Why is the Black Community Still Contracting HIV? by Cleo Manago

Washington, DC – As a first-hand eyewitness to the rising of America's Black HIV/AIDS industry, starting in the mid 1980s, this topic is very poignant to me. Almost 30 years ago, based on Black AIDS programs observed, I literally predicted that HIV would likely be in our communities for an unparalleled amount of time. I vividly remember, while in my early 20's, Black Brothers dying in droves. Legions of once vital, now terrified young males were filling hospital beds, hospices, and cemeteries. It was a virtual hell-o-cost. Many Black communities were already stressed by the challenges of the day (e.g. police brutality, high unemployment, problematic media images, a crack epidemic, being stigmatized for being Black and other social problems.) African Americans, an identity we were just beginning to grapple with, had never in history directly dealt with issues related to same-gender-loving (SGL) or bisexual Black men.

Alarmed, in my own way in 1986, I attempted to stem the HIV tide, beginning with a speech I gave at an HIV/AIDS conference held in San Francisco, California. I was invited to speak by the late Black, Puerto Rican, AIDS treatment pioneer Dr. German Maisonette. This was my first time publicly speaking on the issue. My topic was "Effectively Bringing HIV Prevention to Diverse Black Communities."

During my talk, I expressed to the audience that while it was important that gay identified people continue to get proper resources, a more dimensional approach – in terms of identity, education and outreach – was needed to attract diverse Black people to AIDS related services. I went on to mention that many Black males at HIV sexual risk did not identify with or as gay. I strongly urged them to consider this when rolling out Black prevention and care programs, so as not to alienate people needing prevention services. If not, many would continue to get infected, and there was a risk to Black women.

I was heckled. Someone called me "homophobic" and a "race baiter." These remarks noticeably came from behind a banner that said "Black and White Men Together (BWMT)." BWMT was an organization founded in San Francisco by a White man for White men with a sexual fetish for Black men. The largely White gay male audience, with a smattering of Black men, all of whom were wrapped around White men, did not want to hear what I was saying. They had no interest in anything that wasn't gay identity focused, or Black focused and especially that included women.

As I left the podium, Dr. Maisonette saw the disappointment on my face. I sat next to him, and he said, "Cleo, they don't understand Black communities. You may have to launch your recommended approach." In 1989, I would establish both the Black Men's Xchange (BMX) and the first African American AIDS prevention Institute in the State (possibly the country). I named it the "AmASSI Wellness and Cultural Center." AmASSI stands for the African, American Advocacy, Support-Services

and Survival Institute.

For years, despite BMX and AmASSI's unique capacity to attract and serve diverse Black men, we were treated like pariahs. Just like among the hecklers at that San Francisco conference, work that affirmed being Black and related struggles not solely focused on gay identity, was not valued. In 1994, I successfully developed and piloted an HIV prevention strategy called Critical Thinking and Cultural Affirmation (CTCA). Just recently, in 2010, it was recognized by the Centers for Disease Control and Prevention (CDC) as a "promising" Black community HIV intervention. In four more years it may be considered to fill America's gap in efficient, culturally responsive, African-American designed, HIV prevention methodologies.

In 1986, BWMT was granted millions in federal resources by the CDC for their "National Task Force on AIDS Prevention (NTFAP)." NFTAP was the nation's first project funded to provide HIV prevention services to gay identified Black men in America. However, some years later, due to the organization's mismanagement of funds and inability to reach Black men, it was defunded and closed. BWMT members, such as Phill Wilson, have continued nonetheless to recreate themselves to stay relevant in the HIV field, still attracting federal dollars and notoriety. Nevertheless, HIV is now worst for Black men.

The Black community still has HIV because America has never had an efficient and Black culturally responsive, HIV prevention model, policy, campaign, leadership or agenda – in 30 years. Given that we live in a modern society, this may be difficult to believe. Yet, we also have our first Black president. But even Mr. Obama has had to tip around African American issues not to offend non-Black people. The HIV/AIDS issue has suffered from a similar phenomenon among its self-selected and inefficient leadership.

Preventing HIV among African Americans, especially males

(which protects women as well), requires specific and skilled focus on the mastery of risk-reducing behavior change, and guiding people toward dignity and vigilance toward valuing risky sex related impulse control to protect themselves. This is exactly what CTCA does. Accountability, skilled leadership, and culturally affirming strategies will make HIV a thing of the past.

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