Some came away from Yokohama, Japan disappointed that the Tenth International Conference on AIDS did not produce more breakthroughs. But it is clear that scientists will not, and should not, wait for the annual international meeting to reveal important results. Rather, such results should be presented to the community as soon as they are available.

What, then, does the international conference accomplish? The conference offers an important venue for professionals from different disciplines and people in the HIV-affected communities to share ideas, findings, and practical solutions to difficult problems. These are not the issues that make the headlines, but they are the ones that will prevent HIV from spreading. This article describes the range of psychosocial findings presented at the conference and focuses on research about counseling and support, school-based prevention, and prevention strategies for women.

Counseling and Support

The vast majority of cases of HIV infection are in developing countries, those least able to afford the expensive medications and medical care needed to arrest disease progression and to prevent and treat HIV-related opportunistic infections. As a result, families, friends, and communities must perform the hard work of caring for people with HIV disease.

In Yokohama, there were more presentations on counseling and support in developing countries than there have been at past conferences. These presentations defined the issues people with HIV disease face in resource-poor nations, where counseling and support—a route to prevention—may be all that a society can afford. Care and prevention go hand in hand: when people feel that they will be cared for, that they can turn to their families and communities for help, they may be more likely to tell others that they have HIV infection and to avail themselves of prevention services. It is important to note that these findings are applicable to industrialized nations as well, particularly those where the epidemic is hitting "resource-poor" communities, for example, inner-city neighborhoods.

Stefano Bertozzi of the World Health Organization’s Global Programme on AIDS reminded a plenary session of the conference that the burden of caring, particularly in the developing world, typically falls to households and not to professionals (PS30). Psychosocial interventions should focus on easing this burden, confronting issues such as caring for self and the people for which one has responsibility, planning for the death of a loved one—and the lives of his or her survivors, particularly children—dealing with HIV-related cognitive impairment, and providing basic support such as food, shelter, and medical care. In another plenary session, Thai educator Jon Ungphakorn reframed a familiar theme: the AIDS challenge is as much about responding to attitudes as it is about rebuffing the virus (PS8). As in the industrialized world, many of the psychological issues raised by infection in the developing world are related to social reactions to the epidemic and to infected people.

Several presentations offered innovative responses to these challenges. Elizabeth Marum of the Centers for Disease Control and Prevention (CDC), in collaboration with the Ugandan AIDS Information Centre, reported on the Post-
This year marks the Tenth International Conference on AIDS and inaugurates the conference’s every-other-year schedule. Some would say this hiatus is a long time coming and that the money spent on this extravaganza is better put towards program costs and smaller discipline-specific and regional conferences.

I have expressed my frustrations about the international conference before: its failure to provide an effective and flexible forum for information exchange and, most importantly, intellectual synthesis. Attending a conference on this scale, despite innovative summary sessions, is always a process of describing the elephant after having handled only its trunk—or toenail. It’s exhausting, expensive, and—despite the best intentions—often dominated by mediocre research, especially in the area of the social sciences.

But as Thomas Coates points out in this issue of FOCUS, it is the only forum that brings together a truly international convocation of professionals from a variety of disciplines, laypeople, and activists. While the AIDS effort will not be harmed by a two-year wait until the next conference in Vancouver, this year’s conferences—both in Yokohama and in Brighton—testify to the value of sharing across national boundaries.

Two examples demonstrate this point. Coates observed several Yokohama presentations where researchers from the developing world offered lessons to those of us working in the industrialized world. It is heartening and exciting to confirm that cross-cultural pollination can yield hybrid approaches like the Ugandan Post-Test Club.

The other example came from the Brighton conference. While conference organizers were hugely successful at insuring that this small conference included substantial developing world attendance, the international aspect of the meeting became apparent to me in a more subtle way. At the two sessions on substance use and unsafe sex, which I document in my report, the most vigorous debate occurred among White researchers from English-speaking, industrialized countries, debaters who—from the perspective of someone in the developing world—might appear culturally identical. It was fascinating to note how alcohol use held such culturally different meanings among people who by international standards might be confused with each other.

Culture can become a buzzword that obscures differences among apparently similar peoples even as it magnifies distinctions among patently different groups. Both conferences emphasized, as has been the case over the past few years, the importance of prevention, and the importance of collaboration: across culture and, importantly, between researchers and practitioners. As Jeffrey Kelly asserted at Brighton, such collaborations are the route to creative solutions to the huge prevention challenges we face.

Test Club, an approach to stemming the divisions between seropositive and seronegative people and to facilitating HIV serostatus disclosure (240C). Disclosure is still difficult for many HIV-infected people. It is important to find ways for them to obtain support and avoid stigmatization. The Post-Test Club was established for recently tested people, and, like many U.S. programs, offers a forum to talk about HIV disease and HIV-related problems. Unlike U.S. support groups, however, which are usually segregated by serostatus, the Post-Test Club is open to anyone who has been tested. It is particularly effective because it encourages interactions among people who identify as seropositive and seronegative, and people who choose not to reveal antibody status.

A survey of 1,246 Post-Test Club members found that 60 percent participated in safer sex and 68 percent reported safer sex three months later. In addition, over time, perceptions of safer sex social norms increased and more participants became involved in safer sex programs, including condom distribution in the community.

Michael David Thurnherr of The Test Positive Aware Network (TPAN) of Chicago presented data on peer-led interventions for newly tested seropositive people and for seropositive people having problems with maintaining safer sex (277D). Thurnherr found that recently tested people were confused about safer sex practices. Those who relapsed felt shame about their slips, and this shame—and the belief that their friends would not understand or be willing to discuss instances of relapse—led to a sense of isolation. In response to these findings, TPAN developed a peer prevention case management system, pairing “veteran” people with HIV disease with neophytes. After training, veterans guide their clients through six discussions on safer sex alternatives, correct condom use, personal responsibility, early intervention choices, HIV basics, and STD education.
Knowledge of HIV infection is, of course, the first step to dealing with the range of HIV-related psychosocial challenges. Rapid, on-site antibody testing is one way to facilitate access to this knowledge. But there remain concerns about the counseling implications for such a testing delivery system. In response, CDC researcher William Kassler conducted a study of counselors and clients to examine counseling technique and client and counselor acceptance (518B/D). Counseling modifications for the rapid test venue included: changing consent language, allowing for deferral by those who were not ready to receive results, and conducting a risk assessment before drawing blood.

Clients who tested positive were told that they were “likely to be infected.” Counseling emphasized the importance of returning for results of the confirmatory Western Blot test, further counseling, partner notification, and referral. Although initially reluctant, counselors found these protocols acceptable. Kassler found that 90 percent of clients liked getting their results on the same day and 86 percent of those who had had a previous antibody test preferred the rapid test.

Rapid antibody tests are becoming more and more available. Some test kits may allow individuals (or physicians or employers) to test people on the spot. But providers have raised significant concerns about telephone counseling and “instant” testing, including the unproven specificity of the tests, the lack of confirmatory tests, and the lack of adequate pre-test counseling, informed consent, and post-test counseling. The question is not whether rapid or home-based testing will come, but when. There is plenty of potential for abuse here in the United States, but more so in developing nations. There needs to be research to identify the positive and negative consequences of rapid or home testing, and legal and ethical safeguards to maximize the benefits of such tests.

School-Based Prevention

HIV infection is increasing most rapidly among young people. According to a recent letter in the New England Journal of Medicine, the median age of infection is now 25 years, compared to 35 years a decade ago, and one in four new infections in the United States occurs in people younger than 20.2

Conference presentations affirmed the value of school-based prevention programs at the same time as they questioned the need and efficacy of these interventions for all students. Deborah Rugg of the CDC assessed the effectiveness of the range of school-based interventions reported in the literature and found that well-designed programs do not hasten the onset or increase the frequency of sexual intercourse; can delay the onset of intercourse; and can increase condom use among sexually active youth (371D). Effective programs share several characteristics: a basis in social learning theory; a narrow focus on a specific behavior; experiential activities; instruction on resisting negative influences; reinforcement of positive peer norms and values; and activities that increase skills and confidence.

Alan King of Queens University in Ontario developed a program that seems to meet Rugg’s criteria (372D). He administered a 20-hour educational program to 2,000 Canadian ninth grade students, basing it “on a behavioral change model emphasizing skill development, responsible attitudes, and motivational supports through peer modeling and parental involvement.” Its focus was relatively broad, covering HIV-related knowledge, attitudes toward healthy sexuality, homosexuality, people with HIV disease, and condoms, assertiveness, sexual behavior, and condom use. While the intervention achieved positive results in terms of assertiveness, comfort in talking about condoms, HIV-related knowledge, and behavioral intent, it had little practical effect on delaying vaginal intercourse. In addition, condom use decreased over time, so that by year three, there was no significant difference between the demonstration group and the control group.

If we were really interested in HIV prevention, would we target all youth, or would we target gay youth, adolescents in high prevalence poor communities, and teens who for a variety of reasons may be likely to become injection drug users? The programs presented at the conference target the general population of adolescents, and none talked about sexual diversity and the acceptance of sexual diversity. Part of the problem is that people who are interested in adolescent sexuality issues have appropriated HIV prevention as a way of promoting condom use and other sexual decision-making strategies. While adolescents may
be at risk for other sexually transmitted diseases and pregnancy, many are not at risk of HIV disease. We should be doing a more effective job with those youth who are at highest risk for HIV infection, especially adolescents who are gay or bisexual.

Prevention Strategies for Women

Among presentations that focused on women with HIV disease, there continues to be an emphasis on power dynamics and coercion. Two presentations, which reported on data from a University of California San Francisco, Center for AIDS Prevention Studies investigation of 1,600 Latino men and women throughout the United States, examined these issues.

Barbara Marin analyzed the effects of cultural values on condom use among the 749 respondents 18 to 24 years old (034D). She found that women were less comfortable with sex than were men, that is, less comfortable having sex with the lights on or being naked in front of their partners. Sexual comfort was related to condom use: of those who were comfortable being naked, 64 percent of men and 74 percent of women could use a condom without spoiling the mood. Of those who were uncomfortable, however, 41 percent of men and only 35 percent of women could use a condom without spoiling the mood. Marin states that while the origins of this discomfort are unclear, about half the respondents had never talked to their parents about sex. She concluded that this sexual silence is a likely source of discomfort with sex and is a major impediment to safer sex.

Cynthia Gómez investigated the incidence of sexual coercion among unmarried Latino women in the United States (064D). Of the study's 846 women, 20 percent reported a history of sexual abuse or rape in their lifetimes. Of women who had sex with men in the prior year, 73 percent said that partners insisted on sex when the women were not interested, 23 percent said that partners yelled at them, and 14 percent said partners harmed them in some other way during sex. Responses by men confirmed this coercion data. Men who reported being coercive and women who reported being coerced were more likely to agree with the following statements: women like dominant men; a woman has to pay the consequences when she flirts with a man; it's harmful for a man to get excited without ejaculating; and it's dangerous for a woman to know as much about sex as a man.

A smaller study of Zambian women focused on safer sex strategies and, without documenting coercion, described similar attitudes among male partners (063D). Caroline Chandra of the Kara Counseling and Training Trust in Lusaka surveyed 152 women receiving antibody testing and counseling. At three- to six-month follow-up interviews, some women in “non-steady” relationships chose to abstain from sex in response to partner resistance to condom use, and this led to the break-up of the relationship. Women with steady partners also had difficulty with resistance to condom use.

Conclusion

While progress in vaccines and therapeutics is slow, many presentations and conversations at the Yokohama meetings do support optimism. We have learned much about how to care for and support those with HIV disease, and about how to prevent HIV infection. We are more and more commonly talking about topics in public that 10 years ago were taboo, and these conversations are leading to progress.
**The Brighton Conference and HIV Prevention**

Robert Marks

In response to the emphasis on medical science at the international AIDS conferences, a group of psychosocial researchers established the Conference on Biopsychosocial Aspects of HIV Infection in 1991. The second meeting of this conference—also known as AIDS’ Impact—took place in Brighton, United Kingdom in July 1994. While it covered aspects of counseling and support, its strongest presentations were in terms of prevention strategies for gay men and drug users.

**Safer Sex among Gay Men**

Facing with continuing relapse from safer sex and new populations who do not recognize their risk, and armed with greater sophistication about concepts related to safer sex, researchers are challenging assumptions about HIV prevention, particularly for gay men. In a controversial plenary speech, Ron Gold of Deakin University in Australia questioned the foundations of HIV prevention among gay men and reported on gay men’s attitudes toward sexual risk (Plenary 3 and IP5.3).¹

He cited four studies of gay men who had relapsed to unsafe sex in the recent past and presented three major findings: large numbers of gay men have not embraced a “safe sex culture”; links to the gay community are not effective in helping all gay men establish and maintain safer sex practices; and while safe sex campaigns that emphasize information and exhortation were once successful, they are no longer particularly useful.

Instead, since gay men who participate in unsafe sex use various arguments to “give themselves permission” to engage in these practices, Gold found that targeting these self-justifications directly might lead to risk reduction. He based his intervention on the premise that self-justifications represent thinking that occurs only during actual sexual encounters, thinking that is unique to “the heat of the moment.” Risk reduction occurs when gay men reflect on and evaluate this thinking in the cold light of day.²

Where Gold’s talk identified the limits of current gay-related prevention, Jeffrey Kelly of the Medical College of Wisconsin focused on successful prevention strategies (Plenary 2). Kelly, a pioneer in HIV prevention, reviewed the 20 published controlled HIV-related risk behavior outcome studies. He divided prevention into two categories: face-to-face approaches and community approaches. He concluded that research strongly supports the effectiveness of face-to-face, ongoing group interventions that combine risk education and preparation for change with skills-building, reinforcement, and support. While community models are not as effective, they are commensurate with the societal scope of an epidemic and can change peer reference group norms.

Kelly reviewed two studies that exemplify effective individual and community approaches. In one, researchers worked with 250 women who received care at an

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¹ An issue of FOCUS to be published early in 1995 will include a fuller discussion of Gold’s findings.

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**Body Positive** included conference coverage in its October issue. Sample copies are available at no charge. To order, write: 2095 Broadway, Suite 306, New York, New York 10023, Attn: Kathryn Clark; or call 212-721-1346.

**Bulletin of Experimental Treatments for AIDS (BETA)**, published by the San Francisco AIDS Foundation, covers the international conference in its September issue (which is also available in Spanish). Individual issues are $18. To order, write: BETA, PO Box 2189, Berkeley, CA 94702-0189; or call 800-959-1059.

**The Journal of the American Medical Association** provided brief conference coverage in the September 14, October 12, and October 26 issues. To receive back issues, which cost $11 each, write The American Medical Association, Subscriber Services, PO Box 10945, Chicago, IL, 60610-4377; or call 312-464-5000.

**Medical Alert**, a publication of the National Association of People with AIDS, dedicated its October issue to conference coverage. To order the free publication, write: NAPWA, 1413 K Street NW, 7th Floor, Washington, DC 20005; or call 202-898-0414.

**Positively Aware: The Monthly Journal of the Test Positive Aware Network** devoted its September/October issue to the conference. To order, write: Positively Aware, 1258 Belmont Avenue, Chicago, Illinois 60657; or call Jeff Berry at 312-404-8726.

**Treatment Issues**, published by the Gay Men’s Health Crisis in New York, included conference coverage in its September and October issues, which are available at no charge. To order, write: 129 West 20th Street, 2nd Floor, New York, NY, 10011, Attn: Chuck Sock.
inner-city, primary care health clinic. The intervention focused on debunking myths, skills-building, problem-solving, sexual assertiveness, and peer support. After three months of follow-up, condom use increased from 26 percent to 56 percent, proving that an intervention of five sessions could result in increased sexual communication and negotiation.

The second study—which Kelly has reported before—focused on identifying and harnessing the efforts of “opinion leaders” in eight small cities. In comparison cities, researchers mounted a high-quality, but standard, HIV prevention media campaign. In the study cities, researchers identified local opinion leaders in the gay community, and taught them about HIV prevention and how to disseminate non-judgmental messages endorsing behavior change. Each leader contracted with researchers to talk to a specified number of friends every week. In the study cities, there was a steady decline in anal intercourse, particularly for insertive partners. One-third of the subjects who had been at high risk before the intervention were at no risk after it. There was no comparable change in the comparison cities.

Two other studies organized by Project SIGMA—a seven-year investigation of the socio-sexual impact of HIV on gay men—also examined prevention in the gay community. Ford Hickson documented the flawed process by which gay men assess risk (W4.2). He surveyed 337 gay men, 38 percent of whom had engaged in unprotected anal intercourse in the prior year and 5 percent of whom were seropositive. When asked about casual encounters that resulted in unsafe sex, Hickson found that both seropositive and seronegative subjects often assumed that their partners’ serostatus was the same as their own.

He also found that HIV-infected men, whose major concern was avoiding transmitting the virus, were better at stopping transmission than uninfected men, whose major concern was avoiding contracting the virus. Most notably, untested men who were in fact seropositive had unsafe sex with seronegative men and were more concerned about contracting HIV than transmitting it. Hickson suggested that prevention campaigns focus on the role of antibody testing in making decisions about sexual risk.

Clarification:
Authorship of Lesbians and AIDS Article

Due to miscommunications about the extent of source material used in the lead article of the June 1994 issue, we published an inaccurate byline for “The Myth of Invulnerability: Lesbians and AIDS.” The article was written by Amber Hollibaugh of the Lesbian AIDS Project with contributions from Carmen Vasquez of the Lesbian and Gay Community Services Center and Marcia Quackenbush of the UCSF AIDS Health Project.
such users were likely to be influenced by “chronic patterns of risk-taking.”

Cochran found that “the association between alcohol use and HIV risk appears to involve more than just the immediate affects of alcohol intoxication on sexual behavior choices.” HIV-infected men were significantly more likely than uninfected or untested men to be classified as “possible alcoholics,” to report using alcohol in conjunction with sex, to use drugs, to use drugs in conjunction with sex, to be a current or former cigarette smoker.

It should come as no surprise that drinking would have an effect on risk behavior and at the same time, that it might be indicative of a psychological predisposition to take risks. Cochran’s findings suggest that prevention that focuses on alcohol use cannot simply discourage the combination of drinking and sex. Among heavy drinkers at least—who seem to be more likely than casual drinkers to be HIV-infected—there appears to be a psychological component that will function to impel risk-taking with or without the mediation of alcohol. At this largely European conference, however, these conclusions evoked strenuous debate. Drinking in the United States has different associations and meanings, and research from this U.S. sample seemed to be less relevant in cultures where alcohol use is integrated into society in different ways.

In a session devoted to the relationship between recreational substance use and high-risk sex among gay and bisexual men—David Ostrow of the Medical College of Wisconsin, Michael Ross of the University of Texas, Graham Hart of the University College and Middlesex School of Medicine in London, and Peter Weatherburn of Project SIGMA—spared about similarly divergent perceptions (IP12). By and large, Ostrow and Ross presented data to support the notion that substance use is a cofactor for risk while Hart and Weatherburn questioned this conclusion.

Weatherburn raised eyebrows when he declared that there is no connection between alcohol use and unsafe sex. He said that while about half the studies on this topic support the connection, none of the “event-specific” studies provide evidence for this conclusion. Weatherburn cited a SIGMA study of 1,625 instances where drinking occurred before sex. There was no significant difference in the number of anal sex and non-anal sex instances or in the number of condom use instances that followed alcohol use. He also cited a study of 2,019 sex sessions where only one man had anal sex without a condom to ejaculation and said that this behavior had been affected by alcohol use.

While there was no consensus in the session, the discussion highlighted two points. First, it is important for researchers and educators to be precise about the context in which a behavior—for example, drug and alcohol use—occurs. A good example of this was raised by Australian researcher Ron Gold, who detailed a study of men who had sex without condoms and men who almost had sex without condoms but used them in the end. Gold found that in Sydney, there was a correlation between alcohol use and unprotected sex, but that this relationship was not present in Melbourne. In Sydney, where the gay scene is geographically concentrated and includes a strip of bars, neither getting drunk nor having sex requires a great deal of planning. In Melbourne, however, where the gay scene is much more dispersed and police are especially vigilant about drunk driving, gay men who want to drink and find sex must plan their forays, and it is clear that if a person plans sexual encounters, he or she is more likely to have safe sex.

Second, to the extent that alcohol and drug use occurs and does affect judgment about sexual activity, it might be useful to develop state-specific interventions, that is, persuasive strategies that reach people when they are in the state—intoxicated or sober—they are in when they usually have sex.

Drug Networks

The conference included fewer presentations on HIV transmission and injection drug use, but New York researcher Sam Friedman offered a fascinating analysis of drug user networks (Plenary 3). Friedman, of the National Development and Research Institutes, studied 767 injection drug users in Brooklyn and found that the shape and size of drug use networks were a crucial factor in determining the extent of HIV infection among network members.

To develop this “community ethnography” of the sample, researchers asked drug-injecting subjects to nominate up to

References
1. References to conference abstracts are cited in parentheses: the type of session followed by a number. Plenary Sessions are denoted “Plenary Session”; Workshops are denoted “W”; and In-practice sessions are denoted “IP.”

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10 people with whom they had shared needles, had sex, or otherwise interacted within the last 30 days. Performing a structural analysis, they discovered several levels of membership: members at the “two-core” level are linked to at least two other members in the core of the network; and members on the “periphery” are linked either to only one person in the core or to other people not more than one of whom is in the core. In the Brooklyn sample, there was one big component with 187 members—some in the core and some in the periphery—several smaller components with two to nine members, and 283 individuals unlinked to any component.

Core members were more likely to be homeless, to lack legal income, and to have been in jail. Almost no core members were in drug treatment, and many were syringe sellers on the street. However, bleach and syringe distribution programs were reaching people in all four structural categories including the core. While sexual behavior did not vary by membership level, core members engaged in higher risk drug injection activities. The result was that people in the core were more likely to be HIV and Hepatitis B infected.

Friedman reported on a methodologically similar study in Colorado Springs, a low HIV seroprevalence area. Again, researchers found one big connective component and several smaller ones. While in New York, seroprevalence was high in the core of the big component, in Colorado Springs, the little HIV infection that was present was either outside the big component or on its periphery. Based on this “n” of two, Friedman suggested the following hypothesis: “HIV transmission may remain low while the virus is restricted to people in the small components or the periphery of the big component. If it gets to core of the large component, it may spread very rapidly.”

Finally, Friedman discussed the prevention implications of his data. He cited the SAFE program in Baltimore, where drug injectors come into counseling with members of their network. This intervention has led to reduced risk in needle sharing and injecting in galleries and increased carrying and using of bleach. He said that prevention programs might: help drug injectors avoid dangerous network structures like the core; use network pressure to encourage risk reduction; use larger networks to influence behavior of smaller networks; shape movement patterns within networks by reducing turnover, formation of ties to cores, and size of the large component; and transform the network into a center for harm reduction—essentially becoming a “proto-community organization.” Finally, arbitrarily breaking up high seroprevalence networks may spread HIV, while carefully splitting networks by serostatus thereby segregating infected users and introducing uninfected users to low seroprevalence networks may lead to risk reduction.

**Conclusion**

Despite the fact that there is little published research on what works in prevention—Allan Hauth reported that of 285 articles from 11 representative journals, only 5 percent reported results of interventions on sexual and drug-related risk behaviors (IP5.1)—the conference demonstrated creative thinking. In his plenary speech, Kelly called for greater collaboration between prevention researchers and front-line providers, collaborations that should foster this creativity. Such approaches would benefit researchers by ensuring that studies examine questions of real relevance to the community and would deliver to community organizations evaluation strategies that distinguish programs that work from those that do not.

**Next Month**

In the December issue of *FOCUS*, we continue with a tradition started last year: devoting an entire issue to book reviews. This year we have reduced the number of reviews from seven to five to allow for a more thorough examination of each book. We have also widened the scope of our exploration to include books not only about HIV-related counseling, but also about other HIV-related issues that may affect the counseling relationship.

We have again asked local practitioners to analyze how these books succeed or fail, and to offer readers insights into how these books might best be used. Among the books we review are: *The Changing Face of AIDS: Implications for Social Work Practice; Therapists on the Front Line: Psychotherapy with Gay Men in the Age of AIDS; AIDS, HIV and Mental Health; Breaking New Ground: Developing Innovative AIDS Care Residences; and A Death in the Family: Orphans of the HIV Epidemic.*
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