Clinical and epidemiologic observations in the last 10 years have led to compelling evidence that people with HIV and those at high risk for transmission are likely to have had experiences of physical and sexual victimization. In part, this is because both HIV infection and interpersonal violence share causal pathways due to societally structured inequities in relation to race, economic position, gender, and sexual orientation. Violence may also directly increase the risk of HIV infection, and likewise, HIV infection may increase the risk of violence. For example, people who are sexual within relationships that include violence are more likely to report unprotected sex or needle sharing to avoid conflict. Similarly, women with HIV report that fear of violence is a major reason for not disclosing HIV status to partners.

Among people in the United States in primary care for HIV infection, nearly half who reported partner violence since their diagnosis believed that their infection was a motivation for abuse against them. This raises the further question of whether partner violence and related stress diminish immune functioning and foster disease progression, depression, and suicidal ideation. This article summarizes evidence of the concurrent epidemics of violence and HIV, and offers examples of health and mental health approaches that can reduce risk of HIV infection among people who have experienced or are in abusive relationships. It also provides examples of violence victimization prevention for people with HIV.

How Violence Manifests

Gender-based violence is defined as physical, sexual, psychological, and economic abuse against women and girl children because of their subordinate positioning in many societies. Such violence is common, with estimates ranging from 10 percent to 50 percent of women in more than 50 population-based surveys throughout the world. In the United States during 1998, the National Crime and Victimization Survey and the Federal Bureau of Investigation estimated 876,340 violent offenses against women and about 160,000 violent crimes against men by an intimate partner (gender unspecified). While overall, men are victims of violent crime more often than women are, women are five to eight times more likely to be victims of assault in intimate relationships; in the United States, more than 90 percent of domestic violence arrests involve a male perpetrator and a female victim. In 1996, nearly one million women reported rape or assault by an intimate partner, and more than half of women victims were living with children at the time.

Overlapping risk factors for violence and HIV infection include poverty, unemployment, drug dependency, childhood sexual and physical abuse, age less than 30, and homelessness. Indeed, violence appears to be a marker for poverty, racism, homophobia, and sexism, and throughout the world, HIV and violence tend to co-exist within societies that tolerate abuse of women and girl children, criminalize or degrade same-sex relationships, and punish people who have drug addictions.

Women who are most likely to report domestic violence in the United States are 19 to 29 years old, and living in neighborhoods marked by poverty and high unemployment. One recent study found a sixfold difference between Black and White rates of domestic homicide, but this difference virtually disappeared after controlling for conditions of household crowding, a marker for socioeconomic position. Studies have also found correlations between partner violence and male partners’ injection drug use and the requests of sex workers that partners—both clients and non-clients—use condoms.
Editorial: Survival of the Specious
Robert Marks, Editor

To perpetrate violence against a person with HIV is to add injury to injury, insult to insult. It is to prey upon someone when he or she is already compromised, an act not unlike a lion picking off the weakest in a herd of antelope. But, of course, we are not animals in the wild and, as a society, we reject the survival of the fittest as a principle that is neither useful nor morally defensible.

I find this metaphor compelling: as is clear from Sally Zierler’s article in this issue of FOCUS, HIV-related violence correlates, like all violence, with social conditions that are associated with the most disadvantaged among us. These factors, in turn, correlate with membership in groups with the highest seroprevalence of HIV. Men who have sex with men are traditionally4 Nonetheless, HIV is just one of a number of conditions that seem to foster violence.4

For those who are already preyed upon, HIV is just one more on the list of circumstances that make people targets. (It is true that many perpetrators also come from some of these groups; most violence is within the community, all in the family. But it is societal conditions and stresses that seem to foster violence.)

Violence of any sort—verbal, physical, emotional, sexual—is traumatic for the survivor. Added to the trauma of HIV disease, it can be overwhelming. Everything about coping with HIV, including adjusting to the diagnosis, defining new goals and a new way of living, disclosing serostatus, and seeking and adhering to treatment, requires hope, fearlessness, and a sense of mastery. Violence undermines all of these, even the desire to live. According to Cheryl Gore-Felton, Lisa Butler, and Cheryl Koopman in this issue of FOCUS, violence frequently leads to post-traumatic stress disorder, which can sabotage the effort to undertake any meaningful response to the disease.

In the United States, among women reporting physical assault by their male partners, 33 percent to 46 percent described marital rape as part of this experience. Physical abuse may have dire consequences for people living with HIV, including further disruption of immune function and other bodily systems. Studies have also linked victimization within important relationships to subsequent behaviors, including substance abuse, neglect of health, and risky sexual behavior. For example, the National Crime Victims and Research Center reported that within two years after an assault, drug use had nearly doubled among women, controlling for age at first time drug use, race and ethnicity, age at time of assault, and education. A recent national probability sample of 3,006 women found a cyclical relationship between physical and sexual abuse of women and substance use, with each potentiating the other. Among people living with HIV infection, such stressors may complicate their prognoses.

A recent study, a probability sample of 2,864 HIV-infected adults enrolled in the HIV Costs and Service Utilization Study, investigated the prevalence of violence among U.S. adults receiving medical care for HIV infection. Overall, nearly 21 percent of women, 12 percent of men who reported having sex with men as their mode of HIV transmission (regardless of injection drug use), and 8 percent of remaining men reported physical harm since diagnosis. Of note is that among people reporting physical harm since diagnosis, 52 percent of women, 40 percent of men who have male sexual partners, and 43 percent of remaining men stated that the assault was related to their HIV infection. Overall, the factors most strongly associated

References

Human society likes to see itself as more civilized than its lion and antelope cousins, but it frequently makes choices that belie this distinction. While we seem to be getting better at uncovering violence and treating trauma, we seem to be as ineffective at preventing violence as are antelopes at stopping lions. We respond to school shootings by targeting the “type” of students who might “snap”: those who have been marginalized by the cruel society of school-aged children and the laissez-faire system that encourages boys to be boys. We talk about “personal responsibility”—a crucial ingredient in social change, including violence prevention—but frequently, it seems, we are talking only about someone else’s “person.”

When society embraces its social responsibility with the same vigor that it prescribes personal responsibility, people will come together to protect rather than blame victims of violence, reject rather than disregard the conditions that promote violent behavior. Survival of the fittest works as a guiding principle only when the goal is survival at any cost. The survival of our culture corresponds to its unwillingness to perpetrate such a transaction.
Restraining orders help women leave violent relationships, and many women physically fight their batterers in order to preserve safety or escape.


With partner or relationship violence in this study were drug dependence, homelessness, and unemployment.

Among women in the study, one-third reported partner violence since diagnosis if they lived in the midwestern United States and if they had ever been drug dependent. Women who identified as gay, lesbian, or bisexual reported relationship violence as frequently as women who identified as heterosexual (24 percent versus 20 percent). At the same time, women living with male sexual partners were nearly three times more likely to report violence since HIV diagnosis than were women living with female sexual partners (25 percent versus 9 percent).

Of men who reported sex with women at the time of HIV diagnosis, at least 12 percent reported physical harm since HIV diagnosis. Factors that were associated with physical harm among these men were: being age 40 or younger, being Hispanic, self-identifying as gay or bisexual, having no financial assets, having a female partner, being homeless, or reporting a history of drug dependence. Controlling for socioeconomic factors, drug use, and CD4+ cell level among men who have sex with men, Hispanic/Latino/Chicano men were at greater risk for violence than men of other racial or ethnic identities. This finding did not extend to Hispanic women or Hispanic heterosexual men. Some studies suggest that Latino men are more selective in revealing their HIV status, particularly if they are gay or bisexual, have sex with men, and are primarily Spanish speaking.

The Role of Health Care Providers

The frequency of physical and sexual abuse has prompted emergence of global grass roots organizations that coordinate management of abuse.4,5 The Pan American Health Organization (PAHO) passed a resolution in 1993 to encourage all member governments to develop strategies for prevention and management of violence against women. The World Health Organization has also initiated anti-violence programs, and in the United States, the American Medical Association and the Joint Commission on Accreditation for Hospitals and Health Care Organizations have established guidelines as well as mandates that have become a part of accreditation procedures. Despite these efforts, there is strong evidence that most health care workers do not screen for violence victimization among their patients.

In part, this is because workers share the same social norms of the larger society in which they are practicing. One South African study reported that while women nurses believed that violence against women was a big problem, they also believed that women themselves were often responsible for its occurrence.5 Male nurses in this setting reported ample justification for violence against women, particularly if the women were disobedient to their husbands or negligent of household duties. These health care providers also believed that sex in marriage was a wife’s duty whether she desired it or not; thus rape, as such, was not recognized within marriage.

Programmatic changes can train health care workers in prenatal and infectious disease clinics as well as HIV primary care settings. Among these changes are: coordinating HIV-related care and anti-violence programs, including cross-training and referral; developing curricula and training on routine violence screening for health care staff; and incorporating routine violence screening and counseling at HIV counseling and testing sites. In all of these counseling settings, it is important for staff to inquire if there is a significant relationship in a person’s life, how that relationship handles HIV-related risk and care issues, and more generally, how that relationship handles conflict.

In the United States, there are several models for cross-training interventions that have connected HIV and violence, for example, programs such as PROTOTYPES in Los Angeles and Casa Myrna Vazquez in Boston. Also in Boston, physicians and lawyers collaborate in the emergency medicine department of a large urban hospital, where they treat one to three women every night as a result of acute injury by sexual partners. The program assists women in getting temporary restraining orders without having to leave the hospital. The program identified two major themes: restraining orders help women leave battering relationships, and many women physically fight their batterers in order to preserve safety or escape.

Discussing Violence

How should health care workers discuss violence with their patients? Women and men are mostly likely to talk about abuse when asked empathetically and non-judgmentally a single question such as,
“Because violence is so common these days, I ask everyone if they have been hurt by someone close to them.” This introduction can be followed up with questions such as: “Do you feel safe in your current relationship?” “Is there a person with whom you have been involved who is making you feel unsafe now?” “Has anyone ever forced you to be sexual when you did not want to?” “Do you generally feel that you have control over whether you have sex?”

If universal screening is not feasible, it is important at least to ask similar questions if someone presents with any of the following signs or symptoms:

- Physical injury, at which point, it is wise to ask, “Who did this to you?”;
- Chronic, non-specific symptoms, such as pain, sleep disorders, or gynecologic pain that has no apparent cause;
- Emergency room treatment or mental health services;
- Late entry into prenatal care or, more generally, delay in seeking treatment for any health-related symptoms;
- History of suicidal thoughts or actions, which may indicate hopelessness related to interpersonal violence;
- Irritable bowel syndrome or genital and urinary tract infections.

For people who answer yes to any of these signs or symptoms, it is useful to follow-up with a series of questions: “Your symptoms may be stress-related. Are you experiencing a lot of stress? Is this related to your personal relationships? How do you and your partner handle conflict at home? Have you ever been physically or sexually hurt by your partner or someone else in your life?” Among individuals who screen positive for violence histories, there are often resources available for referral. In acute situations, providers should help develop safety plans for people who are not ready to immediately leave a relationship.

Contacting police or other authorities may not be in the best interests of people reporting abuse. First of all, police may be complicit in propagating abuse, particularly against women and men dependent on sex work for economic survival. Second, without laws to protect victims from their abusers, referrals to police may serve to escalate violence, since abusers are rarely arrested. This may be particularly true in societies that support gender inequity and outlaw homosexuality and drug addiction. Even if arrested, abusers are likely to be readily released from prison.

Finally, post-exposure prophylaxis with HIV antiviral treatments—while so far shown to be effective only among occupationally exposed health care workers—may prevent transmission after rape or coercive sex. Further, this may be accomplished using a single antiviral agent, rather than triple combination treatment, making it potentially affordable in developing countries.

**Conclusion**

The health care system does have a role in preventing HIV and violence through counseling and screening for both conditions, as well as through collaboration with anti-violence organizations and drug treatment programs. But such approaches must also acknowledge the causes of violence. At the most proximal level, programs that work with perpetrators of violence must be a conspicuous part of the response to partner violence. Furthermore, societal factors that inadvertently or intentionally condone violence require government interventions that promote socioeconomic equity for women and men who have sex with men.

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**Clearinghouse: Violence and HIV**

**References**


Maher JE, Peterson J, Hastings K, et al. Partner violence, partner notification, and women’s decisions to have an HIV test. *Journal of Acquired Immune
HIV Disease, Violence, and Post-Traumatic Stress
Cheryl Gore-Felton, PhD, Lisa D. Butler, PhD, and Cheryl Koopman, PhD

Far more than in the general population, people with HIV tend to report experiencing traumatic life events, particularly those that are violent and abusive. Indeed, in a nationally representative probability sample of 2,864 HIV-positive adults, being physically harmed by a partner or other person close to them was reported by 21 percent of the women and 12 percent of the men who have sex with men. Nearly half of the individuals in that study who reported physical harm identified seropositive status as a cause of the violence. Additionally, there is evidence indicating that experiences of physical assault, rape, and robbery are more prevalent among seropositive inner-city African American women when compared to their uninfected counterparts. HIV-positive people are also more likely to be exposed to abuse and violence because they tend to be members of communities—gay, ethnic minority, female, homeless, and drug user—that are disproportionately subjected to high levels of discrimination and violence. This article examines the aftereffects of violence, in particular, post-traumatic stress disorder (PTSD), among adults living with HIV disease.

The Effects of Violence
Violence is distressing not only while it is being endured, but also in its aftermath. In psychological terms, PTSD is the diagnosis most directly associated with the long-term impact of violence or abuse. There are two necessary features of PTSD: symptoms must follow an extreme traumatic stressor during which an individual experienced, witnessed, or was confronted by an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and the individual's response must involve intense fear, helplessness, or horror. Diagnostic symptoms for PTSD include reexperiencing the traumatic event—for example, through nightmares or flashbacks—avoiding reminders of the traumatic event, and suffering hyperarousal—which is indicated by irritability or problems sleeping.

A study of 67 African American HIV-positive women illustrates the relationship between violence and PTSD. The prevalence of criminal victimization, including interpersonal violence, was higher among these women than among women in the general population, and more than one-third of the women met the criteria for PTSD. A Stanford University study found further evidence of this relationship.

Stanford Study on PTSD
The Stanford study, including 61 HIV-positive men and women, has found increased PTSD (and depressive symptoms associated with PTSD) in response to traumatic events such as being the victim of a violent crime. The sample, recruited for a group therapy intervention study, was ethnically diverse with 49 percent White, 33 percent African American, 7 percent Hispanic/Latino, and 11 percent of mixed or other ethnicity. The average age was 38.7 years, 61 percent of participants were women, 20 percent did not graduate from high school, 87 percent had household incomes less than $20,000 year, and 57 percent identified as heterosexual.

References


Resources

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See also references cited in articles in this issue.
Substance abuse may result from or preceed trauma: in the three months prior to the survey, 26 percent of the sample reported significant alcohol use, 3 percent had injected drugs, and 8 percent had used cocaine.

Experiences of trauma were common among participants, with 61 percent of the sample reporting at least one traumatic experience severe enough to meet the PTSD definition for a stressful event. Interpersonal violence was the most common type of violence: 48 percent reported being in a situation in which they might have been killed; similarly 48 percent saw someone being killed. Moreover, 49 percent were forced to have sex by a stranger, 46 percent were attacked with a weapon, 28 percent were attacked without a weapon, 25 percent had been beaten, and 69 percent experienced an attempted robbery.

In response to traumatic events, 50 percent of participants reported moderate to severe trauma symptoms. Almost a quarter of the sample (22 percent) reported current symptoms consistent with criteria for a PTSD diagnosis. Individuals who reported more severe PTSD symptoms also reported significantly more severe symptoms of depression.

The Stanford study, which includes a diverse sample of people with HIV, affirms previous research demonstrating extraordinarily high rates of exposure to interpersonal violence and other traumatic events among people with HIV. In comparison, the National Comorbidity Survey found that while 56 percent of this general population sample reported exposure to at least one potentially traumatic event, only about 25 percent reported witnessing someone being badly injured or killed and only about 8 percent were estimated to have had PTSD at some time in their lives.

While the National Comorbidity Survey cannot be directly compared to the Stanford study for methodological reasons, the data suggest that people with HIV—whether due to serostatus, income level, substance use, ethnicity, or gender—are at greater risk of violence than people in the general population. Additionally, in the Stanford sample, exposure was associated with current PTSD symptoms, which in turn was associated with depressive symptoms.

Treating PTSD

Individuals commonly experience disruptive psychological symptoms almost immediately following violent episodes.

For some individuals, the symptoms persist, developing into PTSD. There is no empirical evidence supporting a particular treatment strategy for victims of violence, however, studies suggest that the most promising approaches adhere to cognitive-behavioral principles. These principles focus primarily on two aspects of PTSD: anxiety and control.

For people with HIV, the stress of the illness becomes a critical component of PTSD treatment. Death-related anxiety coupled with violence-associated anxiety can be overwhelming. Assisting clients in developing meaning in their lives and meaningful relationships is an important component of the treatment. Group psychotherapy, because it facilitates relationships among group members, can be an effective therapeutic intervention, not only reducing feelings of isolation but also validating individual experiences. In this way, group members get to understand the universal impact of trauma, altering the ways they view themselves and beginning the process of regaining personal control.

Treatment approaches should match the symptoms presented. If the presenting problem is hyperarousal, strategies to reduce arousal such as visual imagery and self-hypnosis may be most effective. For depression, cognitive restructuring may alter the client’s outlook on life. Some clients with traumatic symptoms benefit from the combination of psychotherapy and psychotropic medication to reduce symptoms of arousal or depression.

Conclusion

Assessing an HIV-positive client’s trauma history, and particularly his or her personal experience of violence and abuse, should be a standard part of clinical practice. Ameliorating trauma symptoms is crucial to improving quality of life and reducing distress.

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.
Gay Men, Partner Violence, and HIV

A study investigating the experiences of battered gay and bisexual men found that 60 percent of HIV-positive participants said the fear of becoming sick and dying alone played a major part in the decision to remain in the abusive relationship, and 30 percent said that fear of dating played a major part in the decision to stay. Among all participants in the study—including uninfected men—75 percent said they stayed in the abusive relationship because they hoped their partner would change, and 67 percent said they did so because they loved the abusive partner.

Patterns, forms, and frequencies of abuse of gay and bisexual men were similar to what has been found to be true in the large body of literature on battered heterosexual women. However, participants were not as likely as heterosexual women to report feeling financially trapped.

Researchers recruited 52 participants in San Francisco, Boston, Dallas, Los Angeles, and New York, through gay and domestic violence programs and HIV-related agencies that serve men of color. Most respondents were between the ages of 25 and 50. Twenty-nine percent were African American, 29 percent were European American, 19 percent were Latino, 12 percent were Asian/Pacific Islander. Fifty percent were HIV-negative, 38 percent were HIV-positive, and 12 percent did not know their infection status. Ninety percent of respondents had left the abusive relationship by the time of the survey.

Eighty-seven percent of participants reported recurrent physical abuse, and 73 percent had experienced sexual abuse. Thirteen percent of respondents reported that their partners sometimes or frequently “tried to infect or infected” them with HIV, and nearly half of these men reported seroconverting as a result. All respondents had experienced some form of emotional abuse, including excessive jealousy and possessiveness, constant criticism, being lied to, and verbal threats.

Review of HIV and Violence in Women

According to a comprehensive review of the literature, HIV-infected women experienced exceptionally high but equivalent rates of adult physical and sexual abuse (66 percent and 46 percent, respectively) as uninfected women (69 percent and 49 percent, respectively).

Poverty is associated not only with increased HIV risk, but also with increased risk for violence. In the United States, 77 percent of female AIDS cases occur among women of African American or Latina descent, and most HIV-infected women have annual incomes below $10,000 per year and receive public assistance as their primary source of income. HIV-infected women may also experience high rates of violence because they engage in behaviors that are associated not only with HIV transmission but also with violence. Among these behavioral risk factors are cocaine or crack use, injection drug use, trading sex for drugs or money, having sex with multiple partners, and having sex with men who use drugs.

While violence among HIV-infected women is not more frequent when compared to demographically similar uninfected women, for a small proportion of women, violence may occur around serostatus disclosure or condom negotiation. Between 1 percent and 4 percent of HIV-infected women experience violence immediately after disclosure to sex partners. One study found that HIV-related violence was no higher in the first year following diagnosis than in later years, but this study did not include women who did not disclose their serostatus because of fear of violence. Two other large studies of HIV-infected women found that risk for violence was lower among seropositive women with lower CD4+ cell counts, suggesting that the risk for violence may decrease over time or as health declines.

HIV-Related Violence in the Southeastern U.S.

Recent Reports

Among HIV-positive participants, fears of dying alone and dating influenced the decision to remain in abusive relationships.
A study of 194 women with HIV found that 15 percent reported at least one event of physical abuse and 55 percent reported at least one event of verbal abuse in the six months prior to the study. Researchers interviewed participants recruited from public HIV clinics serving both rural and urban areas in the southeastern United States. The study sample was primarily single (74 percent), African American (84 percent), urban dwelling (78 percent), and low income (70 percent). Participants ranged in age from 15 to 64 years. Fifty-three percent of the women reported being yelled at, insulted, or embarrassed in front of others, and 56 percent were made to feel guilty, worthless, or “like a bad person.” Ten percent reported being punched, kicked, or physically injured, and 8 percent reported being threatened with a weapon. Five percent reported engaging in a forced sex act and 3 percent of the women reported being raped, both in the prior six months.

Increased verbal abuse was significantly correlated with decreased feelings of self-esteem and competence; increased physical abuse was significantly correlated with decreased feelings of self-esteem. These effects may increase the likelihood of poor health outcomes resulting from direct injury, decreased willingness to access health services or to adhere to prescribed therapies, and psychological distress that could impact immune function.

HIV Disclosure and Violence among Women
Gielen AC, McDonnell KA, Burke JG, et al.

A study of violent episodes among HIV-positive women found that 4 percent of respondents reported physical abuse immediately following disclosure of an HIV diagnosis. Overall, 13 percent reported experiencing emotional, physical, or sexual abuse by either a partner or a non-partner at some time after disclosure. An additional 32 percent reported emotional, physical, or sexual abuse both before and after diagnosis.

Researchers recruited 310 HIV-positive women enrolled in HIV primary care clinics. Ninety-four percent of the women were African American, 60 percent were between 18 and 39 years of age, and 22 percent had an HIV-positive partner.

Participants distinguished between partner and non-partner violence. From partner or ex-partner perpetrators, 67 percent of participants experienced some form of emotional, physical, or sexual abuse. For 16 percent of the women, violence occurred only after diagnosis, and for 17 percent it occurred both before and after the diagnosis. From non-partner perpetrators, 42 percent of the women experienced physical or sexual abuse. For 18 percent, this violence occurred only after diagnosis; for 7 percent, it occurred both before and after diagnosis.

Younger women who had been diagnosed for more than four years before the interview were at greatest risk for being abused since learning they were HIV-positive: 76 percent of participants younger than age 30 and 63 percent of participants younger than age 40 reported abuse, compared with 39 percent of those 40 years and older. A history of abuse before HIV diagnosis was a significant risk factor for abuse after the diagnosis, as was a history of drug use.

Fifty-seven percent of all participants reported that a health care provider had told them to disclose their status to their sex partners, and 14 percent of all participants reported that a health care provider had helped them disclose. Women who were afraid of disclosure-related violence—29 percent of the sample—were significantly more likely than other women to report that a health care provider had helped them with disclosure. Ninety-five percent of the women disclosed HIV status to more than one person, and 58 percent disclosed to more than 10 people.
ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.htm.