The development of safe and effective HIV preventive vaccines remains a distant hope, leaving behavioral prevention as the only means of slowing the spread of HIV. While there have been major advances in HIV prevention, they have not occurred at the pace that the HIV crisis demands. Upon the 20th anniversary of the first identified AIDS cases, AIDS Impact 2001, the Fifth International Conference on Biopsychosocial Aspects of HIV Infection highlighted the current state of HIV prevention research, its promises and its disappointments.

Conference presentations followed three notable changes both in the epidemic and in prevention strategies. First, there is clear evidence that some of the populations hit hardest by the epidemic and targeted most by HIV prevention campaigns are showing increases in risk behaviors and new HIV infections, signaling a need for new prevention approaches. Second, the field of HIV prevention has matured enough that it is appropriate to ask whether prevention advances offer meaningful results for risk reduction, cost-effectiveness, external validity, and cross-cultural generalization. Third, a new generation of HIV prevention approaches now melds primary prevention services for people living with HIV with care services. This article, therefore, focuses on three major themes of the Brighton, United Kingdom conference: studies that show increasing rates of risk behavior; the state of primary prevention interventions directed at HIV-negative populations; and prevention interventions targeted to reduce risk among people living with HIV.

Resurgence of Risks for New Infections

HIV epidemics continue their global amplification with rising rates of HIV both in regions with the most established HIV epidemics—Western Europe, North America, and Australia—and in regions with incipient epidemics—Latin America, Asia, and Eastern Europe. The situation in Africa is the most devastating, with more new HIV infections occurring in Central Africa in one day than many countries see in an entire year.

Equally discouraging are studies from several countries that show a return to high-risk practices in populations, particularly men who have sex with men, in which risk reductions had been previously observed. Venue surveys conducted in London gay bars, gyms, and health clinics showed that at least one in five gay or bisexual men was practicing unprotected anal intercourse, and many of these men knew that they were HIV-infected [21.3: Dodds, Royal Free and University College Medical School]. In France, unprotected anal intercourse among gay men increased from 17 percent in 1997 to 23 percent in 2000 [39.1: Adam, Paris]. In the Netherlands, between 1996 and 1999, rates of unprotected anal intercourse with casual partners increased from 25 percent to 34 percent, with parallel increases in sexually transmitted infections and a trend continuing into the year 2000 [25.2: Stolte, Municipal Health Service, Amsterdam]. In Cape Town, South Africa, one-third of gay men surveyed had recently had unprotected intercourse with partners of unknown HIV status [39.2: Boxford, Triangle Project]. In Vancouver, a study of gay men found increases in risk behaviors and HIV infection rates [7.1: Martindale, BC Centre for Excellence in HIV/AIDS]. In Australia, rates of unprotected anal intercourse are steadily increasing [26.2: Van de Ven, University of New South Wales, Sydney].

Together, these studies also illustrate that levels of risk are ever-changing within the populations in which HIV prevention efforts have been most concentrated. Populations...
**Editorial: Beginner’s Mind**
Robert Marks, Editor

What happens when you put five dozen people together in a room to talk about the efficacy of HIV-related peer education? Could be as exciting as logistical regression analysis: often, presentations at conferences blur together like a long list of survey variables, as the results of one presenter plot themselves through to the data of the next.

The AIDS Impact 2001 conference was like very few I have attended before. I am not sure if this was because the conference was particularly well-organized, because session chairs took a more active role in coordinating sessions, or because presenters and participants just took more chances. But, I suspect at least part of the reason relates to facts that are both disheartening and exciting. Our understanding of HIV has come of age: over the past 20 years, as clarity and confusion have alternated in quick succession, our sense of the epidemic has been influenced by the certainty that came with our youthful relationship with HIV.

Today, those of us who work with AIDS are more jaded. We now know, in a much more profound way than we did, that we do not know. Neither the excitement of the “new treatments” nor the general success of HIV prevention has blinded us to the intractability of current challenges in these areas. But, the exciting thing, which became apparent at the conference, is that this discovery has not engendered hopelessness or desperation.

One good example: at the session on peer-based interventions, as Seth Kalichman and Eric Benotsch describe in this issue of FOCUS, two presenters from the United Kingdom discussed the failure of their attempts to apply a long-established strategy to diffuse healthy norms regarding sexual practice into geographical communities. Another talked about the pitfalls of employing youth as peer educators. Then, following a presentation by Jeff Kelly, the father of HIV-related peer education, the presenters talked more broadly about why peer education works, the conditions necessary for its success, and the cultural and structural confounders that might undermine it. None shied away from admitting confusion or shortcoming, and none demonstrated the arrogance of certainty. The session did not arrive at a universal theory, but it did identify ideas for future approaches.

In fact, after 20 years, participants seemed to embrace Zen Buddhism’s “beginner’s mind,” a willingness to substitute basic questions for pat answers, an openness to both internal and external truths that may be hidden by tightly held assumptions.

At more than one session, participants asked each other, in moments stunning for their honesty and humility, how should we proceed? One long-time AIDS researcher spoke almost mournfully, but in her willingness to ask the question, I could hear the drive to find the answer. That’s a conference at its best: a coming together of peers to look at a body of research, grapple with its meaning, and reinvigorate their search for answers. Five years ago, AIDS Impact might have ended with a sense of defeat; instead it closed with a sense of the future.

In which risk reduction has been successful must be continually monitored, and new prevention efforts must be launched as the effects of previous interventions lose effect, as people exposed to interventions grow older and face new challenges, and as new generations who have not been exposed to prevention interventions come of age. Risk reduction interventions, facing barriers similar to HIV preventive vaccines, are diminished by “behavioral resistance”: people exposed to behavioral interventions often do not change and many who do change ultimately relapse to risk practices. Data presented in Brighton suggest that prevention messages of the past do not always motivate new population members, requiring constant renewal of these strategies.

**Targeting HIV-Negative Populations**

Research studies are often like pebbles dropped in a pond: only after time do their ripples result in broad effects. The Brighton conference offered participants a chance to examine some of the logical next steps taking place in primary prevention research, including the replication of intervention studies and the synthesis of previous results. Prevention in HIV-negative populations was covered in three major ways.

First, the process of synthesizing research findings is beginning to reveal patterns of what has worked and what has not worked over time. Early findings from a large-scale meta-analysis of 342 HIV risk reduction interventions—involving a total of more than 150,000 participants—found that interventions have generally yielded positive outcomes [14.1: Johnson, University of Connecticut]. Although the overall effects were small, particularly for some sexual risk behaviors, the outcomes were nonetheless significant. The meta-analysis also found that interventions that included
elements of information, motivational enhancement, and behavioral skills training had the greatest effects, lending support to the Information-Motivation-Behavioral Skills model of HIV risk reduction.

The second prevention focus was on the replication and extension of what have become established interventions and the development of new risk reduction approaches. A good example of this focus was one session on peer-based intervention. The session included two failed attempts to replicate natural opinion leader intervention models, one in Glasgow [9.1: Hart, United Kingdom], the other in London [9.3: Elford, Royal Free and University College Medical School]. Both attempted to train “opinion leaders”—people who were held in high-regard within a community—to embrace and diffuse community norms regarding HIV risk, and both focused on men who have sex with men at high risk for HIV. Both interventions failed to reduce risk, findings that contrast with several published reports conducted in the United States.

In the same session, Jeffrey Kelly, an international expert on opinion leader interventions, reported on the challenges and barriers to implementing opinion leader interventions [9.4: Kelly, Medical College of Wisconsin, Milwaukee]. Clearly, opinion leader interventions must be tailored for particular cultures, in this case, British culture, and the intervention must reach a critical mass of the target population (Kelly estimated between 10 percent and 15 percent) in order to ultimately influence social norms and behavior. The need to reach this critical mass of what are often difficult-to-reach populations may especially limit the feasibility of natural opinion leader interventions in dispersed communities. Mary Jane Rotheram-Borus then offered additional cautions about using peers as agents of change, identifying role confusion and sexual activity between peer trainers and clients as complications [9.2: Rotheram-Borus, University of California, Los Angeles]. Obviously, whether peer interventionists actually deliver the intervention and how they deliver it also affects success.

Finally, the third prevention area was the beginning of HIV risk reduction via the Internet. Michael Ross offered an overview of the opportunities and challenges to cyber-space prevention interventions [19.2: Ross, University of Texas, Houston]. While the Internet allows some people to anonymously access HIV risk reduction interventions, the ability to reach populations who are at greatest risk is limited by the socioeconomic digital divide both in poorer areas of industrialized countries and in the developing world.

Other presentations connected HIV risk factors with Internet use: for example, a survey of 742 gay men in London showed that 81 percent had access to the Internet, and of those with access, more than one-third had used the Internet to find sex partners [31.4: Elford, Royal Free and University College Medical School]. In addition, the London study found that seeking sex via the Internet was correlated to having recently had a sexually transmitted disease and practicing higher risk sexual behaviors. One New York study found that using the Internet to seek sexual partners was correlated to HIV risk [31.5: Parsons, Hunter College, City University of New York], and another found that of HIV-positive men who use the Internet to seek sex partners, most seek partners interested in unprotected anal intercourse [31.6: Halkitis, New York University]. Because it may be a magnet for people at greatest risk, the Internet may offer opportunities for innovative interventions at a time when HIV incidence is increasing among these populations and established interventions seem less effective than they once were.

Targeting People with HIV

The third theme of the Brighton Conference was the evidence of continued high risk sexual practices among people with HIV and the potential impact of prevention interventions targeting them. For example, one study found that 56 percent of HIV-positive people in San Francisco continued practicing unprotected anal or vaginal intercourse after having tested seropositive, and 41 percent had done so with partners of either HIV-negative or unknown status [25.4: Ekstrand, University of California, San Francisco].

While conference presentations found waning evidence for a correlation between “treatment optimism”—the belief that recent advances in HIV antiviral treatment makes HIV less threatening—and increased risk among HIV-negative people, some data suggested that beliefs about viral load may affect the risk behavior of HIV-positive people. Two studies suggested that among HIV-positive men, beliefs that HIV treatments
reduce HIV infectivity are associated with increased sexual risk practices [36.2: Davis, Royal Free and University College Medical School, London; and 26.4: Kalichman, Medical College of Wisconsin, Milwaukee.]

The second of these studies also found no correlation between viral load levels in the blood and in the semen, suggesting that reduced infectivity may not automatically accompany reduced plasma viral load. This study also found that men with the highest levels of semen viral load were practicing the greatest amount of insertive intercourse. Therefore while men who were most infectious were least able to make valid assumptions about their infectiousness, they were the most likely to expose sex partners to HIV. Another study found 15 percent of HIV-positive women said that they practiced more unsafe sex since combination therapies became available [25.3: Catz, Medical College of Wisconsin, Milwaukee]. Although Australian researchers found associations between HIV treatment perceptions, viral load, and sexual risk, these effects may not generalize to other countries such as England and Canada [25.6: Rosengarten, University of New South Wales, Sydney; 47: Campbell, Newham Psychology and Counseling Service, London; 35.9: Richardson, Imperial College School of Medicine, London; and 25.5: Lavoie, Action Séro Zéro, Montreal].

Another factor associated with continued unprotected sex was substance use in sexual contexts; studies found further evidence that risky sex among people with HIV often occurs after having used alcohol and other drugs [27.5: Timpson, Behavior Research Group, Houston]. One factor that was not correlated to high-risk sexual practices among people with HIV was the ability to adhere or not adhere to antiviral medications, suggesting that these two forms of behavior maintenance rely on different psychosocial mechanisms [5.4: Amico, University of Connecticut, Storrs]. Although these studies do not fully explain the complexity of sexual risk among people who know they are HIV-positive, there is now sufficient evidence that a substantial number of people with HIV continue sexual risk practices and that risk behavior is often associated with substance use and beliefs about treatment.

Brighton presentations also included early results of studies testing interventions targeting people with HIV. One non-controlled study showed that a group for 15 HIV serodiscordant couples in Uganda successfully reduced HIV risk and averted seroconversion; the group focused on self-empowerment and social support, including observed role plays [12.5: Kiwanuka Kavuma, Joint Clinical Research Centre, Kampala]. A randomized controlled study reported risk reduction following a five-session cognitive-behavioral group intervention that targeted HIV status disclosure and safer sex strategies in HIV-positive men and women: participants significantly reduced unprotected intercourse over a six-month follow-up period, and mathematical modeling suggested that this action potentially translated to reductions in new HIV infections [5.1: Kalichman, Medical College of Wisconsin].

Conclusion

For a variety of reasons, in industrialized countries there seems to be a diminished concern about AIDS (ironically, there is rising concern about AIDS in poorer nations—a response that is overdue and may be too late). A resurgence in HIV risk practices and diminishing effects of risk reduction interventions are undoubtedly related to this AIDS apathy. In the face of these enormous challenges, the world—both industrialized and developing—needs innovative and potent interventions to prevent HIV transmission. Continued research is crucial, and the dissemination of research through conferences like AIDS Impact will help generate new ideas and bolster effective HIV prevention.

Clearinghouse: AIDS Conferences
Mental Health and Quality of Life for People with HIV
Eric G. Benotsch, PhD and Seth C. Kalichman, PhD

In July of this year, leading AIDS prevention researchers, advocates, community service providers, and clinicians gathered in the United Kingdom to discuss their work at the AIDS Impact 2001 conference. There was a variety of presentations about the task of helping people with HIV lead more productive, healthier, and happier lives. This article reviews particularly compelling presentations that documented innovative attempts to improve mental health and treatment adherence among people with HIV.

Mental Health and Coping

Conference presentations focused on a broad range of psychosocial challenges including depression, sexual abuse, and coping with HIV. Overall, considering the substantial coping challenges and mental health concerns of people with HIV, several presenters noted the scarcity of adequate mental health treatment in a wide range of countries in Europe, Africa, North America, and Asia. Even in developed nations, presenters found insufficient counseling and psychiatric treatment. Not only do mental health problems diminish quality of life, there is increasing evidence that they can lead to poor adherence and treatment failure, making the addition of mental health services to standard medical treatment a cost-effective approach.

In one study of HIV-positive people living in the rural United States, more than half of the participants reported moderate to severe levels of depression, along with social isolation, loneliness, and poor coping self-efficacy [15.3: Heckman, Ohio University, Athens]. This study is particularly important because even though as many as 10 percent of people with HIV in the United States live in small communities or rural areas, they remain an understudied population.

In a study of a large national sample in Australia, researchers also reported high rates of clinical depression; they found that while depressive symptoms were unrelated to antiviral medication use, people with depression were more likely to experience difficulties with medication, including adherence problems and resistance [11.5: Grierson, Latrobe University, Melbourne]. At the same time, a British review of the records of people with HIV found the most common reasons for referral for mental health treatment were coping and adjustment problems that did not meet diagnostic criteria for specific psychiatric disorders, but which, nevertheless, adversely impacted clients’ lives [24.6: Macias, Imperial College School of Medicine, London].

A Swedish study concluded that the existence of intrusive thoughts about being HIV-positive was a primary contributor to upsetting emotions [15.5: Nilsson Schönness, Stockholm Southern Hospital]. This study is consistent with others at the conference that suggested that being diagnosed with a life-threatening illness can result in symptoms of posttraumatic stress disorder (PTSD). Many people that are HIV-positive also report a history of other traumatic life events. For example, in a study of 81 HIV-positive men and women, nearly half the participants reported a history of sexual abuse, and many of these reported repeated revictimization [20.6: Kochman, Yale University School of Medicine, New Haven]. As would be expected, individuals with a history of sexual abuse reported more psychiatric and posttraumatic stress symptoms, including feelings of worthlessness, than other participants.

At Brighton, there were a small number of presentations on interventions designed to promote positive coping and improved mental health in people with HIV. For example, in...
response to the PTSD symptoms, one presentation concluded that the most beneficial interventions will combine a “dual understanding” of both PTSD-related and HIV-specific mental health issues, since in many cases, HIV and other traumas both involve issues of shame and secrecy [11.4: Doyle, Imperial College School of Medicine, London]. A second study addressed the needs of HIV-positive substance-abusing men who had lost loved ones to HIV [32.4: Kochman, Yale University, New Haven]. The re-experiencing of personal symptoms previously seen in a loved one who has died can engender profound feelings of loss, guilt, depression, and fear about the future. In this study, researchers applied a small-group intervention focused on AIDS-related grief, amelioration of distress, adaptive coping skills, and social support, and were able to improve coping and reduce dysphoria.

**Treatment Regimens and Adherence**

While HIV antiviral drug regimens continue to offer substantial benefits, combination treatment has not fared as well over time as it had initially. One probable cause for this is the strict adherence requirements of demanding regimens—some entail taking 20 pills a day—and intolerable side effects. Missing as few as 5 percent of medication dosages is associated with viral resistance, cross-resistance, and treatment failure.

Many researchers presented data addressing the needs of people taking antiviral regimens. One qualitative study reported that individuals declining antiviral treatment did so because of concerns about necessity of treatment, side effects, previous negative experiences with medicines, and the practical challenge of taking medications regularly [10.5: Cooper, University of Brighton]. These concerns were echoed in a second study of individuals who reported low adherence; among the most commonly expressed issues were doubts about the necessity of treatment and concerns about adverse effects [35.1: Horne, University of Brighton]. Predictors of nonadherence in other studies included medication side effects, negative perceptions of body shape changes, depression, anger, instability of social support, and provider-patient communication problems [10.2: Bouhnik, ORSPACA, Marseilles; 10.4: Ekstrand, University of California, San Francisco; 11.5: Griersson, Latrobe University, Melbourne; 30.5: Spire, INSERM, Marseilles; and 380: Visitini, University Vita-Salute San Raffaele, Milan].

Finally, researchers presented data documenting the adverse psychological impact of the fat distribution changes (lipodystrophy) caused by antiviral medication use. Patients reported poor body image, low self-esteem, and difficulties discussing these concerns with treatment providers [224: Power, Royal Free and University College Medical School, London].

Other investigators presented approaches for helping people with HIV tackle the demands of adherence. In particular, San Francisco researchers reported findings from a patient-centered intervention for alcohol and drug users that applied cognitive-behavioral and motivational interviewing techniques [10.8: Crosby, University of California, San Francisco]. Researchers determined client needs in the following areas: managing side effects, tailoring regimens to lifestyle, interacting with health care providers, attaining social support, reducing stress, and reducing barriers. When participants presented with problems in one of these areas, researchers applied a standardized treatment module for that area, thereby combining universal and tailored approaches to meet a client's unique needs.

Another innovative study recognized the advantages of social support networks in promoting adherence [35.5: Pererira, Brazil]. The study sought to improve communication among people with HIV, their families, and their health care providers, since in many Latin American cultures, family plays a particularly central role in daily life. This approach may also have an application for Latin American clients outside of Latin America.

**Conclusion**

The work presented at Brighton highlights the challenges facing people with HIV and offers some initial steps toward solutions. In the industrialized world, treatment innovation will improve the quality of life, mental health, and physical functioning of people with HIV. In the developing world, basic resources are needed to respond to the devastating effects of AIDS.

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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. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
Conference Excerpt:
Living Long-Term with HIV
Jonathan Grimshaw

Jonathan Grimshaw is a long-term survivor of HIV who has been a frequently heard and powerful voice expressing the experience of living with HIV. This is an excerpt from his plenary speech at the AIDS Impact 2001 conference.

One of the surprising things about living with HIV for 17 years—and there are many—is that even though you think you’ve said publicly everything you have to say, people still invite you to come and talk about it. I’m grateful for the invitation to speak but I have to say that it does get more difficult as time goes on—for several reasons.

Firstly, it is harder to talk powerfully and movingly to an audience about uncertainty, or security, or taking your pills on time, when what you used to talk about, before combination therapy came along, was your personal confrontation with disease and death, and what that confrontation taught you about the meaning and purpose of your life. I used to talk about sex a lot as well—that’s always interesting—but there isn’t, personally speaking, as much sex to talk about now. But I’ll come back to that later.

Perhaps because of living through all the years when there was no effective HIV therapy, the people with HIV who speak most powerfully to me are from countries where there is now no effective HIV therapy. They have actually been talking for a long time—AIDS in Africa is hardly new—but now that the world is ready, even eager, to listen to them, I feel that I should be quiet for a while so they can be heard more clearly.

Secondly, as the HIV epidemics and people’s individual experiences of living with HIV have become so diverse, you become increasingly unconfident that your own story has any broader relevance. Not just that, but I’ve had 17 years in which to adapt to having HIV, and that too makes my experience now very unusual. Last weekend, I started filling in a research survey about living with HIV. The questions are divided into sections on discrimination, money, relationships, sex, housing, and so on, and at the end of each section, you’re asked to say whether you are very happy, fairly happy, fairly unhappy, or very unhappy with things as they are. Looking back over my responses, either I was in a very good mood last weekend or I’m pretty happy with things as they are.

And finally, I was 30 when I was diagnosed, and now I’m approaching 50. A lot of the things I’m anxious about or have difficulty with psychosocially are probably related as much to coming to terms with late middle age as to HIV.

Before and After Combination Therapy

I say I’m pretty happy, but what I really mean by that is that I’ve just about come to terms with life on combination therapy and settled into a kind of new-found equilibrium. It has not been easy.

Before combination therapy came along, an HIV diagnosis stole your future, or at least the unconscious assumption of a future that most of us need in order to build any kind of meaningful life for ourselves.

My way of coping with that theft was to throw myself into HIV activism: fighting the HIV outside me because I couldn’t do much about the HIV inside me, and trying to change the society I lived in from being AIDS-phobic to being AIDS-educated so that the life I and other people with HIV did have left would not be made intolerable by other peoples’ ignorance and fear. I was really determined that I wasn’t going to die insignificantly. I needed to prove myself, and because I didn’t know how long I was going to live, I needed to achieve a lot quickly: to get to a point where I could leave satisfied that, in my own terms, at least, my life had meant something.

Very occasionally you used to hear people say that HIV was the best thing that ever happened to them, and what they meant was that it had forced them to reappraise their lives, to stop wasting time, and to do whatever they needed to do to achieve a sense of fulfillment. I know I lived my life with an intensity and, ironically, a fearlessness which I would never have known without HIV. . . .

Having prepared so energetically and thoroughly for dying, I was completely unprepared to live on. I’d achieved my
purpose in life, I’d metaphorically speaking disposed of my assets, tidied up, stopped all deliveries, booked the taxi to the airport, and all but said my good-byes, only to find that the flight had been, if not cancelled, at least postponed indefinitely. . . . In many ways it has been more difficult coming to terms with this than the original HIV diagnosis. Some of the possibilities that treatment seemed to open up were, in fact, false: the possibility, for example, of leading a “normal” life. I remember talking at one conference about how I hoped, now that effective treatment was available, to be able to do something better with my life than talk at conferences about having HIV, and I did try going back to work at one point, for an HIV agency, but I was psychologically quite unprepared for it; I wasn’t motivated any more by that viral clock ticking inexorably in the background, and I just got exhausted. Years of living with HIV had taught me to be skeptical of medical optimism, and it became clear that the reality I was dealing with was not normal life at all but a life constrained by uncertainty about the long-term efficacy and safety of HIV therapy. I chose to stay with what seemed the relative security of my pension and benefits and do voluntary work rather than take the risks of trying to go back into the labor market. . . .

Another consequence of trying to live a normal life and of living long-term is that with most of your peers long dead of AIDS, you begin to judge yourself in relation to people of your own age, friends even, who have had a normal life: people whose career path has been uninterrupted by HIV, and sometimes based on HIV, and whose lives by comparison seem far more successful, prosperous, and secure than your own. Strangely, I’ve been far more bitter and resentful about the damage HIV has done to my life in the years since combination therapy arrived than I was when there was no treatment, and it is only recently that that anger seems to have burned itself out.

War and HIV

I read somewhere that there is some-sight there is bitterness about the damage it has done to their lives. They have a sense of not quite knowing where they belong.

That describes almost perfectly where I was for a long time.

What has helped most recently to put things into perspective and give life a greater clarity is becoming involved in international work. I was a member of the British government delegation which went to UNGASS to negotiate the wording of the declaration of commitment on AIDS by member states and to take forward the work on the global HIV and health fund. The UN general assembly is fundamentally a device for enabling a non-violent struggle for supremacy between different beliefs about how societies should be ordered and controlled. Although nominally about AIDS, the very difficult and exhausting negotiation of the declaration, line by line and word and word, was in fact a fierce and at times bitter struggle between governments over issues of stigma and discrimination, social exclusion, human rights, poverty, education, equality, empowerment, access to health care and treatment, and the right of people to have a say in decisions that affect their lives.

It was a reminder to me—and I needed reminding—that globally these are still what AIDS and HIV are about, that these things have to be fought for, that it is a wonderful thing still to be alive to fight for them, and that not to fight for them would be to squander unforgivably the extra life that combination therapy has given me. Thank you.

Next Month

One of the most tangible manifestations of improved health for people with HIV—and, at the same time, one of the most conflicting expectations—is returning to work. In the November issue of FOCUS, Peter Goldblum, PhD, the Coordinator of the Considering Work Project at the UCSF AIDS Health Project, and Betty Kohlenberg, MS, CRC, Career Counseling Consultant at the Positive Resource Center in San Francisco, outline a client-focused model for assisting people with HIV to consider work and to act upon decisions about work. In a second article, Ms. Kohlenberg discusses the results from an evaluation of the Making a Plan group program that is based on the considering work model.
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