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IDCR

INFECTIOUS DISEASES IN CORRECTIONS REPORT

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ABOUT IDCR

IDCR, a forum for correctional problem solving, targets correctional physicians, nurses, administrators, outreach workers, and case managers. Published monthly and distributed by email and fax, IDCR provides up-to-the moment information on HIV/AIDS, hepatitis, and other infectious diseases, as well as efficient ways to administer treatment in the correctional environment. Continuing Medical Education credits are provided by Medical Education Collaborative (MEC). This activity is jointly sponsored by IDCR and Medical Education Collaborative (MEC). IDCR is distributed to all members of the Society of Correctional Physicians (SCP) within the SCP publication, CorrDocs (www.corrdocs.org).

IDCR and AAHIVM have united to improve the quality of health care delivery in the nation's correctional facilities by leveraging the knowledge, experience and resources of two diverse and accomplished groups of HIV and correctional health care experts.

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THE MYTHOLOGY OF THE DOWN LOW: A CRITICAL EXPLORATION OF BLACK MEN WHO HAVE SEX WITH MEN AND HIV TRANSMISSION

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Defining the "Down Low"

Dialogue focused on the "down low" (DL) has been a dominant feature of conversations about black men and HIV/AIDS in both HIV prevention circles and the popular press. The term down low is used most often to refer to black men who are involved in relationships with women but who also have sex with other men, and do not inform their female partners about their same sex encounters. Certainly, male bisexual behavior is not new, but the ways in which it has been discussed has led many to believe that it constitutes a public health emergency due to the belief that DL black men serve as the primary HIV transmission "bridge" to black women. DL men are perceived within some communities as the sole reason for the high rates of HIV among black women. Although a primary thesis of the bestselling book that launched discussion of the DL into to the mainstream media,[1] the evidence culled from the public health literature does not bear this out. There is limited research that focuses exclusively on the experiences of black men who have sex with men (MSM) relating to HIV prevention generally, and even fewer that critically examine the DL. The research literature presents a more nuanced view of the dynamics of black MSM behavior than the popular media, but HIV prevention for black MSM requires a more detailed investigation. In media depictions, DL men have been described as secretive and, because they do not perceive themselves to be at risk for HIV infection, not amenable to standard HIV prevention messages.[2-5]

Further, discussions about the DL generally rest upon four major myths: all DL men are HIV positive; all black MSM are on the DL; the DL can only be applied to black men; and lastly, that DL men are entirely responsible for the rising rates of HIV among black women. Our discussion will center on exploring each of these problematic assumptions. Given the disproportionate rates of both HIV and incarceration among black men, awareness of this issue and the perceptions surrounding the DL are of importance to correctional staff engaged in health care, HIV prevention and community reintegration.

Myth #1: All down low men are HIV-positive

Despite decreased rates of new cases of HIV among MSM following the 1980s, there is evidence for increasing unsafe behavior and HIV transmission among MSM, especially young MSM.[6-8] MSM continue to constitute the largest number of HIV/AIDS patients in the United States, and black MSM are disproportionately affected by this epidemic nationwide.[9] Studies that report the HIV disparity among black MSM, however, are not studies of DL men and should not be confused as such. Much of the discussion about the DL is fueled by a belief that DL men place their female sex partners at high risk for HIV infection. However, this would only be true if most or all DL men were infected with HIV. While a recent study estimates HIV prevalence rates as high as 46% for black MSM,[10] this study did not specifically examine whether these men reported unprotected sex with females. The *Young Men's Study* - a cross-sectional survey conducted during 1994-2000 of men aged 15-29 years who attended MSM-identified venues in six U.S. metropolitan areas (Baltimore, Maryland; Dallas, Texas; Los Angeles, California; Miami, Florida; New York; and Seattle, Washington) - found that com-

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WHAT'S INSIDE

Letter from the Editor

Dear Corrections Colleagues,

Infectious diseases are opportunistic. To establish a niche they exploit opportunities to survive, if not thrive. Human behaviors are the fertile soil in which HIV has been able to establish itself and spread within our species. Poverty, war, mobility, gender power imbalance, the commercialization of sex, disparities in wealth and health care, the prevalence of other sexually transmitted diseases, bad government and ignorance are some of the human forces that have fueled the HIV epidemic and confound efforts to contain its reach.

In our country, the virus has found African-American men and women. Entire careers have been dedicated to understanding why and how the epidemic shifted toward this population but during the past several years, as rates of HIV infection have increased sharply among African-American women, the public spotlight has been focused on their male partners, usually African-American men. In particular, black men who have sex with men (MSM) who also have sex with women have been cast in the role of Typhoid Mary and have been accused of being responsible for the transmission of HIV within African-American communities. A very public, and often contentious, discussion regarding such men, described as being secretive about their bisexuality to their female partners (i.e. living on the 'down low'), and their role in the spread of HIV to women has become a staple of the day time talk shows and the subject of popular books. However, there has been relatively little in the social science or medical literature to indicate just how many African-American women are actually becoming infected with HIV from down low men.

In this issue of *IDCR*, Lisa Hightow, a clinical scientist who first detected an outbreak of HIV among MSM college students in the U.S. South that was subsequently described in the CDC's *Morbidity and Mortality Reports*, and Justin Smith, the director of a project Dr. Hightow founded to provide outreach and counseling to young MSM of color, enumerate and refute the myths they encounter regarding the down low. As a clinician who staffs a department of corrections HIV clinic, Dr. Hightow is familiar with the concerns regard sex between men and incarceration as overlapping forces abetting HIV transmission within African-American communities. To supplement her article, we have included in our Spotlight a discussion of how incarceration itself may produce conditions that foster acquisition of HIV by African-American women. This piece is written with the assistance of my colleagues Drs. Adaora Adimora and Becky White (formerly Stephenson) - experts on this topic.

Together, these articles are intended to be informative and thought provoking - in this, I am certain, they will succeed. Your provoked thoughts can be emailed to me at wohl@med.unc.edu for potential re-print in our Letters to the Editor section of our website.

Sincerely,

David A. Wohl, MD
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THE MYTHOLOGY OF THE DOWN LOW
(continued from page 1)

pared with black MSM who disclosed their homosexuality, those who didn't were actually less likely to be HIV-positive, less likely to have multiple male sexual partners and less likely to report unprotected anal intercourse (see IDCR-o-Gram).[7] Further, although often portrayed as promiscuous, bisexual men compared with homosexual men have been found to report fewer male sexual partners and are less likely than homosexual men to have engaged in anal intercourse.[11-14] Moreover, having a non-gay identity has not been found to increase HIV-risk taking behavior with male sexual partners among black MSM.[15] In summary, the evidence suggests that non-gay identified men (DL men) may, in fact, be less likely to be HIV-positive than gay-identified black MSM, and in turn, less likely to transmit HIV to their female sex partners.

Myth #2: All black men who have sex with men are on the down low

Another assumption underpinning DL dialogue is that all black MSM are on the DL. Evidence does show that black MSM are less likely to disclose their sexual orientation or behaviors,[16-18] and are less likely to identify as homosexual,[16,19,20] and a larger proportion self-identify as bisexual as compared with white MSM.[11,21,22] Further, among HIV-infected MSM, higher proportions of black MSM report also having sex with women compared with white MSM.[21, 23] Higher proportions of bisexuality among black men may be due to the fact that same-sex relationships are often stigmatized in the black community, and black MSM face more disapproval from their families and friends than similar whites.[24, 25] Other factors that may contribute to gender-role expectations and social pressures for black MSM to maintain a masculine identity and conform to sexual norms include: racism, segregation, and the powerful influence of the church within the black community.[17, 26, 27]

However, it is important that these data are evaluated within the context of the relatively low prevalence of bisexuality among black men; approximately 2% overall. [28, 29] Moreover, while DL men are behaviorally bisexual, not all men who have sex with both men and women are on the DL. By definition, men on the down low are leading a sexually duplicitous lifestyle, knowingly lying to their female sex partners about their same sex activities. While some black MSM do not disclose their sexual practices for the aforementioned reasons, there are many who have found ways to integrate their sexuality and their racial identities.

Myth #3: The down low can only be applied to black men

As the high profile "outings" of former New Jersey Governor James McGreevey, and Evangelical leader Ted Haggard illustrate, being on the down low about one's same-sex desire is not the exclusive purview of black men. However, nowhere in the public discussion of these men's sex lives was there a discussion about the risk of these men transmitting HIV to their wives. While data show that black MSM are less likely than other MSM to identify as gay or to disclose their sexual identity or behavior to others, significant numbers of non-black MSM also choose not disclose to others[11, 17]. In a Centers for Disease Control and Prevention (CDC) analysis of data from the Young Men's Survey, 8% of white MSM did not disclose their sexual behavior to others, compared to 14% and 18% for Hispanic and black MSM, respectively (see IDCR-o-Gram).[18] Additional, research has found that substantial and similar proportions of heterosexually identified black, white and Latino men report having sex with men.[11, 21, 22, 30]

Myth #4: DL men are entirely responsible for the rising rates of HIV among black women

Much of the rhetoric surrounding this myth stems from the assumption that HIV is a "gay disease" which spreads outwards from gay communities to infect those in the straight world. This belief demonizes and places the blame for HIV transmission on black men while also removing responsibility for HIV prevention from black women. Further, it obscures some of the other structural factors that influence black women's risk for HIV, including high rates of poverty and concurrent sexual partnerships as well as the higher rates of incarceration among black men which may contribute to the disparity in HIV rates between black women and women of other races (see Spotlight).[31]

While evidence suggests that black men who have sex with both men and women play important roles in connecting sexual networks of MSM and heterosexual women, the extent to which this contributes to HIV transmission to black women is unknown.[32] In 2005, there were 6,978 black female AIDS cases reported in the United States. Out of that number, only 115 (2%) reported "sex with a bisexual male" as the method of exposure. This compares to 1,794 AIDS cases among white women of which 60 (3%) reported "sex with a bisexual male" as the method of exposure.[33] Further research is needed to understand more fully the roles of these sexual networks and other structural factors in facilitating HIV transmission in the black community.

Issues for Corrections

At year end 2004 the rate of confirmed AIDS cases in state and federal prisons was more than three times higher than in the total U.S. population.[34] The racial disparity of HIV rates in the general community is also present in correctional facilities. A Georgia-based study showed that 86% of male state inmates identified as HIV-positive upon entry were black.[35] As of December 31, 2005, 8.1% of black males age 25 to 29 years were in state or federal prison, compared to 2.6% of Hispanic males and 1.1% of white males in the same age group.[34] Some have speculated that the increased incarceration rates among black men contribute to HIV transmission by facilitating homosexual encounters with other men during periods of imprisonment. The contribution of situational bisexuality (engaging in same sex behavior due to the unavailability of and prolonged isolation from female partners) on HIV rates has not been adequately explored. One study of black men with a history of incarceration found these men reported a higher frequency of anal intercourse with men in the community rather than during periods of confinement (45% vs. 16%, respectively). In this study, only 13% of those men who reported anal sex while incarcerated had done so for the first time during imprisonment.[36]

> *"Much of the discussion about the DL is fueled by a belief that DL men place their female sex partners at high risk for HIV infection. However, this would only be true if most or all DL men were infected with HIV."*

Conclusions

Some bisexual men may be in transition to a homosexual identity while others will never identify as gay and will not even identify as bisexual. These non-gay identified black MSM may have risk reduction needs that are different from other MSM. To be most successful, it is critical that HIV interventions take into account that the sexual behaviors of group members may be discordant with their sexual identities.[37] Further, current dialogue centered on the DL must address the veracity of each of the aforementioned assumptions. Therefore, more focused and open discussions with regard to HIV prevention in the black community are needed. Until the myths surrounding the DL phenomenon are appropriately explored, continued placement of blame of the HIV epidemic on black men does not empower black women (or men) to protect themselves and fails to foster strategies to quell the epidemic in the black community.

Continued on page 4

The Mythology of the Down Low...
(continued from page 3)

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Resources

Centers for Disease Control and Prevention: Questions and Answers: Men on the Down Low
http://www.cdc.gov/hiv/topics/aa/resources/qa/downlow.htm

Centers for Disease Control and Prevention: Factsheet - HIV/AIDS Among Women.
http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm

Centers for Disease Control and Prevention: Cases of HIV infection and AIDS in the United States and Dependent Areas, 2005
http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/default.htm

Center for Disease Control and Prevention: Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

US Department of Health and Human Services: Incorporating HIV Prevention into the Medical Care of Persons Living with HIV - July 18, 2003
http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=15&ClassID=4

The Well Project: Health Information for Women with HIV and AIDS?
http://www.thewellproject.org/

Spotlight - Does incarceration of African-American men facilitate HIV infection of African-American women?

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Introduction

A popular perception, fueled by media portrayals of prisons and jails is that as a result of (consensual or forced) sexual activity during incarceration, male prisoners become exposed to HIV and subsequently infect their partners after release. The recent report of transmission of HIV within the Georgia department of corrections provided evidence for HIV acquisition during incarceration and feeds the characterization of correctional facilities as breeding grounds for HIV.[1] However, while it is undeniable that transmission of HIV occurs within correctional facilities, the available data indicate that the majority of HIV-infected inmates enter prison or jail with infection. [2-4]

Subsumed by discussions of intramural spread of HIV in prisons and jails is consideration of the potentially greater, albeit indirect, contributions of incarceration to the general HIV epidemic. Emerging data suggest that incarceration, as a socially disruptive force, creates conditions favoring the spread of HIV and other sexually transmitted infections (STIs), especially in minority communities where incarceration and HIV/STIs are endemic. In this brief Spotlight we describe the potential impact that large-scale incarceration of men, particularly African-American men, may have on the spread of HIV/STIs to African-American women within their communities of origin.

Rates of HIV are disproportionately high among African-American women

African-American women bear a significant burden of the HIV epidemic. From the beginning of the epidemic through 2004, an estimated 84,900 women have died from AIDS - most African-American - and AIDS continues to be a leading cause of death among African-American women.[5] According to the Centers for Disease Control and Prevention (CDC), 14% of adults and adolescents living with AIDS in 1992 were female but as of the end of 2004, this proportion had grown to 23%.[5] Two thirds (68%) of the 45,146 women diagnosed with HIV/AIDS during 2001-2004 in the 33 states reporting HIV diagnoses were African-American; 16% were white. The vast majority of HIV-infected women acquire the infection from heterosexual contact; CDC data indicate that an estimated 70% of women diagnosed with AIDS in 2004 reported sex with a man as the likely mode of HIV transmission (figure 1). [6]

The causes of disparities in HIV/STI prevalence and incidence among African-American women are unclear.

Factors that may contribute to racial disparities in HIV and STI rates include those related to health care access and utilization, sexual behaviors and sexual network attributes, distribution of STIs that facilitate HIV transmission and substance use.[7] However, a cogent overarching explanation for the markedly increased HIV rates among African-Americans remains elusive.

Available data indicate that differences in sex partner number do not fully explain racial disparities in HIV/STIs.[8] Rather, the available evidence suggests that concurrency of sexual partners (the overlapping of sexual relationships in time) and dissortative sexual mixing (sexual partnerships among persons at different levels of risk for HIV/STIs) differs between African-Americans and whites and may provide, at least, a partial explanation for these disparities.[9-11] Data from the 1995 National Survey of Family Growth (NSFG) indicate that concurrency of sexual partnerships was more common among African-American women than white women (21% versus 11%), and that the black-white differences in concurrency were largely due to decreased marriage rates among African-Americans and earlier age at first sexual intercourse.[11] Other data support a role for dissorative sexual mixing in increasing exposure to HIV/STIs among African-American women. In one recently published case-control study of risk behaviors among African-American men and women, a substantial proportion of HIV-infected African-American women reported few risk factors for HIV acquisition and relatively low numbers of previous sexual partners.[8]

The potential role of incarceration

Mounting evidence strongly suggests that the convergence of social contextual factors influence individuals behaviors associated with HIV/STI infection and play a critical role in heterosexual HIV transmission among African-American women. Among these factors are aspects of an individual's environment that may influence individual behaviors by destabilizing partnerships, altering the sex ratio and changing social norms to promote partnership concurrency and sexual mixing.[8,12-14]
In the U.S., there exists a low ratio of men to women among African-Americans. The severity and persistence of the scarcity of men among African-Americans is unparalleled, eclipsed only by the male shortages experienced in some nations post-WWII.[15] A higher death rate among African-American males, due to infant mortality, disease, and violence, accounts for some of this imbalance.[16] Incarceration, which is epidemic in many African-American communities futher exacerbates this low sex ratio. African-Americans comprise 12% of the U.S. population, but represent over 40% of federal and state prison inmate population.[17] The U.S. Department of Justice predicts that one in three African-American men will be imprisoned during their lifetime (versus <5% of white men).[18] The disproportionate arrest and incarceration of African-American has resulted in a pervasiveness of incarceration that has led to imprisonment becoming a 'normal' part of life for many young African-American men, replacing other traditional life events (e.g., marriage).[19]

In addition to contributing to the scarcity of men, incarceration may foster HIV/STI transmission in several other ways. First, incarceration directly affects sexual networks by disrupting existing partnerships. The incarcerated partner may form risky partnerships with other inmates - a group with a high prevalence of HIV, HBV and HCV infection.[1,4,20-22] Second, the partner remaining in the community forfeits the social and sexual companionship of the incarcerated partner and may pursue other partnerships to meet these needs.[8] Loss of a partner to incarceration can also lead to economic losses and less personal safety/security - additional potential motivations for a forming new intimate partnership(s). Incarceration of a partner has been associated with greater prevalence of sexual concurrency among young adults in Seattle.[23] While incarceration may be a marker for sexual risk behaviors, it can also promote sexual partner concurrency by temporarily removing a partner from the relationship. With the absence of her partner, a woman may enter into a new relationship and in a community where HIV is relatively prevalent, her exposure to HIV infection is, therefore, increased. A qualitative study of concurrent partnerships among adults described "separational" concurrency among persons with partners who were frequently incarcerated.[24] Third, incarceration adversely impacts the social fabric of the communities of origin of the incarcerated. A prison record usually makes men less employable,[25] contributing to high community unemployment rates. Therefore, incarceration can shrink not only the absolute number of men but also the proportion of men who are financially attractive as partners. Unemployment also increases the likelihood of poverty and resultant instability of long-term partnerships.[26,27] Lastly, mass imprisonment distorts social norms. The 'downstream' effects of incarceration may be detected in the emergence of a prison/jail culture in communities where incarceration becomes normative [28] - potentially further influencing sexual behavior and sexual networks.[8]

Continued on page 6

Does incarceration of African... *(continued from page 5)*

Studies in the sociology and criminal justice literature provide ample evidence of a deleterious effect of incarceration on families and communities, including African-American communities.[29-36] Although the male partner may be criminally involved prior to incarceration, these men often contribute some of their gains to their partner and this loss of income can be devastating for women straining to live at or near poverty levels.[29] The financial burden of incarceration for those left behind is further compounded by the loss of assistance with childcare and the expenses related to maintaining contact with the incarcerated man. [29-33] Importantly, the loss of a male partner has been found to increase the risk of partnership dissolution.[34] In one study, spousal absence due to incarceration or military service was associated with a two-fold risk of marital dissolution.[35] Qualitative studies find that incarceration of a man leads to loneliness among female partners.[33-36] Lastly, several investigations have described HIV/STI transmission risk behavior among prison releasees, including HIV-infected former inmates.[37-38] Coupled with data demonstrating a loss of the viral suppression achieved during in-prison HIV care following release [39,40] a picture of increased infectiousness and renewed risk behavior on community re-entry emerges and reinforces calls to improve pre- and post-release HIV prevention strategies.

Summary

The high rates of HIV and other STIs among African-American women remains unexplained and likely is results from the confluence of behavior, social and economic factors. The available evidence suggests that the disruptive effects of incarceration on relationships and communities already burdened with HIV and other STIs may facilitate the spread of these infections and place African-American women at increased risk for infection. Further study of the effects of incarceration on the partners and the communities inmates leave behind are required to better understand the unintended public health consequences of incarceration and to develop appropriate strategies to reduce the impact of incarceration on HIV/STI transmission.

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IDCR-O-GRAM

Percentage of men aged 15-29 years who have sex with men reporting selected demographic and pyschosocial characteristics and testing positive for HIV and hepatitis B, by disclosure states and race/ethnicity-- six cities, United States 1994-2000 (Modified from: CDC MMWR 2003;52 81-86)

	Black		Hispanic		White	
Characteristic	Disclosers (n=910) %	Non-Disclosers (n= 199) %	Disclosers (n= 1391) %	Non-Disclosers (n=204) %	Disclosers (n=2237) %	Non-disclosers (n=182) %
Sexual Identity						
Homosexual	66	28	77	43	83	36
Bisexual	24	58	18	46	13	46
Heterosexual	1	6	<1	8	1	10
Transgender	5	2	3	1	1	1
Unknown/refused	3	7	1	2	1	7
STD/HIV Infection						
Previous STD (self report)	21	27	18	15	21	16
HBV	23	20	15	12	13	9
HIV	24	14	10	6	6	3
Previous HIV Tests						
None	24	29	21	35	19	37
≥ 3 tests	36	24	42	24	50	28
Psychosocial						
Homosexual/bisexual identity not important	15	38	13	34	15	46
Homosexual/bisexual friends not important	25	40	24	30	17	33
Feel isolated from others	16	27	18	31	16	32
Sometimes dislike being homosexual/bisexual	16	37	19	39	15	28
Most people disapprove of homosexuals	47	68	61	72	32	57

Disclosure was assessed by asking participants to rate how 'out' they were with others about their sex with men.

Percentage of men aged 15-29 years who have sex with men reporting selected demographic and pyschosocial characteristics and testing positive for HIV and hepatitis B, by disclosure states and race/ethnicity-- six cities, United States 1994-2000 (Modified from: CDC MMWR 2003;52 81-86)

	Black		Hispanic		White	
Characteristic	Disclosers (n=910) %	Non-Disclosers (n= 199) %	Disclosers (n= 1391) %	Non-Disclosers (n=204) %	Disclosers (n=2237) %	Non-disclosers (n=182) %
Sexual Behavior with women						
≥3 lifetime partners	40	61	33	55	31	61
≥1 partner	15	44	11	33	10	45
Main Partner	10	31	6	26	7	35
Casual or Exchange Partner	8	26	6	18	7	29
Unprotected vaginal/anal intercourse	7	23	5	21	6	36
Sexual behavior with men						
≥5 lifetime partners	72	56	77	54	83	49
≥3 partners	41	37	47	35	52	35
Main partner	72	64	73	59	74	51
Casual partner	51	48	59	50	64	55
Exchange partner	9	10	9	11	6	8
Unprotected anal intercourse	41	32	47	42	48	27
Sex with men at public settings(ages 15-22 only)	20	12	20	18	23	15

Disclosure was assessed by asking participants to rate how 'out' they were with others about their sex with men.

Save the Dates

2007 National African American MSM Leadership Conference on HIV/AIDS:
"Brothers, It's Our Time"
Charlotte, NC
January 25-28, 2007
Visit:www.aesmonline.com /Conference.htm

The 2nd National Conference on Methamphetamine, HIV, and Hepatitis
Salt Lake City, UT
February 1-3, 2007
Visit:www.xmission.com/~uhrcmeth/registration.php

2007 National Conference on African-Americans and AIDS Featuring the Rev. Jesse L. Jackson
Philadelphia, PA
February 12-13, 2007
Visit:www.minority-healthcare.com

14th Annual Ryan White National Youth Conference on HIV and AIDS
Oakland, CA
February 17-19, 2007
Visit:www.napwa.org/rwnyc/index.html

14th Conference on Retroviruses and Opportunistic Infections
Los Angeles, CA
February 25-28, 2007
Visit:www.retroconference.org/2007/

Interferon and Ribavirin in Hepatitis C Virus Infection: Mechanisms of Response and Non-Response
Chicago, IL
March 1-3, 2007
Visit:www.aasld.org/eweb/DynamicPage.aspx?webcode=07_hepatitisstc

Academic and Health Policy Conference on Correctional Health
Sponsored by the University of Massachusetts Medical School and UMass Correctional Health
Boston, MA
March 29-30, 2007
Visit:www.umassmed.edu/commedinterior.aspx?id=33110

16th Annual HIV Conference of the Florida/Caribbean AIDS Education and Training Center
Orlando, FL
March 30-31, 2007
Visit:www.faetc.org/Conference/

IAS 2007: 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention
Sydney, Australia
July 22-27, 2007
Visit:www.ias2007.org/start.aspx

News and Literature Reviews

Self-Identification as "Down Low" Among Men Who Have Sex with Men (MSM) from 12 U.S. Cities

A group of researchers from the Centers for Disease Control and Prevention (CDC) set out to compare the racial identity, sexual identity and sexual practices of MSM who considered themselves "on the down low" (DL) with those MSM who did not. Drawing on a convenience sample of men (n=455) from12 northeastern cities, the study found that 20% of participants self-identified as DL; that is they were both aware of the term and considered it descriptive of their own situation. Overall, blacks (41%) and Hispanics (17%) were more likely than whites (4%) to self identify as DL. In regard to sexual identity, participants who did not identify as gay were more likely to describe themselves as DL. Behaviorally, DL-identified MSM were less likely to have had seven or more male sex partners in the prior 30 days, but were more likely to have had a female partner and participated in unprotected vaginal sex. High rates (68%) of both DL and non-DL men had taken part in unprotected anal sex in the last thirty days, but self-identified DL individuals were more likely to have done so with partners of unknown serostatus. Additionally, the DL-identified group was less likely to have ever been tested for HIV. While the investigators concede the limitations of the study, due largely to convenience sample eligibility and varying definitions of the term DL, they also recognize that the results highlight the need for public health programs to adopt and expand risk reduction strategies among this population.

Self Identification as "Down Low" Among Men Who Have Sex with Men (MSM) from 12 US Cities. Wolitski, R et al. AIDS Behavior. (2006) 10:519-529.

Outcomes of Project Wall Talk: An HIV/AIDS Peer Education Program Implemented Within the Texas State Prison System

In this study, investigators in Texas reported select results on Project Wall Talk, a community-based, peer-led HIV prevention and education program implemented in thirty six Texas State Prisons. The data demonstrates significant improvement in HIV knowledge among both the peer-educators (N=257) and students (N=2,506) following enrollment in the program. Importantly, the training was able to erase differences in HIV-related knowledge across categories of prior education and race/ethnicity from baseline to follow-up, a period of nine months. Peer-educators, who received 40 hours of intensive training prior to conducting education sessions with other inmates, reported higher levels of HIV testing. Similarly, more students indicated plans to take an HIV test following receipt of peer-led education, even though fewer students reported knowing their current serostatus. At five prison facilities where Program Wall Talk was implemented, the number of HIV tests was approximately double that of five, matched comparison units in both the 12 and 18 month follow-up periods. Additionally, the authors suggest that the diffusion of the knowledge may spread well beyond the classroom and even outside the prison, with teachable moments reaching as high as 84,000 opportunities per year. While the study data is limited by an attrition bias, which may have positively selected the more able peer-educators (43.6% of baseline sample), the authors strongly assert that peer-education training represents an effective means of improving both HIV knowledge and peer education skills.

Outcomes of Project Wall Talk: An HIV/AIDS Peer Education Program Implemented Within the Texas State Prison System. Ross, M et al. AIDS Education and Prevention, 18(6), 504-517, 2006.

HIV in Prison in Low-Income and Middle Income Countries

While the majority of research regarding HIV prevention and transmission in prisons has occurred in high-income countries, in this review article, published in the *Lancet Infectious Diseases*, Dolan et al provide a summary of imprisonment rates, HIV prevalence, and injection drug use (IDU) in 152 low and middle-income countries. Using data from a variety of governmental and non-governmental sources, the authors found that HIV in prisons was a significant problem, especially in areas where IDU is common, such as Eastern Europe, Central Asia, and Latin America. Overall, the prevalence of HIV was greater than 10% in prisons in 18 countries, including seven in sub-Saharan Africa and at least one country in all the regions of the world except South Asia. Of the eight countries reporting HIV prevalence among IDU prisoners, seven reported HIV prevalence among this group at levels greater than 10%. Unfortunately, data collection proved to be a challenge, as researchers faced poor record keeping, language barriers, and official reluctance to release documentation. For many countries, the lack of data, especially in regard to the relationships between HIV prevalence and IDU, made the contribution of HIV in prison settings difficult to determine. In closing, the authors suggest that further data collection is urgently needed to inform future HIV prevention strategies in these countries.

An accompanying editorial makes the point that richer countries also have HIV levels among prisoners above those seen in their general populations. The U.S., France, Netherlands, Spain and Portugal all have reported HIV prevalences among prisoners substantially above their national rates. In Spain, 24% of inmates were HIV-infected in 1996; however, the prevalence was cut in half to by 2003 following the introduction of harm reduction programs.

HIV in Prison in Low-Income and Middle-Income Countries. Dolan et al. The Lancet Infectious Diseases, (2007) 7:32-47.

Compiled by Ross Boyce

Self-Assessment Test for Continuing Medical Education Credit

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for continuing Medical Education through the joint sponsorship of Medical Education Collaborative, Inc. (MEC) and IDCR. MEC is accredited by the ACCME to provide continuing medical education for physicians.

Medical Education Collaborative designates this educational activity for a maximum of .75 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity. Statements of credit will be mailed within 6 to 8 weeks following the program.

Objectives:

- The learner will be able to describe popular myths regarding the contribution of men on the down low to the spread of HIV infection.
- The learner will be able to describe the results of Project Wall Talk, a community-based, peer-led HIV prevention and education program implemented in thirty six Texas State Prisons.
- The learner will be familiar with potential effects of incarceration of men on the spread of HIV infection to African-American women.

1. The term 'living on the down low' is most often used to refer to:
   A. Bisexual men
   B. Men who have sex with men (MSM) and women but do not inform their partners about same sex encounters
   C. HIV-infected MSM who infect a female partner
   D. Men who do not use condoms when having sex with other men

2. Each of the following are, according to the article by Hightow and Smith, myths regarding the down low EXCEPT:
   A. All down low men are HIV positive
   B. All black MSM are on the down low
   C. The down low can only be applied to black men
   D. Down low men are entirely responsible for the rising rates of HIV among black women
   E. All of the above

3. According to the findings of the Young Men's Health Study, com pared with black MSM who disclosed their homosexuality, those who didn't were:
   A. More likely to be HIV-infected than those who did
   B. Less likely to have multiple male sexual partners
   C. Less likely to report unprotected anal intercourse
   D. All of the above
   E. Only B and C

4. In the Spotlight, the authors describe which of the following potential effects of incarceration on the spread of HIV within some African-American communities:
   A. Incarceration exacerbates low ratio of women to men
   B. Men infected with HIV during incarceration return home and infect their partners
   C. Loss of a partner to incarceration can promote sexual partner ship concurrency
   D. All of the above

5. AIDS continues to be a leading cause of death among African-American women (TRUE or FALSE)?

In order to receive credit, participants must score at least a 70% on the post test and submit it along with the credit application and evaluation form to the address/fax number indicated. Statements of credit will be mailed within 6-8 weeks following the program.

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- Applications for Credit will be accepted until January 30, 2007.
- Late applications will not be accepted.
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Please fill in the number of actual hours that you attended this activity.

Date of participation: _____

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Please Submit Completed Application to:

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For questions regarding the accreditation of this activity, please call 303-420-3252

COURSE EVALUATION

I. Please evaluate this educational activity by checking the appropriate box:

Activity Evaluation					
	Excellent	***Very Good***	***Good***	***Fair***	***Poor***
Faculty					
Content					
How well did this activity avoid commercial bias and present content that was fair and balanced?					
What is the likelihood you will change the way you practice based on what you learned in this activity?					
Overall, how would you rate this activity?					

II. Course Objectives

Were the following overall course objectives met? At the conclusion of this presentation, are you able to:

- The learner will be able to describe popular myths regarding the contribution of men on the down low to the spread of HIV infection. **YES** **NO** **SOMEWHAT**
- The learner will understand the lapses in the literature regarding the role of MSM and women in the transmission of HIV within African-American communities. **YES** **NO** **SOMEWHAT**
- The learner will be familiar with potential effects of incarceration of men on the spread of HIV infection to African-American women. **YES** **NO** **SOMEWHAT**

III. Additional Questions

a. Suggested topics and/or speakers you would like for future activities.

b. Additional Comments