HIV is threatening to devastate Africa. There are now 16 countries with more than one-tenth of the population aged 15 to 49 infected: a total of 24.5 million people. In five of these countries, at least one in five adults is living with HIV. In Botswana, almost 36 percent of adults are infected; in South Africa, 20 percent have HIV (up from 13 percent two years ago). In 1999, four million Africans became infected with HIV.

Set in Durban, South Africa in July, the XIII International Conference on AIDS focused attention on the escalating catastrophe in Africa and highlighted both psychosocial and medical challenges. Using conference presentations as a starting point, this article reviews the HIV-related psychosocial issues facing Africa, focusing, in particular, on data gathered through HIV counseling and testing programs.

The concept of counseling might be thought of as a Western import, imposing new perspectives on culturally established notions of traditional African health care. However, the concerns raised by the HIV epidemic in Africa strongly suggest a response that includes counseling, psychosocial support, and information provision. The willingness with which voluntary counseling and testing has been adopted as a model in Africa indicates that it is generally accepted as a way to ensure informed consent for testing, assist with preparing for the psychological impact of test results, and enable a discussion of prevention-related concerns. Counseling in Africa is currently limited not so much by cultural constraints as by a lack of resources.

Coping and Emotional Support

One of the main aims of voluntary counseling and testing is to help those who test seropositive to understand their status and cope with its consequences. Studies have shown that this approach significantly assists with adjustment.1,2 Counseling and testing improves coping by alleviating anxiety and depressive reactions, enabling a quicker acceptance of serostatus, and enhancing the capacity for self-care, work, and social contact. Counselors are able to foster coping by helping people gain social support and acceptance, diffusing irrational fears, blame, and anger, facilitating discussions in marital and family relationships about sexual behavior, broaching difficult issues such as planning for the future, and promoting the management of medical, practical, and economic problems.

Comprehensive counseling improves the ability of people to disclose HIV status. This facilitates not only emotional support and informed decision making about sexual behavior, family planning, and the future, but also the ability to understand and accept HIV status. Despite the advantages of sharing HIV test results, disclosure rates vary considerably. In rural Tanzania, 80 percent of people who received counseling were able to disclose to someone they trusted, and 75 percent disclosed to partners or spouses. In contrast, more than half who refused counseling did not disclose their status, even to spouses or intended spouses. In Zambia, a seropositive person tended to share test results with a significant other of the same sex—usually a close family member of the same generation—and not with a sexual partner. Similarly, in Uganda, while 90 percent of clients revealed HIV status to close relatives, only 36 percent revealed it to spouses or regular partners.
The XIII International AIDS Conference was the first of the international AIDS conferences to take place in a developing country and the first in Africa. If this event achieved nothing else, it focused attention on the continent hit hardest by the epidemic. In a tribute to the positive effect of media attention, several richer countries and corporations have finally acknowledged the “pan” in “pandemic” and the public has seen a picture of the African epidemic beyond aggregate statistics.

Better late than never, I guess. But it’s only 15 seconds of fame that you get, and they’ve passed; already it seems the media, government, and the public have shifted attention back to more local concerns. If we are lucky, they’ll still remember AIDS in their own communities.

FOCUS does not usually cover the developing world. Most of our readers work in the United States, Europe, and Australia, and the challenges richer nations face in terms of treatment side effects and targeting complex prevention interventions are very different from those faced by countries struggling with tiny health care budgets. But I suspect that the differences are smaller than we think in the realm of the psychological response to disaster. There is something universal in the human response to HIV, despite huge cultural and economic distinctions. In this issue of FOCUS, David Miller, Rachel Baggaley, and Bitra George report on the psychosocial challenges of HIV in Africa, drawing both on conference presentations and on published literature, and offering insights on both differences and similarities.

For obvious reasons, many more African delegates were able to attend the conference than in the past. Given the desperate situation in Africa, the conference was a welcome opportunity to get support and exchange ideas about battling the epidemic in “resource-poor” environments, a powerful boost to often isolated efforts of HIV workers, and a tremendous public information opportunity. For delegates from richer countries seeking cutting-edge scientific findings, the conference may have been a disappointment; it has become a place not so much to announce breakthroughs—there are other clinical and basic science conferences for that—as to express the current medical standard. But this may be good, since there are few forums for such a diverse group of providers to offer another input on the application of research or clinical approach.

At the same time, the number of mental health and psychosocial presentations continued to shrink, and this seems to be a lost opportunity. In putting together her article on prevention and care issues for HIV-positive people, Nancy Geshke was left to choose from relatively few presentations.

Still, there were two experiences that could have come only from the Durban conference. The conference forced much needed attention on Africa, both in terms of HIV and its huge economic problems. And the healthy mixture of delegates from rich and poor countries encouraged a discussion about living with HIV without resources, a situation that crosses cultures.

References


Perhaps one of the most concrete benefits of HIV counseling and testing is access to an increasingly wide range of support services, including peer-support groups or “post-test clubs.” These approaches aim to help people cope following testing by sharing experiences and providing mutual support. In some countries, they have motivated people with HIV to form pressure groups to improve services and challenge discrimination. A Zambian study described the benefits of post-test clubs: 150 of 810 people who tested joined post-test clubs, which provided peer support for members and HIV education for the community [TuPeD3738]. Other services for seropositive people following testing such as tuberculosis screening and prevention are proving to be feasible and popular [ThPeB5283].

Future Planning and Skills Training
HIV-related psychosocial support encourages planning for the future, in particular, dependent and financial planning, including writing a will. “Property grabbing”—when relatives seize the property of a person with HIV after his or her death—occurs in some countries in sub-Saharan Africa, often resulting in the destitution of widows and orphans. A legally binding will ensures that the claims of loved ones and dependents are secure. In Uganda, 39 percent of clients in observed counseling sessions discussed the topic of wills, with 51 percent expressing an inclination to create a will. In Zambia, 37 percent of seropositive men and 35 percent of seropositive women worried about the future of their dependents, and 20 percent of men and 42 percent of women said that they had been able to plan for a dependent’s future following counseling and testing.

Because people with HIV may often experience problems with maintaining
Women were better situated to negotiate safer sex if they could also discuss HIV status or if their husbands had previously been tested.


employment due to intermittent illness and discrimination, some counseling and testing centers refer people who test seropositive to skills training workshops. In Zambia, trainees have gone on to set up viable small businesses and also participate in the program as trainers. In Uganda, 84 percent of those attending a day center said they had benefitted from skills training.

Gender and Sexual Negotiation

Sexual negotiation is crucial to HIV-related risk reduction, and many African studies have shown that women often have little power in sexual decision making. A Rwandan study found that men control sexual behavior, and seropositive women were likely to report being coerced into sex by their partners. The study found that women were in a much better position to negotiate safer sex and condom use if they were also able to discuss HIV status or if their husbands had previously been tested. In studies from Zimbabwe and Zambia, seropositive women stated that they were often unable to insist on (or even discuss) condom use. Men stated that they did not like condoms and that they were inappropriate in marriage.

Men also report difficulties discussing HIV with their partners. In a study from Zimbabwe of 3,381 men enrolled in a factory worker cohort, 56 percent returned for their HIV test results. Although the men were encouraged to bring in their sexual partners for counseling and testing, only 7 percent did so.

Studies have found that counseling and testing couples together is a successful way to help couples discuss safer sex and to prevent transmission in serodiscordant couples. Acceptance of this option varies considerably. In Rwanda, where couples counseling was offered as part of a research project, no couple declined testing. However, in Zambia, there was great reluctance for couples to be tested together at a voluntary counseling and testing service. In Nigeria, Catholic community organizations promote pre-marital counseling and testing. In Uganda, increasing numbers of people said that they were seeking testing because they wanted to get married: in 1992, this figure was 6 percent, while in 1998, it rose to 35 percent.

Finally, services focused on the prevention of mother-to-child transmission are rapidly being established in sub-Saharan Africa. These interventions are much more effective if they include counseling about HIV transmission to and from sexual partners and if male partners agree to counseling and testing. However, in most cases, very few men agree to be tested. In a small study from Uganda, seronegative mothers in an intervention program chose abstinence or condom use until their partners accepted counseling and testing, but it was unclear how long participants could sustain this behavior.

Stigma and Violence

Stigma and discrimination are common barriers to counseling and testing. In Uganda, researchers have postulated that compared to neighboring countries, political commitment to HIV prevention and care has led to reduced discrimination and higher demand for counseling and testing. Others have argued that the converse is true: because a large number of people have tested, this has promoted the normalization of HIV and reduced HIV-associated stigma and discrimination. Using prominent seropositive role models, for example, Ugandan pop star Philly Lutaya, may have helped reduce the HIV-related stigma, motivate HIV testing, and raise prevention issues. Still, in many African countries, there is a great reluctance to disclose HIV status, and very few prominent figures have promoted testing. In Nairobi, Kenya, a study found that of 324 seropositive women, only 66 (27 percent) communicated their test results to their partners and only 21 of those partners subsequently tested. Eleven women were chased from their homes or replaced by other wives, seven were beaten, and one committed suicide.

A Tanzanian study, which followed 340 female clients for three months after counseling and testing, found that both seropositive and seronegative women had experienced high levels of physical violence. Fifty-four percent of seropositive women and 32 percent of seronegative women said that they had had at least one physically abusive partner in their lifetimes. Seropositive women were significantly more likely than seronegative women to report a physically violent episode with a current partner in the three months prior to testing (31 percent versus 16 percent). The study does not reveal whether violence following counseling and
testing was related to seropositive status disclosure or reflected the level of violence experienced prior to testing. Preliminary results from a large national mother-to-child transmission program in Botswana show relatively low usage of counseling and testing services due to, among other factors, concerns about partners’ reactions to a seropositive result.

Nonetheless, the first randomized trial of HIV counseling and testing in developing countries found that counseling and testing led more frequently to beneficial rather than harmful life events. Designed to compare the prevalence of self-reported unprotected intercourse, the study divided 3,120 participants into groups who received either health information only or voluntary counseling and testing.

The study found that the percentage of individuals reporting unprotected intercourse with non-primary partners, as well as the number of these episodes, declined significantly more for those receiving counseling and testing than for those receiving health information only. Among the benefits it identified were: strengthening of a sexual relationship (39 percent, more common among couples), increased emotional support from peers (29 percent), and increased emotional support from families (23 percent). With the exception of the break-up of sexual relationships (22 percent), difficult life events were uncommon (1 percent to 4 percent). Difficult life events—including estrangement from peers, discrimination by employers, and neglect by family—were significantly more likely to be experienced by people testing seropositive. Finally, there were no significant differences between those who received counseling and testing versus health information in terms of reported levels of either beneficial or difficult life events.

Seropositive women enrolled in the study as partners in couples reported higher rates of physical abuse and marital break-up, highlighting the need for additional services for women in relationships. Other studies have identified marital breakup as a result of serostatus disclosure, which may be seen as both a difficult event and a coping mechanism. Aside from the emotional difficulty of marital break-ups, women in sub-Saharan Africa who are left by their husbands may be blamed by their families, and both they and their children may suffer material hardship. But marital breakup may also represent a risk reduction strategy, protecting uninfected partners from transmission.

Conclusion

Counseling and testing services in Africa are available to only a minority of people. Furthermore, people are reluctant to use them because of fears of stigma and discrimination and because psychosocial and medical support after testing is often inadequate. To improve this situation, researchers face a long list of tasks that include: improving the links between counseling and testing and public communication strategies; identifying ethical ways to reduce the time required for counseling and testing; making counseling and testing services youth-friendly; evaluating counseling and testing services; increasing counseling and testing use by couples; reducing the stigma associated with having HIV infection; and facilitating the role of caregivers, particularly the family members. The Durban conference has played an important role in highlighting the benefits of counseling and testing in Africa and focusing attention on the challenges to make it more acceptable and accessible.
Former South African President Nelson Mandela closed the XIII International AIDS conference in Durban by highlighting the urgency of the conference's theme, *Break the Silence.* "Let us not equivocate, AIDS is clearly a disaster, effectively wiping out the development gains of the past decade and sabotaging the future."

Like most of the delegates, those of us from the United States felt overwhelmed by the incomprehensible burden that HIV disease has placed upon all of us and, in particular, on South Africa and its neighbors. While the challenges for providers in developed countries have moved beyond the crisis of dealing with unremitting death, Mandela's message still rings true for developing nations: if we become complacent, AIDS will sabotage our future. HIV treatment continues to complicate the task of living with HIV both in terms of prevention and care.

### Gay Men and the Venue of Unsafe Sex

Over the past few years, HIV incidence among gay men has risen due to a variety of factors. Some of the factors that received the most attention at the conference focused on the sexual activity of seropositive men.

The Centers for Disease Control and Prevention (CDC) presented data confirming that there are increasing rates of unprotected anal intercourse among HIV-infected men who have sex with men in the United States [ThOrC714]. This presentation included reports of recent outbreaks of sexually transmitted diseases in 12 U.S. cities. For example, more than half the people infected with syphilis—in a January 2000 outbreak among gay men in Los Angeles—were also HIV infected. Between January 1995 and December 1998, the CDC's Paul Denning and his colleagues interviewed 5,094 HIV-positive men who have sex with men. Those interviewed in 1997-1998 were more likely than those interviewed in 1995-1996 to report unprotected anal intercourse as well as multiple sex partners. The most significant factor associated with unprotected anal intercourse was current antiviral therapy use.

A study from the Netherlands found that the setting for HIV transmission had shifted from casual partners to steady partners [MoPpC1101]. In a longitudinal study of seroconversions, the researchers followed 143 men who have sex with men who had seroconverted since 1985. All but 10 of the cohort were able to trace the cause of their infection. Men younger than 33 years old were more likely than older men to have acquired HIV from a steady partner, a trend that appeared to have increased over time: between 1985 and 1987, only 12 percent of younger men were infected by a steady partner; between 1996 and 2000, this increased to 46 percent. It was not clear whether these seroconversions were the result of condom fatigue, AIDS burnout, the desire for more intimacy with steady partners, or a combination of these factors. The study also found that treatment adherence was lower among younger gay men when compared to their older counterparts.

Researchers from both Canada and the Netherlands noted that gay men younger than 28 years old take more drug holidays and report being less concerned about transmitting HIV to both casual and steady sex partners [ThOrC715 and ThOrC718]. Higher CD4+ cell counts and lower viral loads seemed to be the major factor associated with HIV-positive men engaging in unprotected anal intercourse.

In a study of 42 serodiscordant couples (83 percent were men who have sex with men), Robert Remien of Columbia University found that seropositive participants who had lower rates of adherence to antiviral medication regimens were more likely to engage in unprotected anal or
vaginal sex with their steady and seronegative partners [TuOrD335]. This was a recent shift from previous safe sex practices and raised the specter of passing drug-resistant HIV from one partner to the other.

Finally, after conducting in-depth interviews with 93 HIV-positive men and women, Robert Klitzman of Columbia University found that lack of “trust”—concerns about whether partners would reject the HIV-positive partner or tell others about the HIV-positive partner’s serostatus—was the main reason participants would not disclose HIV serostatus, even when they engaged in unprotected sex [MoPpe1068]. This was equally true for the 34 percent of subjects who had contracted HIV from partners who had not disclosed their serostatus.

Decreased Concern about Transmission
Several studies reviewed data about increased risk in terms of attitudes toward improved HIV antiviral treatment. In the Multicenter AIDS Cohort Study (MACS), researchers from the Howard Brown Health Center in Chicago presented findings from a cohort of 548 gay men [ThOrC719]. Both HIV-positive and HIV-negative participants who believed that the success of highly active antiretroviral therapy (HAART) reduced their concerns about HIV transmission were more likely than those who did not share this belief to engage in unprotected anal intercourse. In addition, HIV “burnout” independently predicted unprotected anal sex among HIV-positive men.

A New York study of 197 HIV-positive men and women found results that suggest a similar effect [WePeD4659]. Twenty-three percent of the sample said that they practiced safe sex less frequently since the new treatments came along, and 34 percent believed that the threat of AIDS was less serious. Surprisingly, the lower a subject rated current quality of life—including overall function and sexual function—the more likely he or she was to perceive HIV as a less serious threat and safer sex as a less important response because of the new treatments.

Mental Health and HIV Treatment
Two studies looked at the relationship between mental health and HIV treatment. An Australian study of 921 people with HIV found that 7 percent of respondents exhibited high levels of psychological distress, 28 percent exhibited moderate distress, and 66 percent exhibited mild to low distress [ThPPD1457]. In addition, 30 percent of respondents were taking anxiolytic medications, 27 percent were taking antidepressants, and 6 percent were taking antipsychotic medications. The researchers also found that respondents who reported high distress had lower levels of treatment adherence.

Likewise, mental health status was a predictor of antiviral medication initiation among women in the southeastern United States [TPeBS5076]. A North Carolina study of 109 HIV-positive African American women found that women with depression and poorer general mental health were significantly less likely to initiate HIV antiviral treatment. As might be expected, mental health service use was associated with greater likelihood of treatment adherence.

Breaking the Silence
The conference clearly demonstrated that we in the United States have been given the voice that cannot be silenced by our own progress and that the success of HIV treatment has not come without complications. The challenge now is to support HIV-positive people in making treatment decisions, sustaining ongoing treatment, and remaining committed to HIV prevention. Hope is not a cure.

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Comments and Submissions
We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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Needle Sharing among Injection Drug Users

Three presentations on injection drug use from the XIII International Conference on AIDS offer an overview of seroprevalence rates among injection drug users and the factors that affect needle sharing behaviors.

A review of surveys of more than 12,000 injection drug users found that between 1989 and 1997, the rate of HIV infection declined from 43 percent to 35 percent among injection drug users in Bangkok, from 50 percent to 29 percent in New York City, and from 63 percent to 42 percent in Santos, Brazil [MoPpD1053]. The rate of new HIV infections remained stable at 6 percent per year in Bangkok and declined from 4 percent to 1 percent per year in New York. "Risk for exposure" behavior—injecting, in the previous six months, with needles and syringes used by someone else—declined from 35 percent to 22 percent in Bangkok, remained constant at 22 percent in New York, and declined from 55 percent to 24 percent in Santos. "Risk for transmission" behavior—passing on used needles and syringes to others—remained constant at 18 percent in Bangkok, declined from 22 percent to 5 percent in New York, and declined from 59 to 18 percent in Santos.

These cases illustrate the possibility of stabilizing, even reversing, high seroprevalence epidemics. They also show that while reducing risk for exposure behavior is important, reducing risk for transmission behavior may also be critical in controlling high seroprevalence epidemics. This finding is consistent with the growing attention on prevention targeting people with HIV in the context of sexual risk.

Data for 77 of the 96 largest metropolitan areas in the United States indicated that income inequality was associated with increased rates of injection drug use and with higher rates of HIV infection among injection drug users [WePpE1428]. Other predictors for a metropolitan area’s rate of HIV infection among injection drug users were policies that restrict access to clean needles, such as laws against over-the-counter sale of syringes, high rates of HIV infection among men who have sex with men, and proximity to the New York epicenter.

In a Baltimore study of 311 HIV-infected injection drug users, 60 percent of participants (61 percent of the men and 55 percent of the women) reported at the first interview that they shared needles after seroconversion [TuPeC3379]. Two years later, the overall rate of needle sharing among the sample dropped to 44 percent (46 percent of the men and 39 percent of the women), the lowest level of the study. However, needle sharing increased steadily thereafter, to 52 percent six years after seroconversion. Among males, needle sharing rates rebounded significantly to 61 percent, while rates declined to 37 percent among women, suggesting the importance of targeting male drug users over time.

Analysis of 461 injection drug users in the Providence, Rhode Island syringe exchange program found that 46 percent of participants reported needle sharing behaviors within the previous 30 days [TuPpC1248]. Significant predictors of recent sharing behaviors were homelessness, younger age of first alcohol use, greater number of times re-using injection drug using equipment, and fewer number of owned syringes. There were no significant effects on needle sharing behaviors with regard to gender, age, age at first drug use, duration of first injection drug use, number of times skin was cleaned before injection, or receiving money or drugs for sex.

Rates of Mental Disorders and Substance Use

In the first nationally representative study of the prevalence of psychiatric and substance-related disorders among people with HIV, researchers found high rates of psychiatric disorders [MoPe2403].

Using a random national probability sample of people with HIV, researchers screened adults receiving HIV-related medical care in the United States in 1996. Of the 2,864 participants, 49 percent had a psychiatric disorder (depression, dysthymia, general anxiety disorder, or panic disorder), 40 percent used drugs other than marijuana, 12 percent had been drug dependent in the prior year, 53 percent used alcohol, and 8 percent had participated in “heavy drinking” in the prior month. Factors related to psychiatric disorders included number of HIV-related symptoms, CD4+ cell count, illicit drug use, and being unemployed. Factors related to drug dependence included HIV-related symptoms, heavy drinking, and...
Viral Load, Transmission, and Treatment

Three conference presentations refine theories about the effects of viral load on both transmission and disease progression.

In a study from Rakai, Uganda, high HIV viral load was strongly associated with increased transmission rates per act of heterosexual intercourse among mixed serostatus, monogamous couples [TuOrC422]. Thirty-eight of the 174 HIV-negative participants seroconverted during the study period. The rate of infection was 0.09 per 1,000 coital acts at viral loads of less than 3,500, 1.53 per 1,000 coital acts at viral loads between 3,500 and 9,999, 1.94 per 1,000 coital acts at viral loads between 10,000 and 49,999, and 2.98 per 1,000 coital acts at viral loads of 50,000 or higher. In a related study of mixed serostatus couples in Rakai, no male-to-female HIV transmission occurred at viral load levels less than 1572, and no female-to-male transmission occurred at viral load levels less than 1801 [TuOrC423].

Two studies found that rising viral load is not necessarily indicative of treatment failure. In a Washington, DC study, a rise in viral load from less than 50 to as much as 400 did not necessarily indicate the failure of an antiviral regimen [MoPpB1019]. In one case series, 22 participants on stable antiviral regimens achieved viral suppression of less than 50. They then rose to viral load levels between 40 and 400. Seventy-three percent of these participants eventually achieved viral loads of less than 50 again without any change in antiviral therapy.

Similarly, a New York study comparing a group of 54 participants (Cohort I) with viral loads of less than 40 with a group of 41 participants (Cohort II) with viral loads between 40 and 400 found no difference in clinical performance [MoPpB2171]. The two groups were similar with regard to age, HIV risk factors, race, sex, time since HIV diagnosis, time on antiviral therapy, and number of antiviral regimens. The mean change in CD4+ cells was an increase of 240 for Cohort I and an increase of 273 for Cohort II. The number of new opportunistic infections per 1,000 “patient months” was 7.8 for Cohort I and 6.9 for Cohort II. No HIV-related deaths occurred in either group.

Nevirapine and Perinatal HIV Transmission

According to two African studies, nevirapine more effectively reduces the rate of mother-to-child HIV transmission and is as safe as zidovudine (ZDV; AZT).

A Ugandan study found that compared to a short course of ZDV treatment, a single dose of nevirapine to mothers in labor and to infants within 72 hours of birth reduced the HIV transmission rate by 47 percent at 14 weeks to 16 weeks of age [TuPpB1231]. There was no difference in maternal viral load prior to dosing between the two groups of mothers. By the seventh day, however, mothers in the nevirapine group had substantially lower viral loads than mothers in the ZDV group. Despite these changes in viral load after dosing, baseline maternal viral load was highly predictive of overall perinatal transmission. In the nevirapine group, the decrease in viral load after seven days predicted infection in 12 infants who seroconverted after six weeks or longer, suggesting post-natal transmission of HIV.

According to a South African study, a short course of nevirapine is as safe as a short course of ZDV plus lamivudine (3TC) for the prevention of mother-to-child transmission of HIV [TuOrB356]. There were no serious, treatment-related, adverse effects or deaths in mothers or infants in either group.

Next Month

Over the past few years, “co-active coaching” has become a popular alternative to psychotherapy in some areas and some contexts. In the November issue of FOCUS, Miriam Garfinkel, LMFT, a therapist who has worked in the epidemic for many years and in several capacities at the UCSF AIDS Health Project, defines the coaching approach, compares it to psychotherapy in terms of its benefits and shortcomings, and discusses the ways in which coaching can be used to help clients with HIV.

Also in the November issue, Eileen Blumenthal, EdM, JD, former board member of the Coaches Training Institute, a certified coach, and an organizational development consultant, discusses the use of coaching to help AIDS service organizations begin to adjust to the changes in the epidemic.
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