If three themes were central to this year’s AIDS Impact Conference in Melbourne, they were those of culture, community, and empowerment. An emphasis on culture permeated presentations throughout the meeting, highlighting how researchers, health promotion specialists, and program managers are beginning to take seriously the different ways in which HIV disease is made sense of, and its impact upon individuals, groups, and societies throughout the world. A concern for community arose both in relation to understanding contemporary responses to the epidemic, and with respect to the kinds of relationships needed in order for researchers and community groups to together make continued headway against the epidemic. And empowerment was emphasized as a strategy to confront the structured and systematic inequalities that render some groups more vulnerable to HIV disease than others and which deny access to treatment and care in both developed and developing countries.

In her opening words, the conference co-chair Doreen Rosenthal said she hoped that delegates would leave the conference with “recharged energy and will” for the tasks of providing better quality care and support for people living with HIV disease, of preventing new infections, and of building solidarity in circumstances when a multitude of forces divide people from one another. Peter Piot echoed these sentiments. Now, as never before, we know what to do to achieve these goals, but now as never before there exist powerful disorientations to deflect us from the tasks: disorientations due to weakening political will; disorientations arising from the damage HIV has inflicted on infrastructures for prevention, support and care; and disorientations brought about by those who seem more interested in establishing the credibility of a “science” of HIV prevention than in scaling up nationally and globally to use what we already know to work in HIV-related health promotion.

Culture and Inequality

Numerous presentations during the conference highlighted the importance of local beliefs, practices, and sexual cultures as factors influencing HIV related risk. Tom Mboya’s eloquent plenary address described cultural practices in Kenya such as polygamy, widow inheritance, woman-to-woman marriage, and traditional group forms of circumcision, that may heighten the risk of HIV transmission (T7.2). In a discussion of beliefs and attitudes of young men in Zimbabwe, Agnes Runganga observed that “sexual conquest” is a fundamental part of being a man in Shona culture (W14D.1). Finally, in a presentation on changing patterns of risk, Catherine Hankins suggested that economic development and rural and urban migration, which in many countries separate partners and facilitate sexual networks, cause the epidemic to grow most rapidly (T8A.3).

Elsewhere, the importance of culture as a factor structuring the forms, contexts, and meaning of sex was amply illustrated. A number of papers analyzed the complex expectations and beliefs that may encourage either young women or young men to enter sex work. Studies conducted in Thailand, for example, described how the need to provide for the family, as well as the pursuit of a better life, may encourage both women and men to sell sex (M4B.1 and M5B.4). A range of studies conducted among young people in places as diverse as Italy (M5E.1), Australia (M5E.4), Cambodia (M3A.3), and

Footnotes:

*AIDS Impact, the 3rd International Conference on the Biopsychosocial Aspects of HIV Infection took place in Melbourne, Australia from June 22 to June 25, 1997. This issue of FOCUS includes the perspectives of three conference participants.

†References to conference abstracts are cited in parentheses.
**Editorial: Great Expectations**

Robert Marks, Editor

Unlike the International Conference on AIDS, the AIDS Impact Conference draws hundreds, rather than thousands, of participants, providing a relatively intimate setting in which to exchange ideas and information about the psychosocial aspects of HIV-related care.

AIDS Impact Conference participants, however, resemble those who attend the international conference in the diversity of their backgrounds, interests, goals, and expectations. The result is a rich blend of research data and frontline savvy. The reports in this issue of *FOCUS*—by Peter Aggleton, David McInnes, and Purnima Mane—clearly represent this breadth of experience. Aggleton’s article, in particular, describes a range of presentations on topics such as HIV and culture and formulations of basic concepts such as risk and sexuality.

In an excerpt of her conference presentation, Mane explores women and power, focusing not only on the ways in which women are disempowered but also on the ways in which societal pressures on men lead them to disempower their female partners.

**Form Follows Function**

In his report, McInnes takes a different tack, focusing less on the content of presentations than on their form. In paying particular attention to two papers, he shows how the approaches of academic and front-line presenters can collide at interdisciplinary meetings such as the AIDS Impact Conference.

The source of this collision, McInnes suggests, lies in expectations. Most professional conferences center around the discussion and interpretation of research, and so presentations focus on study populations, methods, and data, and use jargon, a perfectly acceptable shorthand for presenters speaking only to people from their fields. Researchers— even those who are prepared for audience members to ask pointed questions about the real-world applications—come to conferences expecting and preferring this type of academic presentation. On the other hand, providers and activists—even those who have come to appreciate the role of theory and data in developing practical programs—come to conferences expecting to learn about what’s happening and what’s working on the front lines. McInnes offers some compelling examples of this collision of expectations. The surprising thing is not that such collisions have happened, but that they continue to happen with such regularity.

It would seem that after more than a decade of AIDS conferences, researchers and providers would have come to understand each other’s approaches and to have developed common standards for the language and format of conference presentations. If this goal cannot be achieved at a place where people are receptive to communication, can we expect to reach a world that remains resistant to hearing about HIV?

In the end, each of us must not only consider our own expectations about what is appropriate communication, but also anticipate the expectations of others—a "client-centered" approach that is the hallmark of HIV-related care.

the United States (M5E.4) demonstrated how sexual culture may either facilitate or militate against consistent condom use among young people. And studies conducted in prisons showed how cultures of sex and of drug use can emerge with consequences for HIV-related risk that stretch well beyond the prison gates (M6C.1).

As at earlier AIDS Impact conferences, a number of studies identified inequalities in heterosexual relationships and the limitations these impose on sexual communication. Papers also highlighted the need for further inquiry into women’s and men’s sometimes differing perceptions of risk. In her plenary address, Purnima Mane called for a move beyond overly deterministic analyses that see men as the cause of women’s inequality, to those that focus on gender as a set of principles structuring both women and men’s relationships (see page 8 of this issue for more on Mane’s presentation).

In one of a number of papers highlighting the effects of rapid economic and social change on changing patterns of sexual practice, Kong-lai Zhang candidly described elements of a “sexual revolution” currently underway in China (M4C.4). He detailed a dramatic increase in sex work and in a number of major cities, an increase in extramarital sex. In addition, he reported that more than 7 percent of college students recently surveyed indicated that they had had sex with someone of the same sex. Along with these behavioral changes has been a dramatic increase in sexually transmitted disease and HIV incidence, which Zhang suggested indicated the potential for an epidemic of catastrophic proportions.

Finally, for once, the conference sustained a clear focus on the experiences and rights of indigenous peoples, and there were several presentations from countries such as Brazil, Australia, and New Zealand that highlighted ways in
which successful HIV information, education, and communication activities could work within indigenous populations.

**Drug-Using and Gay Cultures**

Cultures of drug use were highlighted in a number of presentations, be these cultures linked to heroin and cocaine injecting or associated with the recreational use of more newly available drugs such as ecstasy and crystal meth. A Canadian presentation described an ongoing epidemic of HIV and Hepatitis C among drug injectors in Vancouver, with unstable housing and involvement in sex work among the most important factors predictive of seropositivity (M4E.1).

Stephanie Knox found important differences in drug use cultures among gay men in three Australian cities. In particular, while levels of drug use were highest among men in Sydney, heroin and needle use were highest among men in Brisbane (M4E.3). In addition, gay men who injected drugs were more likely than those who did not to engage in anal sex and “esoteric” sexual practices (even after controlling for age, city, level of drug use, and HIV status). Studies from a number of countries reaffirmed the relatively high levels of injecting drug use in prisons.

Two studies of particular interest sought to determine why gay men continue to be among those most affected by HIV disease in Western countries. Michael Bochow reported on a national survey of German gay men that found class-related differences in seroprevalence rates: 17 percent for men in the lowest socioeconomic class; 13 percent for men in the lower middle class; and 8 percent for men in the middle class (M4A.1). This was true despite the fact that men of higher socioeconomic status report being more sexually active than their lower status counterparts. In a widely reported paper, Andrew Grulich found that among gay men in Sydney who had recently seroconverted, 34 percent reported having had five or more drinks at the time of the seroconversion event (M4A.3). This is a notable finding, but one that must be interpreted in light of the possibility that excessive alcohol use may offer people who seroconvert a more “legitimate” explanation for seroconversion than some other explanations.

A number of papers explored the continuing role of homophobia in HIV-related stigma, and identified both instrumental and symbolic dimensions to this stigma. Homophobia may also enhance gay men’s vulnerability to HIV infection, as was stressed by Paul van de Ven in his report on data collected during the Sydney based Male Call Study (M4D.1). The study found that 40 percent of gay men reported having experienced some kind of abuse ranging from verbal abuse or bashing to refusal of services in the 12 months prior to interview. Younger men who were open about their sexuality were among those most likely to be affected.

In a study comparing homophobia among participants in the gay “dance” and “rave” scenes in Australia—dance subcultures attracting large numbers of young gay men and lesbians—Alison Turtle found that “ravers” were more likely than “dancers” to have cognitive, affective, and behavioral attributes associated with homophobia (M4D.3). In particular, ravers had higher scores in anger and guilt and lower scores in delight than did dancers. Turtle suggests that the dance scene has maintained closer ties to the gay and lesbian community than has the rave scene, and this may explain the results.

**Language and Notions of Risk**

New research methodologies may be needed to analyze many of the processes described above. In an important plenary address, Susan Kippax argued forcefully for a reconsideration of contemporary formulations of risk, replacing them with more socially informed notions than those traditionally used in epidemiological and behavioral studies (T7.1). For example, she suggested concepts such as risk management, risk negotiation, and social practice should and have replaced traditional notions of risk takers, relapse, and promiscuity. Kippax stated that new formulations need to consider context, interpersonal relations, and the social, political, and sexual dimensions of community as factors influencing both HIV-related behavior and sexual life in general.

Issues of representation were central to many presentations throughout the week. A series of papers exploring images and narratives in AIDS work demonstrated once again the prevalence of negative images of the syndrome in the early days of the epidemic and their impact on public perceptions in the years that followed. Just as importantly, Colin Dixon reported on the difficulty of promoting more positive images of seropos-
Cindy Patton, in considering supranational, national, and local conceptions of HIV disease, also looked at communication regarding seropositivity (W12.2). She drew attention to the absence of a common language to describe what it is like to live with HIV disease. Because of this, seropositive people have few options beyond embracing narrowly defined biomedical constructions of their condition and the (sometimes false) promises these understandings offer. In addition, this failure of language limits desirable partnerships between science and community, leaving activism as the only structure for interacting with researchers and policy makers.

In a significant presentation also dealing with language and understanding, Gary Dowsett warned against the use of overly simple sexual categories, such as “heterosexual” and “homosexual” in defining HIV-related risks (W13B.1). He noted that Western paradigms of sexuality have gained ascendency over other cultural formulations of sexuality. For him and for other presenters, sexual culture—the way we live our lives sexually—is more relevant than sexual identity to identifying vulnerability to HIV transmission. Dowsett made a powerful plea for educators on a global scale to take care not to obliterate difference among cultures in a desire to obliterate HIV.

Finally, Elizabeth Reid talked of the silence and paralysis that comes from fear when dying is everywhere—a silence which gnaws away at the sense of self (W13B.2). She talked too of the need to develop a new language for analyzing the impact of HIV disease, one sensitive to the ways in which illness, psychological trauma, and death feed opportunistically on existing social problems. In many countries around the world, the epidemic exacerbates existing deprivations and dysfunctions in the ability of social systems to offer support. Bill O’Loughlin focused on a similar theme in his talk regarding the manner in which “shame” affects not only personal responses to HIV disease, but also community responses to the epidemic (M2.2).

Conclusion

In his presentation on the closing day of the conference, Sam Friedman talked powerfully of the politics of HIV, and its relation to national and international processes of exclusion. He described changes in belief systems; patterns of national, international, and regional migration; and the scapegoating of minority groups and communities—all processes that provide stimulus for, and reinforce, negative societal responses to HIV disease.

But Friedman also pointed to the ways in which solidarity can and does emerge as a counterbalance to social division and social exclusion. He cited the harm reduction movement, AIDS activism, and other grassroots movements in both developing and developed countries as illustrations of these countervailing forces.

The challenge for all of us, therefore—in preparing for the 12th International Conference on AIDS in Geneva and the 4th AIDS Impact Conference—lies in building bridges in circumstances where prejudice, hostility, and suspicion pull us apart. If the first two decades of the epidemic have been characterized by too much confusion and dissent, let us move towards the millennium with a greater sense of purpose, seeking to build the kinds of partnership that will offer an example to other fields of endeavor once this terrible epidemic has passed.

Authors

Peter Aggleton, PhD is Professor of Education at the University of London. He is Director of the Thomas Coram Research Unit and Associate Director of the Health and Education Research Unit of the Institute of Education. He has worked in HIV-related social research and health promotion for many years. Dr. Aggleton adapted this article from the closing plenary summary address he gave at the AIDS Impact Conference in Melbourne.

Clearinghouse: AIDS Conferences

Journals and Newsletters

AIDS Care will publish a Special Supplement of papers from the AIDS Impact Conference in 1998 (Volume 10). After publication, this issue can be ordered from: Subscriptions Department, Carfax Publishing Limited, PO Box 25, Abingdon, Oxfordshire, OX14 3UE, United Kingdom; 44 1235 401000.


Future Conferences

October 25-29, 1997, Manila, Philippines: 4th International Congress on AIDS in Asia and the Pacific. Contact: GNP/ICW Conference Secretariat, 2nd Floor, Physicians’ Tower, 533 United Nations Avenue, Ermita, Manila 1000, Philippines; 63 2 526-8103 or 63 2 526-8105; 63 2 522-1090 or 63 2 522-8130 (fax); aidsphil@philonline.com.ph (e-mail).

November 5-12, 1997, Chiang Mai, Thailand: GNP 8th International Conference for People Living with HIV/AIDS. Contact: GNP/ICW Conference Secretariat, 12/14 Rajchiansaen Road, Soi 2 Kot, Haiye,
Peter Aggleton, at the end of his summation for the 3rd AIDS Impact Conference, implored participants to “Never confuse our concern for theorizing with a desire to do something constructive about the epidemic, and let us seek to build the kinds of partnership that will offer an example to other fields of endeavor once this epidemic has passed.” The partnership between researchers and providers, in particular, was the subject of a great deal of discussion at the conference.

According to Aggleton, external pressures determine each of these group’s needs. For researchers, the pressure arises out of a need to be productive within an academic environment and to create a solid methodological and disciplinary base. For providers, the pressure comes from the need to rapidly disseminate information and to develop approaches and programs that respond to the needs of client populations.

Since conferences like AIDS Impact are ostensibly about collaboration, they provide a perspective from which to consider both the research and education paradigms that inform the kinds of presentations and presenters who participate. This article looks at the possibilities of collaboration, identifying problems, perspectives, and solutions, through the lens of conference presentations on negotiated safety and clinical discourse.

Publish, Perish, or Present

A presentation by Christopher Candlin from Macquarie University in Australia provides a good illustration of conflict between the research and education paradigms and the frustration that can follow the resulting failure of communication (M3B.3). Candlin discussed the linguistic and structural aspects of the doctor-patient interaction and documented a power and knowledge imbalance, a failure of communication, and the barriers to negotiation between doctor and patient. He identified statement and questioning strategies that perpetuate miscommunication and provided examples of more productive approaches. While the paper was fascinating and the situations it described were recognizable to many of the practitioners, Candlin’s insights were obscured by the density and abstractness of his material and the speed of his presentation. Ironically, many participants felt that they were placed in the same kind of position by Candlin’s paper as patients were by the doctors he described.

Ultimately, the failure of communication was related to the nature of an academic presentation and the goals and self-perceptions of both researchers and providers and educators. The abstractness, technical nature, and theoretical aspects of Candlin’s paper are essential elements of successful academic presentations and are necessary components of the kind of analytical work done by linguists. But is the AIDS Impact Conference and other AIDS conferences intended to be an academic forum or the site of dialogue between practitioners and researchers?

Academics are not, by and large, trained educators, nor are they trained presenters. The highly technical and specific body of knowledge about which Candlin spoke was not within the "discursive domain" of educational practitioners, that is, it was unfamiliar and uncomfortable not only in terms of language but also in terms of the integrated system of values, priorities, preferences, and self-perceptions that frame and give meaning to what a person does.

See also references cited in articles in this issue.
It could be argued that Candlin’s presentation was aimed at an academic audience and its style and content were determined by the need to function within the “publish-or-perish-or-present” environment of academia. But the mis-match was also about expectations, from both sides of the researcher-practitioner relationship. On one side, the academic expects an audience familiar with the content of a presentation and the concepts and values of the disciplines in which it is based; on the other, the provider or educator expects a digested set of findings and ideas about how these findings might be applied.

Candlin’s presentation suggests that if we are to have effective partnerships between researchers and providers, there needs to be a dialogue between these two groups. This dialogue must be less about the rhetoric of partnership—the high-sounding statements that have peppered conference plenary sessions for years—and more about developing effective strategies for interacting. This is not about teaching researchers to be providers or providers to be researchers: it is about developing a common understanding, based on an ongoing dialogue, which then influences both undertakings. Candlin’s presentation might have fostered dialogue if it had used a workshop format in which Candlin conducted a textual analysis and interpretation, explaining this process as it unfolded and responding to participant’s comments during the process. But, such a presentation would have required new styles and expectations, a re-shaping of the presentation paradigm, and in some sense, the creation of a discursive domain common to both researchers and providers.

Negotiated Safety

Another good example of the failure to bridge the gap between research and practice was the debate surrounding the issue of negotiated safety. In a paper entitled “Talking and Trusting: The Unrecognized Risk of ‘Negotiated Safety,’” Heather Worth from the AIDS Trust of New Zealand, discussed the value that gay men give to skin-to-skin contact, insertive anal sex, and semen exchange, and the sense that these practices are a “given” within the gay community (T11C.3).

Worth presented a set of theoretical ideas she considered essential to understanding how gay men perceive sex, sexuality, and condom use. Her thesis hinged on the idea that gay men are too often considered “knowing agents” of their actions. Worth claimed a negotiated safety media campaign—“Talk, Test, Test, Trust”—assumed that gay men were rational and decisive in relation to sexual choices, including the use of condoms. Her analysis clearly showed that rather than being rational agents, gay men were cultural subjects, positioned within the expectations and value systems of their broader culture. Worth went on to conclude that “Talk, Test, Test, Trust” was “dissonant” with the gay male culture in terms of their desires and expectations. She claimed that gay men are not rational and decisive in any simple sense.

The fact that gay men are “victims” to the conceptions—the “discursive traces”—of heterosexuality, that is, that gay men value certain sexual practice because their culture values them, is vitally important to sexual decision-making. This perspective provides an important backdrop for interventions that seek to deal with what informs gay male sexual choice. But Worth’s “dislodging” and “de-centering” of what is “authentic” in sex can only be an academic theoretical pursuit, because it asks questions driven by theoretical and academic ideas rather than those motivated by educational needs. If, as Worth argues, anal sex is the central sexual activity of gay men, this does not necessarily mean that an uncritical acceptance of unprotected anal sex equates with a lack of volition and knowledge among gay men.

The Australian educators present at this session were vocal in their objections to Worth’s presentation. While Worth’s academ-

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ically based and theoretically informed critique might be seen as central to the concerns of both researchers and educators, in reality, it was probably next to useless in the field. While educational program developers are unlikely to be concerned with “de-centering and rewriting the discursive configurations of sex and sexuality,” this is one of the sexiest areas of contemporary academic research on sex and sexuality.

Worth might have fared better had she considered the participants of the session in a different light, as an “audience” rather than as “subjects,” informing them about theoretically based ideas. In this way, front-line providers and educators would learn about a particular theory and its practical applications and be in a better position to explain the theory to others and to deploy it through their interventions.

Strategies for Dialogue

Candlin warned that a doctor’s or patient’s particular perspective can detract from effective exchange. The same warning should apply to partnership between academics and practitioners, who need to define the nature and purpose of their interaction and to be sensitive to the knowledge, beliefs, and values of all involved.

As part of this process, it is important to ask what underlies the academic presentations of Worth and others. This means asking questions such as: How do academics see their audience? What are the expectations of the audience? How does the academic’s perspective of gay men as research subjects differ from the educators’ perspective of gay men as clients?

It is clear that many of our approaches fail to bridge the relationship between researchers and providers. But, how do we share theory and perspectives and create a way of crossing the boundary between academia and providers working within the epidemic? Most crucially, this partnership must not be like a traditional heterosexual marriage in which one group is relegated to a less valued role. Notions of difference—so often used at conferences by one group or another to view the “Other”—can disrupt this ingrained relationship.

At conferences, workshop formats that both inform and seek feedback benefit both researchers and practitioners. Beyond re-shaping of the presentation styles and formats, workshops also require a difference in the way language is used and necessitate processes which explicate theory in the process of using it.

Outside of conferences, partnerships must be sustained. In Australia, these ongoing relationships are becoming more common. For example, providers at the AIDS Council of New South Wales work with researchers at the National Centre for HIV Social Research at Macquarie University through participation in forums driven by practitioner needs, during sessions at which academics report on preliminary research, and in community-based forums at which both providers and researchers discuss the implications of research for the community. In working with organizations such as the Australian Federation of AIDS Organizations, academics seek to focus their presentations on the forms of cultural analysis that relate most directly to educational work.

Theorists and researchers need to develop a range of presentation styles and formats that can facilitate dialogue. Providers need to appreciate the role of theory, in particular, the cultural analyses that should underlie their interventions. These adjustments may be unsettling, but each is crucial to partnership, and both should be the focus of future conferences.

HIV Prevention and Gender

Purnima Mane, PhD

Much of the literature on gender and HIV disease has focused on women’s vulnerability, a topic undoubtedly critical to understand and address. Gender inequality constrains sexual expression, diminishes access to information on sex and safer sex, decreases the availability of the means to protect against HIV and other sexually transmitted diseases (STD), and impairs the ability to use the available information for safer practices.

Data from a range of studies suggest that men are seen as sexual beings but women are not. Men are expected to gain sexual experience by having sex outside marriage while women who have extramarital sex are shunned. Women are expected to submit to the demands for sex from their husbands or partners and not to negotiate when and under what circumstances sex occurs. Economic factors that heighten women’s dependence

Authors

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on men support these norms and create situations under which safer sex is difficult if not impossible to ensure.

However, researchers have given inadequate attention to the societal pressures that make it difficult for men to change their behaviors and so reduce women’s vulnerability, and even less to how these societal pressures, in fact, heighten men’s own vulnerability to HIV disease and STDs.

Male Vulnerability

Men are often socially pressured into narrow conceptions of male sexuality that privilege them in the short term, but expose them to the risk in the long term. This is especially true when these pressures are accompanied by lack of information or worse, by false beliefs about male invulnerability to HIV infection or about the inconsistency of condom use with masculinity.

A variety of other gender-related factors may increase the risk of HIV transmission among men and boys, as well as increase the vulnerability of women and girls to disease. Among these factors, which are elaborated in a Joint United Nations Programme on HIV/AIDS (UNAIDS) technical update on gender and HIV disease (in process), are:

• The inability of men to find work may result in delays in marriage that combined with existing masculine sexual norms, may lead to multiple, casual, and unprotected sexual partnerships.

• Migration to work and working in “mobile” occupations may lead to separation from family and community support and security, creating risk-generating situations for both men and women.

• Alcohol and drug use are encouraged by a “macho” image, and these enhance the HIV-related risk.

• Because of stigma regarding STDs, men often do not seek STD diagnosis or care.

• In most societies men who wish to participate in caregiving are often prevented from doing so by societal attitudes about masculinity, and this increases the pressure on women to sacrifice their own well-being to the care of others.

Gender-Focused Approaches

By focusing only on women in the power equation, HIV interventions ignore these societal forces—the root cause of both women’s and men’s vulnerability to HIV. As a result, men are freed from the responsibilities for their own and their partners’ health and for sharing the work of care and support that so often falls to women alone.

In its technical update on gender, UNAIDS proposes a range of more gender-focused approaches to prevention, care, support, and the alleviation of the impact of HIV disease. Among these are: expanding efforts to promote HIV prevention technologies; enhancing gender-sensitive STD services; addressing coercive, violent, and exploitative sex; focusing on the reproductive and sexual rights of women; and encouraging social and economic policies that address family disintegration, displacement, and poverty, thereby increasing the involvement of men in caregiving and reducing the caregiving burden on women.

The efforts to “gender” the response to the epidemic are fraught with challenges. Some of these challenges pertain to balancing the special needs and vulnerabilities of women with the expansion of the focus to include men’s vulnerabilities. In this way, the work of HIV prevention offers the possibility of addressing more fundamental issues in gender relations.

Next Month

Managed care, the “evil” and surviving twin of health care reform, is changing the relationship between people with HIV disease and their health care providers. While many people receive quality care through health maintenance organizations, many others have found that managed care has cut their choices and limited their interactions with providers, and that it is inadequate when dealing with a complex condition such as HIV disease.

In the November issue of FOCUS, Perry Halkitis, PhD and Tracy Mayne, PhD, clinicians and researchers at Gay Men’s Health Crisis in New York and adjunct faculty at New York University, discuss the effects of managed care on seropositive clients and on their clinicians.

Also in the November issue, Ruth Clifford, PhD President of the California Coalition for Ethical Mental Health Care, discusses the effects of managed care on mental health services and the work of mental health providers.
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