government sponsored health care and the promotion of private, for profit and non-profit solutions to health care. Without universal health care, the supply and demand logics of healthcare delivery fall flat as profit interests necessitate a continually manipulation of supply, which is limited in order to increase rates of profits. These limitations come in the form of services, care, treatments, and prevention. Therefore, this relationship with mainstream healthcare delivery, maps onto HIV prevention and its delivery. How people engage these systems create opportunities for a counterpublic that doesn't eschew power but alters the established order to create new relationship between them and HIV prevention. While this isn't always the case for a counterpublic formation, the narratives shown produce a relationship that is worthwhile for understanding how punitive health structures triage as an ongoing process within HIV prevention and how communities navigate these health landscapes.

Chapter 6 Conclusion

6.1 COVID-19 and HIV/AIDS

The current health crisis COVID-19, like the HIV/AIDS epidemic, functions through the logics of accounting and triage. The national accounting of people with COVID-19 and those that have died from COVID-19-related complications have been limited due to the lack of testing and reporting of mortality rates which has created an undercount of the real impact of the pandemic. As I write this conclusion, half of the United States are under lockdown to stop the spread of the disease with many waiting to open up soon to jump start political economic stagnation and unemployment, which have signaled another looming crisis of capitalism. State's making the decision to open up their economies will do so with limited testing and a lack of purposeful accounting of new COVID-19 cases and those who have died due to the virus. Similarly, the language of triage, during this health crisis, has been central to demonstrating the lack of health infrastructure related to hospital beds, Intensive Care Units, and ventilators to deal with spikes in hospital admissions. Decisions are being made around who should live and those who should die, which unfortunately has seen older generations, those living in short and long-term health care facilities, and the homeless form the bottom of the triage social ladder. While research on the social and political implications of the COVID-19 epidemic have provided insights into the lack of government response (Kayyem 2020), information (Sorkin 2020), and the limits of a national health care system (Russell 2020), it is clear that those most burdened are also low-income racial and ethnic minorities (Taylor and Brown 2020). For many, the

socioeconomic and racial implications of COVID-19 are not surprising and that this current crisis is nothing more than a reflection of already existing health inequality.

The HIV/AIDS epidemic much like COVID-19 further exacerbates health inequalities in the United States. Time will tell COVID-19's implications, however, what we do know about the ongoing proliferation of the HIV/AIDS epidemic is that health inequalities are fundamentally unequal and fall along racial difference as it is mutually constituted through gender and sexuality. Any casual observer can discern health inequality from the production of statistics about the HIV/AIDS epidemic where indigenous, black and latinx communities have disproportionate rates of infections. Therefore, this dissertation isn't concerned with the epidemic itself. Rather, I am interested in how the HIV/AIDS epidemic subsumes and distributes knowledges about black LGBTQIA communities through HIV prevention. Hence, my empirical focus on HIV prevention landscapes and HIV interventions, demonstrates the ways in which theories of biological citizenship fail to consider approaches from the experiences of black LGBTQIA communities. In line with Black Feminist and Queer of Color scholarship, my dissertation takes the black LGBTQIA communities as an object of knowledge that can demonstrate the ways in which a counter public can be generated under anti-black systems of domination, in particular, the unequal distribution of HIV prevention resources in Atlanta, GA.

My engagement with antiblackness is at-times scattered due to my wish not to recreate the ontological and epistemic violence that accompanies scholarship on the topic. This uneasiness has led black feminist scholarship to consider other forms of relationality that

black communities occupy within and outside of the death grips of antiblackness, which brings black communities closer to premature death (Gilmore 2002). What's at stake for trying to produce scholarship that doesn't give into the totalizing weight of antiblackness is a social responsibility for researchers who conduct and do research on communities they have an identity formation with. There is an added level of commitment to scholarship beyond scholar-activists' considerations of praxis and feminist standpoints, when a scholar comes from the communities they are researching. When this relationship is taken too lightly it can undermine the subjective capacities of communities as writing about them just reproduces the totality of antiblackness. Therefore, I seek a research approach between the totality of antiblackness and the challenges to the object-subject relationship of black LGBTQIA communities. This brings my political commitments forward through my methods, empirical considerations, and theoretical commitments. As such, I take accounting and triage as concepts that allow me to work between antiblackness and substantiations of black life. Taken together the outcome demonstrates how biological citizenship is premised on an emergence between both antiblackness and black life. It is between black life and antiblackness that I develop the concept of the "hidden epidemic."

Therefore, I am onboard with the general focus of biological citizenship as a relationship between biological harms and groups of people who emerge to seek redress. I do believe that the weight of societal risk materially produced through biological harms creates avenues for people to seek redressed based on failed protections against harms or a subject position that is outside the care of the state. However, I am interested in how

groups seeking redress are continually limited from rights and recognition through their social position within value systems of difference which mediate how harms are experienced. HIV/AIDS response like COVID-19 response fall along unequal racial landscapes which limits who are brought into the protections of health as a form of triage and how we document those at risks. I argue in chapters 4 and 5 what structures this are the technologies of accounting and triage which reflect how Foucauldian biopolitical practices are deployed to subsumed hierarchies of difference and send them back out to populations. It is through the material and imagined technologies of accounting and triage that we witness limitations which speak back to how the totalizing power of antiblackness is limited. It's important to recognize that this limitation isn't a wholesale removeable of antiblack conditions but that there are lives to be made in systems of oppression. This has been the intervention of black geographies in general which is to show the limitations of hegemonic forms of subjection that pin black communities to the margins of spaces.

The project of Black Geographies centers communities and their concerns as fundamental to the production of space. However, geography is difficult site to do this due to communities being considered as real objects rather than objects of knowledge. Taking communities as real objects, geography assumes that the quality of life is known throughout which uncritically engages in objection without a consideration of other relationships. Black people within geography are depicted as being passive to spatial production as geography was something that happened to them. As such, scholarship on communities and geography unwittingly wield communities alongside environmental,

political economic, health and other subdisciplines without a consideration of communities' own understanding of geographic subjects.

This changes with McKittrick and Woods (2006) intervention that builds from a salient trajectory of geographic scholarship that connects the Geography to Feminist studies and Critical Race and Ethnic studies. In evoking the feminist language of the “mythical norm” where critical geographers insert themselves as the bears of situating an understanding of communities, McKittrick and Woods call for a serious consideration of the ways in which black communities are central to geographic processes and not mere observers. Through their intervention we seek how “geographies and geographic subjects can help us better understand the racialization that has long underpinned the production of space” (8). The task is to understand the ways black communities underpin the production of space. Ultimately, what McKittrick and Woods call for is taking communities as objects of study, rather than real object adjacent over submerged within spatial processes. How to do this becomes a point of contention in the afterlife of slavery as antiblackness becomes the general mode of social organization.

Taking black people as objects of study calls for a reconsideration of methods, epistemic foundations, and ontological considerations that guide academic scholarship. These considerations have wrestled within the domain of critical race and ethnic studies where debates around the ontological status of communities as non-human or the subjective nature of communities in the face of anti-violence becomes the basis to center black people as real objects. However, as these discussions have led to a number of critical

engagements around the archive, social death, and substantiations of black life, there is not a clear break from previous regimes of thought which reproduce the anti-epistemic violence of researchers. Arguably, the harm of one's research can never full be absolved or repaired. Therefore, the work of a researcher then becomes situating one's self to understand how people as objects of knowledge challenge systems of power. Hence, black geographies task is to mine the harms of epistemic violence on black communities engaging with antiblack violence while also searching forms of black substantiations of freedom. Yet, this is from an understanding that freedom is limited in the post-slavery era.

In the late 2010s, I argue a method for excavating substantiations of freedom in the face of anti- violence through the guise of the "hidden epidemic". Within the work of McKittrick (2016), Hartman (2019), King (2019), Sharpe (2016), and other scholars, taking people as an object of study requires mining and paying close attention to the empirical limitations of antiblackness in unrecognized geographies. This is a methodological approach that takes absent as a conceptual piece to feel in what isn't accounted for or the triages undocumented. I call this speculative non-fiction as incomplete archives or accountings that are made to critique the dominance of antiblack violence. McKittrick develops this through the refrain of an enslaved person as "she says she was born free" (21). The use of this shows the way in which the archive of accounting practices of black people are "full of truthful lies and bloodshed" (21). It is through the use of "she says she was born free" that new histories emerge that challenge antiblackness but speak to the substantiations of black life. The stakes of this

methodological speculative non-fiction is the potential abandonment of disciplinarity in particular and African-American studies which seek to make black communities knowable in the world. Yet, I call for an approach similar to the work of the speculative nonfiction that seeks to mine disciplinarity for what isn't accounted for and isn't stated.

Therefore, I situate myself within the discipline of Geography and the subfield of health geography as part of a trajectory in Black and Queer studies that seeks to unpack the silences that forms around black people. My dissertation does this by addressing accounting and triage in HIV prevention in two ways: first, I consider the ways in which antiblackness is articulated through the technologies of accounting and triage which bring antiblack violence to HIV prevention. Second, I seek to understand the limitation of accounting and triage through the experiences of black LGBTQIA communities as they navigate racially uneven HIV prevention landscapes. By situating black LGBTQIA communities we can see the way world making and abolitionist racial thinking are key to how these communities navigate these landscapes. Overall, my work takes black LGBTQIA communities as object of knowledge within geography.

5.2 Research on HIV Prevention

My dissertation strives to bring critical health geography, black studies, and queer theory to bear on US public health interventions. I do this by developing the concepts accounting and triage through Black Feminist Thought and Queer of Color Critique in order to expand health geography literature on landscapes and health care access. I hope to offer new insights into how health is central to the proliferation of antiblackness and

how black communities resist dominant structures of power. Through the lens of accounting and triage, I work with biological citizenship to show the ways in which black LGBTQIA communities emerge as a social and political body in opposition to adverse health conditions due to already existing racial formations. Situating biological citizenship with Black Feminist Thought and Queer of Color Critique, I show how a counter public emerges from the spaces that are outside of official accountings of the HIV/AIDS epidemic and the triages that distribute resources in HIV prevention landscapes. The goal is to show that totalizing power is limited when we take black LGBTQIA communities as the object of study. Therefore, focusing on how black LGBTQIA communities are documented in HIV interventions and the ways they navigate HIV prevention landscapes provides a strong theoretical referent to bring more social theory to Health Geography. Finally, my dissertation is part of a small but growing body of queer scholarship that takes health as an optic to understand the what it means to be black and queer in the 21st century.

Empirically, my argument speaks to the limitations of HIV prevention and public health intervention in general. As part of the black health tradition, I argue for health scholarship to take race, gender, sexuality, ability, and class seriously as intersectional forms of difference making that structurally impacts how people engage in a number of health studies. The impact of my dissertation can be found in Atlanta, where decades of social and political resource denial has created health landscapes that aren't able to meet the needs of the poor in the city and the region. My hope is that access is no longer seen as the sole purpose of health care but that knowledge production about people in relations to

health and health access is taken as important. My dissertation does this by showing the ways in which community-based organizations' relationship to the volatility of HIV prevention landscapes, necessitates that new forms of health engagement are needed given that the public or social mandate of health is unfortunately in favor of private capital. Although my dissertation doesn't show how to navigate larger scale health and health care access, it does show communities navigating deficiencies within HIV interventions and HIV prevention landscapes. Therefore, my dissertation's engagement considers the possibility of having bottom up community driven health promotion as a vehicle to understand what community driven systems could look like for universal health care and other forms of social needs. As such, my dissertation extends beyond the academic silo that I am in and I hope to see cross collaboration between the social sciences, public health, and the humanities.

5.3 Searching for Minor Theory, Searching for Connection

“The minor is not a theory of the margins, but a different way of working with material” (Katz 1996 289). My dissertation isn't concerned with totalizing theory that provide universal explanations of the ways things come to pass, nor is it interest in supplanting dominant theories with another theory. I came to this consideration through my time in graduate school and my research in Atlanta. Throughout my graduate studies, it was clear that outside of my academic silo, folks didn't care about whether or not a theory could explain the world. However, folks were interested in if a theory could help acquire various drugs or if a theory could help navigate under resourced healthcare clinics. In an interview, Hortense Spillers (Lenard 2007) states that she wasn't looking for a totalizing

theory in *Mama's Baby, Papa's Maybe* (1987) but to speak back to Feminist Studies' move away from gender. Spillers was concerned that if we lost gender, we would lose the ability to talk about historical legacies of slavery which carried a sexual economy that is key to its proliferation. Like Spillers, I take my theoretical engagement to try to read against other scholarship that makes black LGBTQIA communities as part of the natural landscapes of difference and its proliferation in scholarship and theoretical engagement. Yet, within my own theoretical consideration, I can't help but consider what does all this theory mean for the day to day lives of those who engage harms. I've been fortunate enough to have intellectual communities and collaborators outside of academic silos. These work relationships have been fruitful as I can provide university resources and contribute but don't necessarily have to be the focal point of the relationship. In considering the use of theory within this space, it's apparent that theory provides a different way to work with materials.

The result of my collaboration's use of theory wasn't to challenge opposition theory. It was to consider the ways in which theory can be used to know something about something else. This created an opportunity to do something different. This is where theory found its own use and it shaped two projects that I was a part of during my time in graduate school. In the summer of 2015, I engaged in a project with a local book seller to understand the way north Minneapolis residents engaged the literary arts. We had an expanded definition of the literary arts that included reading books, making poetry, distributing reading materials and providing resources for people to engage in literature, prose, poetry etc. What guided this research was discourses found in literary studies

about people who buy and access literature, and the way low-income racial and ethnic minority communities were never factored into those who were thought of coming or benefiting from the literary arts. When these communities were considered it was often in the context of writing from a social position to let white or middle-income writers in or stories of exceptionalism were someone beats the odds of the local communities.

Therefore, the communities of low income racial and ethnic minority communities were static and provided a fixed narrative that highlighted their engagement to the literary arts. My collaborator and I would spend hours talking and it became clear that theory provided an avenue to understand processes that viewed communities as non-contributors to literary arts landscapes and the ways these communities did in fact have a relationship. With the help of theory, my collaborator and I were able to consider new materials, in particular, different ways to value literature. These ways included thinking through different ways people consume new literature without putting that value in dollars or thinking through the role of space in helping access on a local level. As such, value was central to our project which is reflected in Chapter 5 of my dissertation which focuses on community-based organizations navigating limitations in HIV resources through their own relationship to triage.

The second experience that help me understand the role of theory outside of the academy was my summer at Antipode's 6th Institute in Geographies of Justice in Montréal, Québec, Canada, 2017. The institute was a week-long seminar with evening plenaries that engaged in conversations around social justice within the discipline of geography. The goal of the institute was to provide a space to learn from the knowledge of junior

academics, middle career, senior professors, along with community members engaged in local social justice struggles. Similar to other academic/activist spaces, there was a certain kind of tension that translates into an attentiveness as those of us being academics and on formerly indigenous land wanted to pay respect. However, this comes at the expense of a more engaged conversation as people will hold back. Unfortunately, this was put to the test as a bus driver taking us out to the First Nation community of Kenehsatà:ke was wearing a disparaging indigenous logo appropriating baseball cap. The quiet talk amongst ourselves about the hat during the trip contributed to a general silence about the ongoing incident. In that moment the theory of indigenous erasure and appropriation came full circle, but it became clear that we couldn't chat or think our way out of this. Finally, after some time, a participant asked the bus driver to take off the hat. In this moment it was clear that theories about what is wrong if not acted on just reproduced the system that we have been trying to write about. Therefore, it was ever present that theory in action was needed in particular praxis.

Praxis is a word that I am very mindful about but uncertain in my own execution of it in the world. For Geographers, praxis lends itself to social justice research with attention paid to empirical, methodological, and theoretical commitments that seek to pry apart systems of power. Part of this research has been developing research programs that work with people most impacted by systems of domination and allows them to speak for themselves within academic spaces. However, my considerations about the role of theory, I find a similar need with my use of praxis. The tensions that were expressed by the scholars in the example above calls into question; what, if any, does praxis do to address

anxieties researchers have with the populations they work with or research? I believe the tension is productive. It provides a materiality to engage in what I believe to be the subject position of the academic vs. that of someone outside and if there can be any resolution of the two. The difficulty among this tension is due to the social category of the scholars/academic that is a privilege position of choice. Returning back to the example above, we were a privilege selected group of people who were guest on another people's land. A group of people who didn't choose to be under settler colonialism and whose identity is a choice in a wage relationship. Therefore, praxis as a relationship to the type of scholarship for social justice is more complex than clear. If anything, praxis can be thought of as theory in action, where the action is just more confusion. This confusion is key to my dissertation especially when I first went to Atlanta to engage in community-based research. I came as a willing participant where others especially those HIV positive had no choice in the matter. Hence, the groups of people who form due to biological citizenship from cancer patients, HIV positive people, or Chernobyl survivors had no choice in the biological harms they face. As such, praxis if it were to be anything, it would show that the experience of harm isn't the exception but the everyday realities of people who have been over burdened by systems of domination.

5.4 Future Directions

My dissertations empirical and theoretical considerations are valuable for geography, queer studies, black studies, and health geography. A deeper engagement with the history and ethnography to solidify connections between theory and the empirical case study can not only advance scholarship but it can have policy and organizational implications. In

Chapter 5, where I explore the impact of triage on HIV prevention and how this creates a lack of transparency or clear idea of who is the ideal community-based organization provides a foundation to build connections between long term community engaged organizations and HIV prevention. Additionally, this could bring the academic silos of implementation science and emergency delivery science together to be in conversation with social science literature based in social theory. When placed together, this will provide a better understanding of how triage connects to the intersections of race, gender and sexuality along with structural determinants of health like racism.

Additionally, my dissertation builds on a long tradition of critical inquiry in Queer and Black Studies that seeks to materialize the impact of racism and heteronormativity on black populations. I have found but have yet to explore material to develop a geographical engagement with the Black Studies concept of the intramural. From the early days of my graduate studies, I was attentive to the roll of black life in the production of geographies. This was not a space in opposition to dominate oppressive spatial formations, but it was a sociality that exists alongside these oppressive structures. My work on a queer counter public and world building speaks to the shape and form of the black intramural, but this is something that still alludes my thinking. However, I believe there is something fruitful in black queer cultural production, especially in the face of the HIV/AIDS epidemic.

In addition, my dissertation's work on the archive provides a unique perspective to provide a methodological intervention to Geography. Given that much of critical

geography scholarship is premised on ethnography, calling attention to the role of archival research and the conceptual theoretical archive can enrich the role of the humanities in geography. I want to develop an engagement with the archive in order to speak to a process that is central to geographic inquiry but does not receive a firm consideration from scholars who are critical.

Finally, the project of Black Geographies to bring Black Studies and Black Feminist Thought to Critical Geography is a project that can extend Marxist, Feminist, and Settler Colonial perspective. Not only does this impact how social theory is taken up within Geography, it also provides an avenue to engage in critical geographies focus on social justice. Although this wasn't the explicit focus of my dissertation, I am personally committed to a politics based in the lives of marginalized people, in particular, racial and ethnic minority communities many of which are queer and many of whom are punks. It's from this standpoint that I offer a document that is mindful of the power relations I have and the epistemic violence they may come from my research. I will do better. My dissertation is my first attempt to produce something with dignity and respect.

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