

Religious Rhetoric(s) of the African Diaspora: Using Oral History to Study HIV/AIDS, Community, and Rhetorical Interventions

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As oral performances, HIV/AIDS sermons across the African diaspora are transitory, but ministers' memories and those of their parishioners are not. This poses the problem, for communication historians, of recovering this significant rhetorical activity. This study does so by using oral history interviews with Black Protestant church leaders in three AIDS-stricken areas: Sub-Saharan Africa, the Caribbean, and the United States. I discuss how oral history methodology, heretofore underutilized in communication studies, allows me to recover their evanescent rhetorical strategies, underpinnings, and justifications. Specifically, through the use of oral history I argue that church leaders' religious rhetorics of identification yield interventional strategies and rhetorical resources that create safe spaces for people living with HIV/AIDS and models for future rhetorical interventions to address the crisis.

Keywords: HIV/AIDS, intervention, Black diaspora, religious rhetoric, identification, Black church

Introduction

The destructive effects of HIV/AIDS on humankind have gone beyond victims, their families, and their health practitioners to become the focus of international attention among leaders of the faith community who are entrusted to preach sacred words of life, hope, and grace to the hurting in times of hopelessness. This has occurred despite these leaders' traditional reluctance to address openly the interrelationship of sexual practices, sexually transmitted diseases, and the larger society. Take, for example, this statement from an oral history interview I conducted with Reverend Al Miller, pastor of Fellowship Tabernacle in Kingston, Jamaica. He said of Jamaican clergy that "we must have a proper understanding that HIV/AIDS is not just the homosexual issue, we [all] need to be responsible in our sexual behavior. I have to give a balanced perspective on the issue." Therefore, "we should call all of our

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citizens, both church and community, to more responsible sexual behavior" (A. Miller, oral history interview, June 21, 2010).

In another interview that same year, Reverend Denza Cunningham, pastor of Christ Community Church in Nassau, Bahamas, spoke of the gravity of the epidemic in his country and the breadth of religious rhetoric needed to address the issue. He put it this way: "HIV/AIDS is a real issue in the Bahamas. There is a high rate of it, especially among young people. We deal with it not only from the pulpit, from preaching and teaching, but in our various ministries. It is addressed on the children's level straight up to the adult level of our church" (D. Cunningham, oral history interview, June 30, 2010). In an interview I conducted in South Africa in 2009, Pastor Titus Sithole recounted how he used his sacred space of influence to speak about the issue as part of his divine mandate to preach the gospel. He had no moral qualms about this move, bluntly stating that for three months, "I began to preach on HIV/AIDS from the pulpit. I read, I studied and preached on it from every angle" (T. Sithole, oral history interview, June 27, 2009).

For all these leaders, the HIV/AIDS crisis has occasioned an important broadening of the scope of their ministerial rhetoric. Historically, Judeo-Christian traditions and scriptures brim with examples of trusted individuals who were "called" by God to be his spokespersons—to stand in sacred spaces and address exigencies of social ills, epidemiological crises, and destructive individual behaviors within religious communities (House, 2007). Scholars (Clement, 1965; Westerman, 1991; Zulick, 1992) have already focused on the rhetorical dimensions of earlier historical instances of religious public address, especially in sermons, but few have addressed what religio-rhetorical challenges the HIV/AIDS crises have posed for people of African descent or how Black religious leaders are responding nationally to this epidemiological terror wreaking havoc in their communities (Bongmba 2007; Moore, Onosomu, Timmons, Abuyu, & Moore, 2010; Muturi, 2008). However, comparative identification of religiously grounded discourses used by religious leaders across the diaspora has been largely neglected, even by communication scholars who might be expected to probe into the rhetorical, interventional, and performative dimensions of such discourses (Beckley & Koch, 2002). Muturi (2008) employs social influence theory to examine Jamaican religious leaders' contributions to addressing HIV/AIDS across various traditions and practices. Her work, however, stops short of addressing the rhetorical strategies, warrants, and underpinnings of their communication on HIV/AIDS through prayers for healing, health fairs, seminars, and workshops.

This study, propelled by questions surrounding rhetorical strategies used by religious institutions in the diasporic battle against HIV/AIDS, aims to understand better the rhetorical and interventional use of power that resides in the collective voice of religious institutions. Through grounded inquiry (Glaser & Strauss, 1967),¹ it examines how oral history methodology and testimonies collected from pastors of African descent across the diaspora illuminate ways of addressing HIV/AIDS through sermons and other forms of religious rhetoric. Specifically, this study uses oral history to investigate religious uses of

¹By grounded inquiry, I mean informal induction from oral history testimony, as distinguished from the more formal protocols associated with the grounded theory method of Glaser and Strauss (1967). For more on this use of grounded inquiry, see Wise (1980).

rhetorics of identification that function as a predominant interventional strategy and rhetorical resource for many Black diasporic religious leaders. Further, I argue that the rhetorical strategies identified through the use of oral history methodology can serve as models for churches that use their most powerful weapon, religious rhetoric, along with everyday pastoral work to create a theological framework for helping people of African descent lead their lives under the shadow of HIV/AIDS. Moreover, the use of such a framework strengthens the overall messages that aim to reconfigure at-risk behaviors and practices and work to counteract the disproportionate epidemiological presence of the disease in communities. Accordingly, religious safe spaces dedicated to improving the life chances of people living with HIV/AIDS (PLWHA) emerge when Black diasporic religious leaders integrate these effective tools into their rhetorics on HIV/AIDS (Beadle-Holder, 2011; Fullilove & Fullilove, 1999; Lemelle, 2004).

Using oral history methodology, I localize the rhetoric, religious performances, and discourses of health and healing of several pastors across the African diaspora within one study as part of a larger and ongoing diasporic intervention in the battle against HIV/AIDS. To begin, I briefly present epidemiological background information on the three regions under consideration, followed by a discussion of oral history methodology as the framework from which I gathered excerpts of religious rhetorics. Next, I discuss my data collection practices. Finally, I present my findings of excerpts of identificational religious rhetoric on HIV/AIDS that operate as rhetorical interventions.

Epidemiological Background

HIV/AIDS respects no geographic boundaries, but for the purpose of this study, I focus on three areas of the world currently ravaged by AIDS: Sub-Saharan Africa, the Caribbean, and the Washington, DC, area. A "2009 AIDS Epidemic Update" by the UNAIDS Joint United Nations Programme on HIV/AIDS found the Sub-Saharan Africa region most heavily affected by HIV/AIDS, as it accounted for 67% of HIV infections worldwide in 2008. Amongst the Sub-Saharan countries, HIV prevalence was 16.9% for South Africa, 7.8% for Kenya, and 6.4% for Uganda. The update went on to report that the Caribbean has "the second highest level of adult HIV prevalence" after sub-Saharan Africa (1.0% [0.9–1.1%]) (World Health Organization, 2009). The Bahamas stands out with the greatest HIV prevalence at 3%, Jamaica's being 1.6% (UNAIDS, 2010a, 2010b). Equally staggering, a Washington, DC HIV/AIDS Administration epidemiology report of 2008 found that 3% of African American residents in the DC area were living with HIV/AIDS. In terms of HIV/AIDS rates, this number put Washington, DC, "on par with Uganda and some parts of Kenya" (Vargas & Fears, 2009). Most recently, a poignant 2010 Centers for Disease Control and Prevention study placed the estimated lifetime risk of HIV diagnosis for African Americans across the United States at 1 in 22 ("Estimated Lifetime Risk," 2007, p. 1). The presence and impact of the disease caused a shift in meaning as the virus changed from being something that an individual is infected with to also include something that, by its epidemiological presence, adversely affected communities resulting in social fragmentation and the alienation of the community's most vulnerable individuals. Because this disease first affected members of the Black community who occupied multiple oppressed identities cutting across class, gender, and sexuality—that is, "undesirables"—many community leaders rendered the issue invisible and met it with silence, thereby further exacerbating the fragmentation. The silence that once characterized Black religious responses to HIV/AIDS is best understood as symptomatic of the social impact of the disease in their communities (Cohen, 1999).

The carefully selected countries of Kenya, Uganda, South Africa, Jamaica, and the Bahamas, along with the hard-hit District of Columbia in the U.S., furnish fruitful areas of study that aptly provide a representative sample of both HIV/AIDS cases and diverse Christian churches that speak to multitudes on a weekly basis through culturally and geographically specific rhetorics. Given the long tradition of pastoral concern for social justice, as well as ministers' unparalleled local networks, pastors and churches are well positioned to play a crucial role in HIV awareness (Clifford, 2004, p. 4). I acknowledge the work that, for example, the Catholic Church, NGOs, and other faith-based organizations have done to address the pandemic (Eugene, 1997; Kelly, 2009); however, for this study I focus on the work of Protestant churches (e.g., Baptist, Evangelical, and Pentecostal/charismatic) led by pastors of African descent, as these churches are growing faster in numbers than are many mainline denominations in the areas under consideration. Furthermore, because these types of churches are largely outside of formal national or international ecclesiastical hierarchies, they can be more responsive to their congregants than can churches that answer to higher authorities for their actions or look to such authorities for guidance on their AIDS policies. As an oral historian, I pursue this research by identifying and evaluating the salient theologies of HIV/AIDS that serve as the rhetorical underpinnings of pastoral communication in local settings in each region.

Methodology and Theoretical Context

Oral history methodology is incorporated into this project because it entails the oral testimony of firsthand witnesses to a matter under consideration. As such, oral history is concerned with meaning-making aspects of a rhetorical event that are not salient when exploring a formal written document using, for example, rhetorical criticism (Spradley, 1979; Thomas, 2000; Yow, 2005). Oral history methodology, however, cuts to the heart of these issues by using in-depth interviews in which the interviewer frames a topic and questions that inspire a narrator to recollect past experiences. Together, the interviewer and narrator work to co-create a record of the past event. The resulting dialogic record as a text is amenable to rhetorical analysis insofar as it provides evidence of the history of narrators' rhetorical activities.

In current research centered on HIV/AIDS, Oppenheimer and Bayer have employed oral history as their methodology. In their works *Shattered Dreams? An Oral History of the South African AIDS Epidemic* (2007) and *AIDS Doctors: Voices from the Epidemic. An Oral History* (Bayer & Oppenheimer, 2000), they used this methodology to uncover an important viewpoint held by doctors and nurses working on the front lines of the epidemic. Their studies resemble mine in that they probe into the professional practice of encountering this specific disease, but my work departs from theirs in its focus on diasporic ministers and their professional speech acts and related rhetorical activities. Scholars have also used oral history methodology to gather testimony in order to understand meaning making as it relates to homiletic theory. Specifically, they have employed oral history to give voice to marginalized groups and ways of knowing in general (Madison, 1993) and, with respect to religious communication, to move beyond a preacher's written sermon text by shedding light on the production of the text and the life of the preacher. *Martin Luther King, Jr.: An Oral History of His Religious Life and His Witness* (Moldovan, 1999) and *Singing in a Strange Land: C. L. Franklin, the Black Church, and the Transformation of America* (Salvatore, 2005) are striking examples of how oral history methodology has been of service to religious studies.

I used the oral history methodology of the in-depth interview, which allowed me to engage narrators in the dialectic inquiry that is impossible in analysis of, say, written or recorded sermons. In other words, written and recorded religious discourse cannot respond to questions or offer follow-up responses and rejoinders. Thus, oral history allows for clarification, augmentation, and discovery of important rhetorical strands of thought, simultaneously creating space for the lived experiences and voices of people of African descent living with HIV/AIDS in the production of knowledge. From a methodological perspective that examines the physicality, space, and oral performance of preaching, I cannot but recognize that the space in which the sermon is delivered—the pulpit—has a history and is a physical representation of ideas and ideology (Crowley, 2008, p. 315). That is, in addition to the text of the sermon, the rhetorical space of the pulpit is saturated with rhetorical meaning worthy of scholarly attention. Furthermore, following the lead of previous research on the rhetoric of bodies (Selzer & Crowley, 1999), this study interrogates the rhetoric of the preacher's body as infused and inscribed with meaning and implications, taking up the story told about the body of the preacher alongside the story told by the preacher. The exposition, then, sets out to overcome the limitations of examining oratory on HIV/AIDS that is confined to the physical space of the pulpit by examining "pulpitized" areas touching on HIV/AIDS, which are inclusive of, but not limited to, sermonic presentations (Crowley, 2008). That is, these pulpitized spaces and presentations include materials such as books, outlines, and pamphlets authored or endorsed by clergy members and then distributed to their congregants as part of what I am calling "religious rhetorics on HIV/AIDS" (House, 2012, p. 10).

The oral history methodology used in this project contributes to a reconstruction of diasporic religious institutions' past engagements with HIV/AIDS. My informants, through what they tell me in interviews, add to knowledge and scholarship in the international study of communication and history, specifically in how rhetoric has played out over time in the church's engagement with HIV/AIDS. Moreover, the methodology of oral history stands as an intervention that can be used to mediate critically in the present. After all, ministers' HIV/AIDS sermons across the diaspora themselves do not generally survive, but their memories and those of their parishioners do, which presents communication historians with the challenge of recovering this significant rhetorical activity. Oral history allows narrators to articulate, often for the first time, their engagement with the disease in its diasporic context. Testimony from narrators concerning their ministerial roles beyond the pulpit licenses me to recover their rhetorics. The oral histories from my local-level narrators can help public health officials identify additional ways of creating and translating knowledge and can advance pedagogical approaches to enhance public health vis-à-vis HIV/AIDS.

I rhetorically analyze my interviews using Burkean theory of identification. Kenneth Burke (1962, 1969) was interested in understanding how human motivation is reflected through discourse. Accordingly, understanding how a rhetor's motive functions as the driving force behind his or her discursive acts is paramount for rhetorical critics. Whereas "persuasion" was the key term for old rhetoric, "identification" is the key term for the new rhetoric, according to Burke (1962). Persuasion, then, is accomplished only when one speaks the language of another "by speech, gesture, tonality, order, image, attitude, idea, identifying your ways with his [*sic*]" (p. 579). Regarding the uses of tropes, figures, and commonplaces in the service of identification, Burke suggested that expressing a proposition "in one or any of these rhetorical forms would involve 'identification' first by inducing the auditor to participate in the form, as a

'universal' locus of appeal" (Burke, 1969, p. 59), which leads to consubstantiation. In other words, identifying with an audience as a means to an end (i.e., identifying with the audience's beliefs), or by identifying opposites based on a common foe, or through an unconscious identification (e.g., being of the same race, gender, or region as are those one seeks to persuade) creates what Burke called "consubstantiality" or oneness with an audience (p. 21). Burke held that the process or act of consubstantiality should be thought of as the prerequisite of persuasion. It is through identification with another that two become "substantially one," whereupon the conditions necessary for persuasion emerge (p. 21). In the history of Black resistance in the United States, identification played a key role in Black religious leaders' attempts to place ministry within a context of Black oppression. Black liberation theology, for example, grounded its appeals for liberation in a rhetoric of identification shared between an oppressed Black people and a God who was on the side of the oppressed (Cone, 1970). Several scholars (Kennedy, 1984; Medhurst, 1991; Watson & Hauser, 1993) have found rhetorical criticism, including Burkean theory, helpful as a distinct approach to understanding the rhetorical dimensions of biblical texts, biblical hermeneutics, and religious oratory as sites of struggle. Since preaching concerns the use of symbols and engages in the production of symbolic activity, a rhetorical critic of homiletics should consider how these symbols influence human beings.

Data Collection Practices

To date, I have interviewed a diverse group of 40 narrators. Of these, the overwhelming majority are pastors (i.e., religious leaders) of African descent. In addition to these pastors, I have interviewed medical practitioners and leaders of faith-based NGOs. All interviews were conducted in my study regions: Africa (Kenya, Uganda, and South Africa), the Caribbean (Jamaica and Nassau Bahamas), and the United States (mostly the District of Columbia). Interviews for this study each lasted about 40–70 minutes. I conducted them in person at churches, offices, and restaurants. With respect to educational level, several pastors held college or advanced degrees, were ordained, or were seminary graduates. Of the 40 narrators, 9 self-identified as heterosexual female and 29 as heterosexual male, 1 man self-identified as gay, and 1 woman self-identified as lesbian. The churches in this study represent different theological orientations and range in size from small, with as few as 15 members, to mega-churches with more than 8,000 members. Only 4 narrators self-identified as pastors of affirming churches,² meaning that most of the pastors and religious leaders interviewed for this research self-identify as Protestant clergy members of Pentecostal, Charismatic, Baptist or nondenominational affiliation and orientation. I employed the ethnographic methodology of participant observation to examine the rituals and practices of religious groups that address HIV/AIDS. My identification as a black, male, heterosexual clergyman whose religious roots are in the Pentecostal tradition, along with my theological training, afforded me the privilege of being an insider within these Protestant circles; however, my academic affiliation positioned me as an outsider, whereby I was able to maintain a critical distance from the religious communities under study.

² An "opening and affirming" church is defined as one that "publicly declared that gay, lesbian, bisexual (GLB) people (or those of all sexual [inclusive of transgendered persons] orientations) are welcome in its full circle and ministry (e.g., membership, leadership, employment, etc.)." For more on this definition, see ONA basics (2012).

Beyond the oral history interviews, my data collection and analysis practices included studying pulpit oratory in the past by observing church services, listening to and videotaping sermons, and participating in and observing the churches' community outreach programs, all concerning issues relating to HIV/AIDS. The result was an extensive base of different types of primary sources with great interpretative potential. In each region under consideration I employed two purposeful selection methods based on specific criteria and snowball sampling (Merriam, 2009). The three criteria were: (a) the church was English-speaking and led by a pastor of African descent, and its congregation consisted predominantly of people of African descent; (b) the church provided some type of AIDS-related service; and (c) the church was located within the African diaspora. These criteria were applied prior to selecting targets for interviewing. Snowball sampling as a means of selecting informants—or, in oral-history parlance, "narrators"—lends itself to oral historians pursuing a story in an open-ended fashion, in contrast to researchers in more social-science-based disciplines that demand the sample be identified a priori. This sampling involved selecting narrators and organizations by asking early key narrators for referrals to other organizations and key narrators. All additional narrators selected by snowballing, however, had to meet the three initial criteria for inclusion (McMahan & Rogers, 1994).

Oral history protocols govern the types of questions the interviewer may ask. They cannot be standardized across different narrators and must be open-ended, meaning they cannot restrict narrators' responses to a specific number of options as answers (Yow, 2005). For example, I asked narrators, "How have you addressed HIV/AIDS in the past?" and "Have you addressed the issues of HIV/AIDS and human sexuality in your sermons?" Each narrator consented to being interviewed at the start of the recording and to subsequent use of the recorded testimony by a signed deed of gift conferring rights of further use upon me (Neuenschwander, 1974). None of the narrators wished for anonymity in my future presentation of their testimony, and I had no occasion to destroy any part of the testimony to protect narrators from libel, slander, or other acts that could lead to criminal prosecution or civil suits. Through adhering strictly to oral history protocols, this study falls under a May 2004 agreement, between my graduate studies program director and the university's institutional review board (IRB), to exclude oral history from IRB oversight, including prior review.

The resulting data were handled as follows. All interviews were recorded on digital media, and portions of some services were videotaped. Notes were taken during several interviews and after participant-observer experiences and nonparticipant observations. All the interviews were later indexed, and the most salient passages were transcribed. After assembling indexes, transcriptions, notes, videos, and photos, I reviewed the data to identify major rhetorical themes, justifications, warrants, strategies, tensions, and concepts. I coded, for later retrieval and analysis, key themes and tensions that emerged as I engaged and synthesized the materials. My reading of the coded material through the lens of rhetorical criticism allowed me to formulate the generalizations manifest in this study. What follows are the findings of my oral history interviews offered for use in the service of HIV/AIDS religious rhetorical interventions.

Discussion **South Africa**

In 2009 and 2011, I traveled to South Africa and spent a total of 23 days conducting oral history interviews and performing ethnographic fieldwork on HIV/AIDS. The religious leader who most often used the words “identify” and “identification” in the oral history interview to explain the rhetorical motivations, justifications, and underpinnings of his or her religious rhetorics on HIV/AIDS was Titus Sithole, senior pastor of the Charity and Faith Mission (CFM) in Mamelodi, South Africa. My interview with Sithole clarifies the possibilities that the often overlooked relationship between oral history, rhetorical performances, and religious rhetorics holds for HIV/AIDS interventions. Sithole’s sermons on HIV/AIDS were not recorded at that time, and his sermon notes were subsequently lost because of a hard-drive failure. Still, during our interview he spoke at greater length about, as he phrased it, “what I did” as part of his rhetorical performances and overall interventional strategies than about “what I said” in sermons that addressed HIV/AIDS. My analysis of Sithole’s rhetoric reveals that he used his sermons to predispose his audience to action and his rhetorical performances to crystallize identification in their consciousness. Whereas past religious constructions of HIV/AIDS were used to create us-versus-them divisions between infected persons and righteous congregations, Sithole explained, his performance of unification through the religious ritual of the shared cup attempted to bring an end to the segregation and social fragmentation taking place in his society and congregation. Sithole recollected a service about HIV/AIDS that was perhaps his most memorable preaching performance:

I did something where I brought in the nutrition supplement that people who are infected with HIV take. The supplement comes in the form of a powder and you mix it with either milk or water. So that Sunday we tasted the vitamin. I brought it to church and we brought small cups, and I had everybody [the church has 3,000 members] drink it to identify with PLWHA. That went a long way [in terms of the impact], as we did that.

In this statement, Sithole points us to the rhetorical aim of such a performance: egalitarian identification. Such a rhetorical performance seems to tap into the rhetorical power of identification located in another widely recognized motif, the community table (Williams, 2004). Indeed, communal drinking together is a common practice in Christian Protestant circles, performed through the sacrament of Holy Communion. For example, through the symbolic drinking of wine and eating of bread together, Christians the world over affirm their unification and oneness with Christ and with his Body, the church. Analogously, by drinking the vitamin solution together, Sithole’s audience members affirmed their unification and identification with PLWHA, thereby creating a rhetorical vision of “we” opposed to us-versus-them rhetorical postures. Sithole’s use of identification through the performance of the shared cup prompted his audience to act in certain ways that support his rhetorical vision for the collective body:

I dream of the Church leading the way in the fight against HIV/AIDS and [in helping] to finding a cure [for it]. I dream of *the Church becoming the Acts Church, where our homes will be opened for the sick, widows, and orphans* . . . If we can unleash all the Church members to be *salt and light*, the world will be different from what it is today Charity, let’s get involved in the fight against HIV/AIDS. We cannot sit back, pray, and

do nothing. The world is waiting for the manifestation of the *sons* and *daughters* of God. Let us use what we have to serve the people, [i.e.,] *your houses, talents, and resources* to contribute to the fight against HIV/AIDS [emphasis mine].

Metaphors of "salt and light" and familial metaphors such as "sons and daughters of God" function as means to the rhetorical end of identification within Sithole's larger purpose and social vision for CFM. Thus the rhetoric of identification inherent in becoming a member of CFM church or internalizing the rhetoric of "the Church" is laid bare for our examination. Either way, upon aligning oneself with CFM and/or internalizing the rhetoric of the church, the HIV/AIDS mission of CFM becomes a means of creating consubstantiality with PLWHA. Metaphors of salt and light are one example of a rhetorical method used to effect identification, regulating and socializing religious adherents' bodies, minds, and actions as they align themselves with Sithole's vision for social relations inclusive of those infected and affected by HIV in Mamelodi.

In response to a later question, Sithole succinctly addressed his motivation behind the use of such rhetorics: "to keep casting vision to our members that this is what we are about. We are not ashamed. We do things that will align us with our vision to reach people where they are." Hence, in performing as members of the church (i.e., identifying with the vision), congregants are expected to engage in the work of creating a safe space for PLWHA throughout the community, consistent with the church's mission. Identification strategies like Sithole's are also salient in informal and formal communications such as the sermons, songs, and rhetorical performances in other African countries I visited. Sithole used rhetorical performances of identification strategies based on common ground to create an evoked audience—a united, diasporic Black church that is socially, spiritually, and practically engaged in the battle against HIV/AIDS.

The Caribbean

When religious leaders in Jamaica and the Bahamas began to address the issue of HIV/AIDS, many took a strong position against earlier rhetorics that had defined HIV/AIDS as "God's judgment" on homosexuals in particular and other "sinners" who engaged in religiously proscribed sexual practices. With great trepidation, Denza Cunningham, senior pastor of Christ Community Church in Nassau, Bahamas, suggested that preaching that HIV/AIDS is a judgment from God is logically flawed because such generalized rhetorics fail to account for people who have "contracted HIV through blood transfusions." Moreover, Cunningham suggested, if persons infected with HIV/AIDS are guilty of committing a sin, then as Christian doctrine teaches, "no one can cast judgment on them because we, too, have sinned in one way or another." He went on to ask "which one of us has the right to pick up a stone and throw it at anyone." Cunningham's comments, like those of other Caribbean narrators who follow, introduced me to the rhetorical act of identificational (re)naming of the HIV/AIDS virus. Burke (1969) said about the function of this rhetorical act:

[T]he rhetorician uses titles (either imaginal or ideological) to identify a person or a cause with whatever kinds of things will, in his judgment, call forth the desired

responses. He will select such "titles" in accordance with the bias of his intention and the opinions of his audience. (p. 86)

Similarly, when Cunningham (re)titles HIV/AIDS as a "virus" rather than a "sin," he creates a new paradigm of understanding, speaking, and responding to the disease, thereby fostering a rhetorical moment in which PLWHA embrace a shared substance of being one with other Caribbean folk in particular and all humanity in general, who too are vulnerable to a plethora of infections and diseases. Such moments of identification empower PLWHA to resist dominant religious narratives that explain their infections through judgment rhetorics that engender alienation.

In another religious rhetorical community, Cunningham's fellow Bahamian, Dr. William Thompson, senior pastor of Faith United Missionary Baptist Church, like other narrators in the Bahamas and Jamaica, tapped into the rhetorical power of the enthymeme to substantiate claims put forth in his sermons on HIV/AIDS. For example, with the authority of Scripture functioning as the explicit, authoritative warrant for their audiences, religious leaders in the Caribbean supported their claims by drawing on the lives of biblical characters who suffered great misfortunes, not because of their sinful deeds but rather because of their common humanity. Thompson's sermons, for instance, frequently highlighted the familiar biblical narrative of suffering in the life of "the righteous" Job as his point of departure. Speaking enthymematically in one sermon, he declared that "some *Christians* have AIDS" [emphasis mine] (W. Thompson, oral history interview, June 29, 2010). Using this rhetorical tool to create a safe space to minister to PLWHA, Thompson positioned his audience to supply the missing premise that, as in Job's case, it was not sinful behavior that caused those infected with HIV to contract their disease.

Several ministers in my interviews spoke of their desire to meet PLWHA at "the human level." With this in mind, some religious leaders used rhetorical strategies to affirm the humanity of PLWHA in rhetorical performances operating through narratives inscribed on their bodies, that is, narratives that then legitimized that body as a vessel of God. In other words, religious bodies came to hold rhetorical meaning for parishioners through the use of narratives and sacred discourses that constructed religious leaders as shepherds, watchmen/women, messengers of hope, and God's entrusted ones, which were subsequently projected on the religious body, imbuing and charging it with social meaning. Thompson had occasion to deliver such a performance when a young woman who had contracted HIV/AIDS was in the audience to hear his weekly sermon. He shared the story of how he used his religious body as a rhetorical intervention to help create a safe space to address the issue of HIV/AIDS. During the sermon, Thompson said, he "came out of the pulpit and hugged her." What happened next testifies to the depth of discrimination against PLWHA in the hearts and minds of members of Thompson's church. After the hug, "folks in the church" did not want to shake his hand "because they felt I was contaminated," he said. Nevertheless, Thompson decided that the best way to handle this situation was not with words but with the "personal touch." At the same time, he confessed, "at first, I was uneasy with it," but he then let his "calling overshadow his personal feelings." This type of ministry, Thompson said, cannot be done to "dehumanize or bastardize" PLWHA but should be used as a means of rhetorical intervention to break the stigma and ignorance shrouding HIV/AIDS.

I maintain that the preacher's touching a person infected with HIV could be read anthropomorphically as the hand of God extended toward PLWHA, rather than as the hand of God withdrawn in judgment from PLWHA seemingly implied in early rhetorics. Thus the religious leader who wishes to address HIV/AIDS must, as Thompson said, "be able to walk out of church with both sides [people infected and affected by HIV/AIDS] walking together." In other words, the preacher's rhetorical task is to locate common ground between PLWHA and the uninfected to reduce religion-based stigma, discrimination, and alienation. Ostensibly, Thompson succeeded in locating common ground in his audience's shared humanity. The most compelling evidence he supplied to support this claim was his assertion that after his sermons, "many PLWHA have said [to him] 'thank you for making me feel like a human being.'"

Another Bahamian, Ross Davis, bishop of Golden Gates World Outreach, goes so far as to not even preach "HIV/AIDS as a separate thing." His sermons address HIV/AIDS in terms of "disability" rather than the "sins" of PLWHA (R. Davis, oral history interview, June 29, 2010), which removes moral judgment from any one specific action, person, or sexual orientation. In our interview, Ross concluded that when speaking of human beings, "for the most part we're all in the same boat [in terms of vulnerability to HIV infections], not because you're homosexual, double-partners, or multi-partners, you got it [HIV/AIDS] because of your lifestyle [i.e., unsafe sexual practices]." The rhetorical strategy of identificational (re)naming is clearly seen in the key excerpts presented above, where pastors seek to work a rhetorical shift in social understanding and public discourse about the religious explanations for the presence of HIV/AIDS. Thus they rhetorically frame HIV/AIDS as part of the human condition, as all human beings are vulnerable to various types of infections, including HIV/AIDS. I further contend that identificational (re)naming then helps to destigmatize HIV/AIDS as judgment from sin and replaces it with an affirming rhetoric located in a shared humanity. My analysis of these excerpts illuminates the uses of religiously affirming rhetorics as interventional strategies—the necessary first step in creating safe spaces where religious leaders subsequently articulate messages of hope and healing to PLWHA, and unification to communities impacted by the presence of the disease.

The United States of America

Analogous to religious rhetorics extrapolated from my oral history interviews conducted in Africa and the Caribbean, identification on the basis of common ground reemerges in the U.S. context as a rhetorical strategy and impetus driving religious rhetorics. Take for example Joseph Garlington, PhD, senior pastor of Covenant Church of Pittsburgh and presiding bishop of Reconciliation Ministries International, who began to speak about HIV/AIDS after his son-in-law's 1988 HIV diagnosis. He described for me how, after experiencing "the whole gamut" of emotions and attending stages of grief associated with the disclosure of a loved one's HIV infection, he "finally came to a place of acceptance" (J. Garlington, oral history interview, November 11, 2010). At that decisive moment of acceptance, Garlington inwardly resolved that he "could not look at him [his son-in-law] as an object." In contrast to earlier religious responses to HIV/AIDS, Garlington's response was grounded in his understanding of God's ethic of love toward all humankind. "The reality is," he went on to suggest, "if it [his son-in-law's past sexual indiscretions] is something that God in his mercy has forgiven, then it's something that I need to find a way to extend grace and compassion toward."

In this same interview, I inquired how this acceptance had impacted Garlington's familial relationship with his son-in-law and by extension his commitments to minister to people infected with HIV through sexual intercourse. His response, akin to what my other African American narrators said, pointed to the most compelling claim that moves religious leaders to action against HIV/AIDS. For Garlington, it came as he pondered the question "How does God feel about this [HIV/AIDS]?"—that is, when he looked to Scripture for guidance and concluded, "God is not counting our trespasses against us." In that moment the question was settled. From then on, Garlington's interpretation of Scripture and seminal messages of reconciliation confronted "twelve distinctions dividing the church," for example, racism, classism, and sexism. And for the first time, Garlington's international message, "Right or Reconciled," began to confront a distinction the Black church was largely silent about until relatively recently: "the AIDS distinction" (Garlington, 1998, p. 126). It is important to emphasize that Garlington's religious rhetorics on HIV/AIDS were shaped by his recognition of the oneness, or the consubstantiality, he shared with his son-in-law. In other words, the recognition of a shared humanity between persons infected (e.g., Garlington's son-in-law) and person's affected (e.g., Garlington) by HIV/AIDS started with Garlington's refusal to objectify and "other" his HIV-positive son-in-law, which resulted in a host of opportunities to share his HIV/AIDS-inclusive message of reconciliation. "The moment we became compassionately focused and interested [in ministering to PLWHA], then all these opportunities emerged. We saw our church come to a place of compassion," he fondly recounted.

Within the District of Columbia, according to Pastor of First Baptist Church and Chairman of the National Black Leadership Commission on HIV/AIDS and vicinity affiliate chapter Frank Tucker, religious rhetoric on HIV/AIDS has "not unfolded in a sermon" (F. Tucker, oral history interview, October 10, 2010). Nevertheless, parishioners at First Baptist in DC routinely hear, in Tucker's weekly remarks during their Sunday morning services, what he calls "a fair dosage of health care information." In these services, Tucker speaks to the audience for about "five minutes" to "lift up" the issues plaguing the Black community, relative to which, he told me, "the issue of AIDS pops out in a number of services." Given the alarming STD statistics and HIV/AIDS infection rates in the African American community in the DC area, no subject is taboo for Tucker to address in his sacred space.

Tucker's personal experience with cancer, another disease that has been shrouded in silence, helped crystallize another way a religious leader can use personal experience to generate safe spaces for PLWHA, provided that HIV/AIDS is first destigmatized in religious spaces (Fife & Wright, 2000; Gullatte, Brawley, Kinney, Powe, & Mooney, 2010). Tucker was diagnosed with cancer in January 2010. As the spiritual shepherd of his flock, he addressed his diagnosis in the pulpit as a method of creating identification with others in his audience who had been diagnosed with HIV/AIDS. The rhetorical strategy for this approach in his pulpit ministry is clear-cut: "What I decided to do," he said, "was to talk to my congregation about cancer in hopes to educate them about HIV/AIDS and to have them open up about HIV/AIDS." He then explained to me how his strategy in doing so was not relegated to sermons:

Every week I give them a report about my progress, what happened with me, and what's going on with me because cancer was and still is taboo—people didn't talk about it. Since January, every week, I've been telling my people, I am doing this not because I have cancer, but because this is what we need to talk about even with AIDS. We need to

open up about this. Since I have talked about this cancer, several of my members have come up to try to encourage me, [and] have shared with me that they have cancers that I didn't know about.

This excerpt reveals that there exists a relationship between the impact of Tucker's illness and his willingness to serve others who are experiencing the trauma of HIV/AIDS. Burkean theory of identification aids investigation of the rhetorical dimensions of African American religious leaders' rhetorics on HIV/AIDS that intensify identification with PLWHA. Whereas Caribbean narrators created identification mostly through (re)identificational rhetorics, African American pastors created identification through consubstantiality by invoking a shared humanity and consequently a shared vulnerability to illness and diseases. Taken together, I contend that the rhetorics of Garlington and Tucker illuminate a strategy of identification on two levels: substantial and consubstantial. Craig Smith (2000) suggests that in rhetorical presentations, substantial identification, commonly employed by religious speakers, uses a shared substance to the speaker's advantage. When speaker and audience share a substance—for instance, a locale, product, or school—identification is often achieved, and it is easier to form a bond. Furthermore, Smith notes, "each substance provides for common ground that intensifies the identification between Christians" (p. 96).

In terms of rhetorical invention, then, Garlington's and Tucker's personal knowledge and experience of suffering are the impetus driving them to minister to community members who are suffering in silence with HIV/AIDS. From another angle, Garlington's and Tucker's stories help to sharpen this analysis of how religious leaders affected by two very different diseases strategically use those experiences as platforms from which to address HIV/AIDS. Tucker's narrative elucidates precisely how a religious leader who is personally diagnosed with a disease rhetorically uses that experience in his religious rhetorics as a point of departure from which to address HIV/AIDS. In these cases, rhetorical invention shifts when a disease, including HIV/AIDS, personally affects a religious leader. Only then, at least for my narrators, did judgment rhetorics become untenable. While not an exhaustive list of their sources of invention, experiences with illnesses like HIV and cancer that affected my respective narrators often serve as starting points for conversations about HIV/AIDS, as these are public health issues and diseases that, along with diabetes, high blood pressure, strokes, and cardiovascular diseases, disproportionately affect African Americans (Centers for Disease Control and Prevention, 2005).

The second strategy at work in their rhetorics is consubstantial identification, which, once achieved between speaker and audience through the realization that they are of the same substance, enhances identification of shared substance, as in my religious leaders' case (Smith, 2000, p. 98). Use of this genre of rhetorics, I argue, gives voice to the suffering that is common to humankind; it is this rhetorical strategy that allows Black religious leaders to achieve consubstantiation with their audiences. I further contend that only through acknowledgement and recognition of the religious leader/speaker and interlocutor being of the same substance—humanity, subject to all types of diseases and infections—is identification achieved, social distancing diminished, and safe space produced in which to broaden ministry to PLWHA.

Among religious rhetorics on HIV/AIDS, the current use of identification rhetorics rooted in the human condition marks a sharp departure. In earlier rhetorics, the presence and impact of HIV/AIDS on gay communities was the starting point for moral religious judgments. But as my analysis has revealed, my narrators used their status as people diagnosed with and/or affected by a disease as the starting point of their religious presentations on HIV/AIDS. Moreover, these presentations were steeped in identification strategies that engender reconciliation through the acknowledgement of a common humanity. Therefore, I posit that HIV/AIDS-related religious rhetorics that are primarily shaped by religious leaders' personal experience of being affected by or diagnosed with a disease are undeniably distinct from earlier judgment rhetorics, in which religious leaders spoke about a matter that did not affect them personally.

Conclusion

Findings from this study suggest that identification is a predominant rhetorical thread and strategy used in HIV/AIDS religious rhetorics. Literature emphasizes that HIV-related stigma is best addressed in safe, liberating spaces for PLWHA and in those spaces where stigma-generating ideas, practices, and beliefs are challenged (Beadle-Holder, 2011; Fullilove & Fullilove, 1999; Lemelle, 2004). The oral history excerpts presented in this study illuminate how strategies of identification woven into religious metaphors, religious performances, and identificational (re)naming have been employed as rhetorical interventions in various pulpitized spaces as a rhetorical tool to combat the antipathy and indifference toward HIV/AIDS in African diasporic communities. The emphasis on Black religious leaders moving beyond the sermon text to use their rhetorical bodies and personal narratives of illness and disease as entry points into conversations about HIV/AIDS should largely resonate with other Protestant Christian groups whose faith is rooted in their identification with a suffering savior—the crucified Christ, whose life was marked by ministry to the downtrodden, marginalized and social outcasts of his day.

In addition to highlighting my narrators' uses of identification in their religious rhetorics and rhetorical performances, this study expands the understanding and definition of intervention. That is, it demonstrates how oral history itself can be used to intervene critically in the present, as in the case of the evanescent HIV/AIDS sermons delivered by the ministers quoted here. Because it devotes scholarly attention to recovering pastors' important rhetorical activity through their own words, oral history is a critical methodology allowing pastors to develop interventions into the HIV/AIDS crisis, both for future use and for use in emerging religious responses to the presence of the disease in other areas of the world.

Like other qualitative studies of this nature, this study has several limitations. My use of the snowball method was successful, to some degree, in that it afforded me access to religious narrators in other areas of the world with whom I would not have come into contact without use of this method. Nevertheless, this method poses a limitation, in that the religious leaders interviewed for this study were predetermined and pre-selected by virtue of their relationship with the key religious gatekeeper who gave me access to their network. Consequently, the religious leaders I interviewed held very similar religious views and ideologies. Although rhetorical approaches used to address the issue of HIV/AIDS varied from narrator to narrator, a lack of diversity of thought remains apparent concerning religious ideologies and norms as they intersect with HIV/AIDS. Even so, the oral history methodology used in this project is

worthy of additional scholarly attention, as it contributes to a meaningful reconstruction of religious institutions' past engagements with HIV/AIDS.

The fruitfulness of this methodology draws attention to future areas of research within the international study of communication, specifically those focused on how rhetoric has played out in the diasporic church's engagement with HIV/AIDS over time and space. This study therefore recommends further research to interrogate to what extent the identificational strategies employed in each region grow from the local culture. Such research will improve understanding of how the diasporic response to HIV/AIDS is shared transnationally and experienced locally, and above all will further understanding of the intercultural dynamics of communication across the diaspora.

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