For the first time in its seven-meeting history, the International Biopsychosocial Conference on AIDS—AIDS Impact—was held in the region of the world that carries the greatest burden of the epidemic. Nowhere could the need for behavioral and social research on HIV be any greater than it is in southern Africa. The Republic of South Africa has a greater number of people living with HIV than any other country in the world. Cape Town, where the Atlantic and Pacific Oceans meet in the shadow of the majestic Table Mountain, seemed the perfect setting for this historic conference.

The conference theme was “The Moment is Now” and the presentations took on an air of urgency that can be felt only in AIDS epicenters. As occurs with all such conferences, the atmosphere and energy of the April 2005 meeting was set in motion as much by the people and the place as by the topic.

Conference presentations reflected the enormous challenges of AIDS at this point in history, as well as the continued hope that only scientific progress can bring. Olive Shisana, the new Chief Executive Officer of the Human Sciences Research Council of South Africa and local host for the conference, opened the scientific sessions by noting that there have been more than 20 million cumulative deaths related to AIDS and more than 12 million children who have become orphans because of AIDS. Conference sessions spanned the full range of HIV-related behavioral research from all regions of the globe. This article reviews the high points of the conference; naturally, it cannot cover all of the sessions. It focuses on what seemed to be the most significant advances in HIV prevention, gender issues relevant to HIV, and HIV treatment issues.

The Internet and HIV Prevention

Because AIDS Impact is a behavioral conference, there were no reports on vaccine development. It is clear, however, that there are few promising candidate vaccines and none of these will be available any time soon. It is also clear that even if there is, one day, a preventive vaccine, it will not be 100 percent protective. Willo Pequegnat of the U.S. National Institute of Mental Health told the conference that “Behavioral prevention is today’s HIV/AIDS vaccine” [MON/2/005]. It is, in fact, well known that many current behavioral interventions are at least as protective as one could hope an efficacious vaccine would be. The availability of these interventions set the theme for the prevention presentations at the conference.

One area that received considerable attention was prevention delivered on the internet. Michael Ross of the University of Texas presented what he called the “Quin-A engine” model as a way of characterizing the five advantages of the internet for HIV prevention: anonymity, affordability, accessibility, acceptability, and approximation [TUE/3/007]. Interventions online can be delivered anonymously and at low cost. They can be accessible to nearly everyone who uses the internet and can be tailored to be acceptable to a variety of people. They also can approximate realities in risk situations. These advantages can be capitalized on when delivering HIV prevention interventions to risk populations via the internet.

Ross highlighted studies of sexually transmitted infection outbreaks among internet-based sex networks. For example, research has shown that men who meet their sex partners online report that they meet more partners with whom they have face-to-face sex than they do at brick-and-mortar venues such as bars and bathhouses. Men who meet sex partners online tend to be younger, less educated, less acculturated, more rural, and are more
likely to have sex with men. This profile suggests that the internet is a venue rich in opportunity for reaching people who might most benefit from HIV prevention.

However, the internet is not without its limitations. One problem is that users typically have limited attention span for online intervention activities. This reduces the feasibility of adapting intensive prevention programs, originally delivered in an effective face-to-face format, for use online. Shorter attention span is among the many factors that may account for the high levels of dropout rates from internet-based prevention programs. Other presentations at the conference reviewed methodological and practical limitations of the internet [Adam et al., WED/33/003; Cherry et al., WED/35/006; Elford et al., TUE/11/006]. Still, the opportunities for internet-based prevention seem endless. Among the most promising interventions were those that involved social influence and peer models by way of online chat/instant messaging and discussion groups.

Multiple Levels of Prevention

Promising outcomes were reported from prevention interventions targeting multiple populations from multiple levels. At the individual level, Leickness C. Simbayi of the Human Sciences Research Council in South Africa and Demetria Cain of the University of Connecticut presented a promising HIV risk reduction counseling intervention based on the Information-Motivation-Behavioral skills model [WED/27/004]. The 60-minute, single-session counseling intervention, tested in a randomized clinical trial in a South African sexually transmitted infections clinic, demonstrated significant reductions in unprotected sex acts and increased condom use among participants at very high risk for HIV transmission. Interestingly, there were no differences in outcomes between men and women despite the well-recognized differences in risk factors and gender issues, a result attributed to the individual tailoring of the intervention session. The intervention was an adaptation of a single 90-minute counseling session the research group had successfully tested in the United States; the study results raise the question of how brief can risk reduction counseling be and still remain effective?

At the level of families, there were new approaches targeting adolescent risk reduction. Research presented by Larry Brown and his colleagues at Rhode Island

Clearinghouse: AIDS Conferences

January 12–13, 2006, Miami: 6th National Conference on HIV/AIDS and Aging. To contact organizers, phone or write: Sue Bazner, The New England AIDS Education and Training Center, 23 Miner Street, Boston, MA 02215; 617-262-5657 (phone); aised@neaetc.org (e-mail); http://www.nmac.org/conferences/USCA (web site).

April 20–21, 2006, Sydney: Stigma-Prevention Practice: The 9th Social Research Conference on HIV, Hepatitis C, and Related Diseases. To contact organizers, write: Rodney McDonald, StigmaPreventionPracticeConference, National Centre in HIV Social Research, Robert Webster Building, University of New South Wales, NSW 2052, Australia; 61-2-9385-9455 (fax); nchsconference@unsw.edu.au (e-mail); http://nchsra.unsw.edu.au/conference2006.html (web site).

March 8–10, 2006, Jersey City: 2006 NIMH/IAPAC International Conference on HIV Treatment Adherence. To contact organizers, phone or write: Aimee Clark; 312-795-4934 (phone); aclark@iapac.org (e-mail); http://www.iapac.org/home.asp?pid=6314 (web site).

April 30–May 4, 2006, Vancouver: 17th International Conference on the Reduction of Drug-Related Harm. To contact organizers, phone or write: Harm Reduction 2006, Conference Management Team, c/o Advance Group Conference Management, 101-1444 Alberni Street, Vancouver, British Columbia, V6G 2Z4 Canada; 604-688-9655, ext 2 (phone); 800-555-1099, ext 2 (phone); 604-685-3521 (fax); info@harmreduction2006.ca (e-mail); http://www.harmreduction2006.ca (web site).

September 21–25, 2006, Hollywood, Florida: 2006 United States Conference on AIDS. To contact organizers, phone or write: Conference Registrar, National Minority AIDS Council, 1931 13th Street, NW, Washington, DC, 20009; 202-483-6622, ext 343 (phone); conferences.nmac.org (e-mail); http://www.nmac.org/conferences%5F5F%5Ftrainings/USCA (web site).

August 13–18, 2006, Toronto: The XVI International AIDS Conference. To contact organizers, phone or write: IAS Conference Secretariat, Ch. de l’Aranchet 33, CH-1216 Cointrin, Geneva, Switzerland; 41-22-7-100-800 (phone); 41-22-7-100-899 (fax); info@aids2006.org (e-mail); http://www.aids2006.org (web site).

February 27–28, 2006, Philadelphia: The 2006 National Conference on African-Americans and AIDS. To contact organizers, phone or write: Maggie Boyle, Minority Healthcare Communications, PO Box 540, Ellicott City, MD 21041; 866-901-6267 (phone); mhcc@npedu.com (e-mail); http://www.minORITY-HEALTHCARE.COM (web site).

WED/33/003
WED/35/006
WED/27/004
Hospital and Brown Medical School suggests that cognitive-behavioral strategies to address key family factors may be useful in preventing HIV among vulnerable adolescents in the United States. Researchers described an ongoing multi-site trial of the adaptation of family-oriented models for use in southern Africa [TUE/5/004]. The key elements of the intervention emphasized the improvement of adolescent decision-making skills, parent-adolescent communication, and parental monitoring and supervision skills. The intervention also includes parent-only, adolescent-only, and combined adolescent and parent sessions during a full-day workshop to enable families to discuss issues.

At the level of schools, Arvin Bhana of the Human Sciences Research Council in South Africa found significant effects of behavioral interventions on several outcomes, including impulsive decision making, alcohol use attitudes, self-efficacy in sexual negotiation, and peer communication [TUE/8/007]. He reported the results of two evaluations following the implementation of a prevention curriculum that was delivered to ninth and tenth grade learners in eight township schools in KwaZulu-Natal. The intervention was a two-group (skills-based HIV and alcohol intervention condition or brief informational HIV and alcohol intervention condition) randomized post-only design trial with two follow-up assessment points one to three months post-intervention. Analyses controlling for age and gender, indicated significant differences between the two groups in terms of alcohol refusal, self-efficacy, attitudes about early initiation of sexual activity, condom attitudes, and condom self-efficacy. This intervention model could be delivered in schools across cultures.

Godfrey Woelk of the University of Zimbabwe reported on promising approaches to community interventions for HIV prevention in southern Africa, suggesting that since such interventions can reach large numbers of people, they can be cost-effective, less complex, and sustainable [TUE/14/005]. These approaches, some of which are based on Jeffrey Kelly’s Opinion Leader Model can and do alter social, cultural, economic and physical environment, as well as shifting communities away from conditions favoring the occurrence of transmission-related behaviors.

**Gender and HIV Prevention**

A focus of the conference was on gender and gender relations in the context of the global epidemic. Erika Burger, of the International Institute on Gender and HIV/AIDS in Halifax, Canada stated that, in heterosexual relationships, women are at a substantially higher risk of becoming infected than men. Rachel Jewkes from the Medical Research Council in Pretoria spoke about the “dangerous intersections” of HIV and gender-based violence. She reviewed previous research that has shown gender-based violence is common in countries with high rates of HIV infection among women and that HIV-positive women in southern Africa are more likely to report a history of physical and sexual intimate partner violence [TUE/3/004]. In one South African study she cited, HIV-positive women were 30 times more likely to report interpersonal violence than their HIV-negative counterparts. Jewkes presented multiple pathways by which violence can be related to HIV risk for women including direct paths, in which trauma incurred during sex increases the physical likelihood of transmission, and indirect paths, in which inequality in relationship power can increase susceptibility by limiting a woman’s options for protecting herself from HIV transmission.

These presentations were elaborated by Professor Tammy Shefer from the University of the Western Cape in South Africa [WED/23/005]. She spoke of the gap between science and practice in gender research and...
cautioned us to remain vigilant against the pitfalls of mainstreaming gender in HIV research. Mainstreaming gender involves bringing the study of gender as a multifaceted area into the generalized biopsychosocial research arena. For example, HIV is not solely intertwined with gender but also other sources of discrimination such as racism, classism, and homophobia. Shefer sees HIV as opening windows of opportunity to challenge gendered norms, particularly in HIV epicenters. There was a clear sense of importance in her message of involving men in HIV prevention efforts. From her view, focusing on women in HIV prevention legitimizes male power differentials and reinforces stereotypes of female powerlessness. However, like other speakers at the conference, Shefer warned of the risks in excluding women from HIV prevention as we move to include men.

Interestingly, these sentiments are similar to those expressed in the United States, where there could be concern that focusing on heterosexual men in HIV prevention could detract from prevention efforts focused on women. Clearly, the call is to focus on both men and women.

**HIV Treatment-Related Issues**

There was considerable attention at this year’s conference on access to HIV antiviral treatment in the poorest countries that have the greatest numbers of people affected by HIV. Yves Souteyrand from the World Health Organization (WHO) updated the conference on the WHO’s “3 X 5 program” a global initiative to treat three million people in developing countries by the end of 2005 [TUE/3/001]. While several countries are set to meet the treatment goals, others are hampered by basic limitations such as scarcity of public health workers, doctors, nurses, and clinic facilities. Further, the effort requires community preparedness, home preparedness, and individual preparedness.

Ashraf Grimwood from South Africa’s Absolute Return for Kids (ARK) reported that the country has treated only 68,000 of the 1.4 million patients it had planned to reach [TUE/3/002]. From an economics perspective, Jean Paul Moatti of the University of the Mediterranean commented that the tripling of global funding over the past five years is nonetheless far from sufficient to reach international treatment goals. Moatti stated in sub-Saharan Africa, countries spend an average of $32.00 per person on health care compared to more than $2,500.00 per person in many developed countries. To provide minimal services, the figure needs to rise to $50.00 per year per capita [MON/2/002].

Moatti noted that most health care expenses in developing countries are out-of-pocket or private health insurance payments He discussed how direct government funding of HIV treatments can be cost-effective in developing countries, perhaps because of the sheer numbers of people with HIV in these countries. The strongest evidence for government investment in HIV care is that many large companies in developing countries are now funding access to HIV treatment because they see this expenditure as a cost-effective investment in the viability of their work forces.

HIV treatment access was also considered in the context of HIV prevention. In particular, Francois Ventu of the University of Witwatersrand in South Africa discussed research showing the most infectious periods for HIV transmission are in the first six months after infection [THU/3/006]. The concept of treating people during this time and its potential impact on HIV transmission seems clear. Still, there are no strategies in place for identifying individuals soon after they become HIV infected in order to implement behavior change strategies and initiate HIV treatment.

**Conclusions**

AIDS Impact expanded its horizons in Cape Town. Conference attendees from North and South America, Europe, Australia, and throughout Africa converged in this place of beauty and intrigue, a place that is also being ravaged by HIV. AIDS Impact likely benefitted the researchers and service providers of southern Africa and the hope is that southern Africa gained some benefit from the researchers attending the conference. One only hopes that the conference energized behavioral scientists from the United States to pursue new avenues of research in the developing world as well as at home.
An Unbridgeable Gulf between Research and Practice
Les Pappas, MPA


Community Interventions and AIDS provides a thorough survey of current theories of community-level HIV prevention interventions. The collected authors are leaders in their fields, and their writings shed light on new ways of thinking about HIV prevention and provide a considerable exploration of the intersection of research and community. The unfortunate notion that remains after reading the book, however, is that these two worlds, the academy and the real world, remain far apart and may ultimately be irreconcilable.

The chapters present the latest theoretical frameworks influencing prevention, including social networks, rapid assessment, community mobilization, and community narrative or storytelling. Descriptions of these approaches, along with some case studies, leave the reader with a reasonable understanding of how behavioral academic researchers view both the current state of HIV prevention and how they would like to direct it for the future. The chapters are not weighted with statistical data, but they are heavily footnoted, a benefit for those seeking further amplification. As an HIV prevention practitioner for more than 20 years, especially in the area of social marketing, I found the book stimulating on several levels.

New Concepts

Community Interventions and AIDS introduces some methodologies and constructs that were new to me. For example, in discussing the Hartford Model, Merrill Singer and Margaret Weeks describe the theory of Oppression Illness (OI), defining it as “the chronic, traumatic effects of experiencing social bigotry over long periods of time combined with the negative emotional effects of internalizing such prejudice.” They go on to state that this type of victimization results in self-esteem issues, high rates of substance abuse, and other barriers to mental and physical health.

Reading about OI helped me place many of my prevention work experiences in context. In working with gay men, I often identified internalized homophobia as an obstacle to achieving health and wellness. Similarly, heroin and other drug users suffer from similar “internalized oppression” that comes from the same “structural violence” Singer and Weeks identify. The question of course, is how do HIV prevention practitioners make use of this information.

No doubt, providers are already aware of the negative health outcomes that are a product of the oppression and discrimination under which marginalized populations live. The Hartford Model offers two solutions: first, planners should physically house researchers with service providers under the “one roof” approach; second, planners should utilize ethnography as the primary research methodology. These seem like useful strategies, albeit counter to the mainstream behavioral research method used today. The most striking feature of OI and the Hartford Model is the manner in which they embrace activist research. According to the authors, the Hartford Model “rests on a commitment to advocacy and social change.” Of all the chapters in the book, this one seems to make the strongest case for effective collaborations between researchers and providers.

Historical Perspective

Second, the book presents a fair amount of historical perspective. As someone who was deeply involved in the evolution of HIV prevention, it is always interesting to see how others recount these matters, especially when this recounting is done as an academic exercise.

The emotion, the panic, the uncontrollable fear and despair are hard to convey unless you lived through it. It often sounds
like hyperbole, but the trauma of AIDS in the early 1980s was real, and historical accounts never seem to effectively translate into words what it felt like to live through it.

Likewise, the response of preventionists at that time has not been well documented. The role of activists, in particular, ACT-UP, is usually cited when recounting the success of early prevention efforts. However, it is worth recalling that many people in health departments and community-based organizations around the world were the ones who created most of the initial interventions. We are indebted to those who chained themselves to buildings and threw blood on dispassionate government officials, but we also need to do a better job of acknowledging the prevention work conducted at the same time by providers and prevention workers. This work was done without the benefit of academic research; however, prevention planners did use market research extensively, working with community representatives and using surveys and focus groups to identify messages that would be meaningful and interventions that would be accepted.

**Involving the Community**

The thing that most struck me about this book, and what I have not been able to stop thinking about, is how research (and researchers) interacts with the community or population it is observing. It seems that every chapter author was keenly aware of the problems between researchers and their subjects and the inclusion of and collaboration with prevention practitioners and community-based organizations in their research process. The question of how best to involve communities and their representative organizations ranges from concerns about gathering data, sharing planning and decision-making authority through to analyzing and disseminating results. I think that researchers in general, and these authors in particular, are acknowledging the rather abysmal relationship that has traditionally existed between research and community.

The ongoing nature of research continues to benefit those doing the studying more than those who are the object of the study. It seems that no matter how hard they try, academics are unable to effectively bridge the divide. I do not want to suggest that researchers stop trying, but it may be that these two worlds are just incompatible. It simply may be that the manner in which research is organized, with its academic leanings, lengthy outcome horizons, and its need to be a career driver, causes it to be removed and otherworldly. To the person doing prevention on the ground, the relevance of various academic theories and the corresponding nomenclature, will be difficult to access and assimilate.

**Conclusion**

This book will be helpful to those with the capacity and inclination necessary to digest the complex conceptual frameworks the authors present. While this book certainly makes an important contribution to the academic discourse, I wonder how many community interventionists, not to mention less involved community members, will find the writing particularly engaging, relevant, or accessible. It may be just another example of the internecine discourse of researchers talking to researchers, exactly what the authors would like to change.

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**Clearinghouse: HIV-Related Books**


The Relationships of HIV-Positive Gay Men

Mario Sandoval, MA


HIV+ Sex: The Psychological and Interpersonal Dynamics of HIV-Seropositive Gay and Bisexual Men’s Relationships is a book of narratives, the words of gay and bisexual men who describe their experiences living with HIV. It documents primarily the qualitative results of the Seropositive Urban Men’s Study (SUMS), which collected quantitative and qualitative data on 250 HIV-positive men in New York and San Francisco. This combination of data and expression—the sprinkling throughout the book of study participants’ salient and powerful quotations—enriches the book and gives voice to the range of attitudes, behaviors, sociocultural factors, and interpersonal dynamics that the study uncovered.

The working assumption of the editors and contributing authors is that gay and bisexual men are sexual beings and that it is important to “examine the meanings that they give to their sexual behaviors through lenses that incorporate the physical, emotional, and social aspects of these behaviors.” Among the most compelling goals of the book was to move beyond an analysis of HIV-positive gay men purely in terms of their risk for transmitting HIV.

The study found that not only are most HIV-positive gay men sexually active, but also most “saw themselves as having a special responsibility to protect their partners from HIV infection and had taken steps to do so.” Providers working with HIV witness these realities everyday, but this clearly written and objective book explores these realities in all their subtleties and permutations. It divides the breadth of topics into chapters running the gamut through lenses that incorporate the physical, emotional, and social aspects of these behaviors.” Among the most compelling goals of the book was to move beyond an analysis of HIV-positive gay men purely in terms of their risk for transmitting HIV.

The study found that not only are most HIV-positive gay men sexually active, but also most “saw themselves as having a special responsibility to protect their partners from HIV infection and had taken steps to do so.” Providers working with HIV witness these realities everyday, but this clearly written and objective book explores these realities in all their subtleties and permutations. It divides the breadth of topics into chapters running the gamut from “Community Affiliation and Social Support” to “The Roles of Public and Commercial Sex Environments in the Sexual Lives of HIV+ Gay and Bisexual men.”

Diversity

A great strength of the study and the book is the diversity of the sample population, including ethnic make-up, and socioeconomic status. Of the 250 men, 30 percent were White, 29 percent were African American, 24 percent were Latino, 6 percent were Asian or Pacific Islander, 2 percent were Native American, and 9 percent were of mixed race or other. A plurality of the sample had annual incomes of less than $10,000 (45 percent), and 38 percent earned between $10,000 and $29,000, 12 percent between $30,000 and $49,000, and 5 percent more than $50,000.

The book dedicates a chapter to the issue of culture and race. The study found, “For most men, particularly men of color, their racial and ethnic heritage was a source of disapproval . . . which left them feeling rejected, judged, and shamed by their cultures of origins.” Further, the study’s results suggest that being HIV-positive added to “this rejection, and for some, reinforced their own feelings of low self-worth.”

The authors assert that by examining the interplay of race, culture, and sexuality, providers can achieve a greater understanding. At times, for example, sex with a partner of the same race affirmed a sense of heritage for a study participant of color. The authors also describe how race can be divisive among men of different ethnic backgrounds. Here, the use of quotations is a particularly effective way of presenting difficult topics. For example, a 39-year-old White man generalizes from one interaction in a way that may easily cross the line into stereotype, “I had an experience with a Puerto Rican, and it was totally insane . . . they are wonderful for sex . . . just don’t get caught up in their craziness.”

The narratives equally reveal internalized racism. For example, a 32-year-old African American man states, “I don’t date Black men. . . . They carry a lot of excess, unnecessary baggage that I don’t have to have in my life.”

The effects of race, discrimination, and culture are linked to risk for HIV and was described by one mixed race man, “Because when it comes to sex and HIV, those are not the top things for men of color to deal with. We have a lot of other barriers and baggage to deal with . . . that come before dealing with [HIV].”

Sex, Risk, and Serostatus

Of particular relevance to the HIV prevention community are the chapters on sexual negotiation and communication, serostatus assumptions, substance use, and HIV treatment optimism. These chapters explore the intertwining factors that lead to decisions around level of risk taking during sex.

A notable example is the study’s exploration of the effect of HIV antiviral treatment on sex and relationships. The authors discuss
how HIV-positive men have “greater sexual interest and frequency of sex because of treatment advancement.” The study, however, found that most participants had not changed their level of sexual risk taking due to treatment advances: unprotected anal sex was correlated with a low perception of risk of transmission, but HIV-positive men who were on treatment had higher perceptions of the risk of transmitting HIV to an uninfected partner than HIV-positive men who were not taking treatments. The authors admit that they cannot prove causality, but they imply that HIV-positive men on antiviral treatment may be less likely to engage in risky behavior.

**Conclusion**

HIV+ Sex works as an engaging, succinct, and well-written tome of gay and bisexual male sexuality. It is an excellent tool for the practitioner new to the world of HIV and those limited in their experience of working with non-heterosexual male clients. Practitioners who are experienced in working with this population will surely recognize many of the issues raised as familiar, perhaps even self-evident. However, since the book presents these issues in the context of research, it raises the foundation for these concepts from the anecdotal to the empirical.

Above all, the narratives of the HIV-positive men in this volume are a compelling display of the diversity and complexity of experiences, and the interplay of interpersonal and psychological factors. Rather than focusing on HIV-positive men only with regard to their risks of infecting HIV-negative men, HIV+ Sex observes and portrays the totality of the HIV-positive gay and bisexual male experience in terms of culture, personal beliefs, and relationships with others.

Kramer presents a sustained case that depression, far from enhancing cognitive or emotional powers, essentially pokes holes in the brain... Rallying his extensive familiarity with art and literature, Kramer argues that history’s depressive luminaries were creative not because of but despite their struggles with mental illness—as a result of their underlying resilience, a quality he admires...
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