HIV prevention interventions have traditionally focused on encouraging HIV-negative people to protect themselves from infection, but prevention efforts targeting people with HIV are becoming increasingly common. This issue of PERSPECTIVES discusses the challenges of preventing transmission for people with HIV, the health concerns of STD co-infection, and prevention interventions targeting people living with HIV.

Research Update

Every new HIV infection involves contact with a person with HIV. Yet, despite the fact that there are between 600,000 and 900,000 people living with HIV in the United States, it is only recently that prevention interventions have been designed to address people who are already infected. Advances in HIV treatment have helped many HIV-positive people enjoy better health and longer lives and fostered a renewed and healthy interest in sexual activity. But more sex—and in some cases drug use—among HIV-positive people increases the possibility of new infections. Interventions that help HIV-positive people to practice safer sex and drug use play an important role in curbing the epidemic.

People with HIV are rarely the specific target population for prevention campaigns, largely because of concerns that this may be perceived as blaming infected people for the epidemic. The few prevention interventions targeting people with HIV generally focus on preventing reinfection with treatment-resistant strains of the virus or co-infection with other sexually transmitted diseases (STDs). For people who continue to engage in high-risk sex and drug use after testing HIV-positive, interventions that focus both on self-help benefits and altruism may be most successful in decreasing risky behaviors.

Risk Behaviors

Many studies indicate that people with HIV tend to report lower levels of HIV risk behaviors compared to people who have tested HIV-negative. But research also indicates that they still take significant risks.

In a study of 408 gay and bisexual men between the ages of 18 and 29, 37 percent of participants reported engaging in unprotected anal intercourse during the previous year. Of these, 59 percent knew they were HIV-positive, 35 percent reported themselves to be HIV-negative, and 28 percent were untested for HIV antibodies. Among HIV-positive participants, 56 percent reported unprotected receptive anal intercourse in the past year, compared to only 24 percent of HIV-negative men and 21 percent of untested men. In addition, 30 percent of HIV-positive participants also reported engaging in unprotected insertive intercourse, a behavior that poses the highest risk for transmitting HIV to sex partners. Of the HIV-positive men involved in a “boyfriend” or primary relationship, 28 percent reported being in “seroconcordant” relationships—in which both partners have the same HIV infection status—suggesting that at least some of the unprotected sex reported by HIV-positive men occurred with an HIV-positive part-
ner. Study participants, regardless of HIV-infection status, reported similar predictors of unprotected anal sex, including sexual impulsivity, substance abuse, decreased sexual enjoyment with condoms, and communication difficulties.4

A study of 86 ethnically diverse, HIV-positive, gay and bisexual men found that during the prior three months, 22 percent of participants reported engaging in unprotected insertive anal intercourse, and 33 percent reported engaging in unprotected receptive anal intercourse. Twenty-five percent indicated that their most recent sex partner was also HIV-positive, 24 percent reported that their most recent partner was HIV-negative, and 51 percent did not know their most recent partner’s HIV status. Unprotected anal sex was associated with using amyl nitrate inhalants (also known as “poppers”), substance use among partners before sex, and low intentions to change risk behaviors.5

A study of 129 HIV-positive women found that 42 percent of participants engaged in unprotected vaginal intercourse, and 10 percent engaged in unprotected anal intercourse during a six-month period. Unprotected sex frequently occurred outside of long-term relationships and with partners who were not known to be HIV-infected.6

In a study of 50 HIV-positive injection drug users entering methadone maintenance treatment programs, 66 percent reported engaging in HIV risk behaviors since learning of their infection status. Fifty percent reported engaging in unprotected sex, and 48 percent reported unprotected sex with more than one partner. Of the 35 participants who were sexually active during the previous month, 40 percent reported that the infection status of their most recent partner was either HIV-negative or unknown. Since testing HIV-positive, 58 percent reported sharing injection drug-using equipment. During the previous month, each participant had injected drugs, 40 percent did not always use a clean needle, 36 percent used an inadequate needle-cleaning method, 26 percent shared needles or other drug-using equipment, and 16 percent let others use their injection equipment after them.7

Partner and relationship type can play a crucial role in sexual risk behavior and the decision-making process. A study of 133 HIV-positive gay and bisexual men in San Diego found that participants with “steady” partners and those with “anonymous” partners tended to have the most unprotected anal intercourse, while men with “casual” partners tended to have the least. Men with anonymous partners also received the lowest scores on self-efficacy skill tests for condom use, sexual negotiation, and HIV disclosure. Researchers defined steady partners as people with whom study participants had sex on a regular basis, casual partners as acquaintances with whom participants had sex once or twice, and anonymous partners as people whom the participants did not know.8

Prevention Challenges

The majority of people with HIV feel a sense of responsibility to prevent HIV transmission to other people. In fact, many HIV-positive people show a greater degree of preventive altruism than do HIV-negative people, whose efforts reflect a more self-protective approach. According to a review of 66 studies that include data about the effects of awareness of HIV-infection on preventive behaviors, nearly 75 percent of the studies report HIV-positive participants doing more than HIV-negative participants to prevent transmission, including engaging in safer sex and drug-using behaviors. Two studies reported a decrease in STDs in the period after an HIV-positive test result as an indication of increased condom use and other risk-reduction measures, a decrease that was not observed in participants who received HIV-negative test result.9

However, becoming infected with HIV does not immediately eliminate psychosocial factors that had influenced people to put themselves at risk before becoming infected. As a result, many people living with HIV are sometimes less safe than they would like to be.10 Historically, there has been limited support and few resources available to help HIV-positive people adopt safer behaviors.

In a qualitative New York study of 18 HIV-positive, heterosexual men who relapsed into unprotected sexual behavior after consistently practicing safer sex, all participants expressed concern about the health threats of unprotected sex for themselves and their partners. However, all participants reported intermittent relapses to unprotected sex.9 Common factors related to relapse were alcohol and other drug use,

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There is often a difference of opinion about which partner—the HIV-positive partner, the HIV-negative partner, or both—should be responsible for initiating safer sex practices.

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* For more information, refer to the December 1998 issue of PERSPECTIVES, Returning to Unprotected Sex (Volume 7, Number 7).
desires to “live life to the fullest,” personal satisfaction with appearance and health, the influence of friends, risk analysis, sexual preparation, uncontrollable sexual urges, and feelings that condom use was physically desensitizing and stigmatized them as HIV-positive. Several men in the study also indicated that they did not discuss HIV-status or negotiate condom use with their partners, primarily due to fear of rejection. In addition, the participants consistently indicated that their female partners were responsible for and controlled safer sex practices, and several participants believed that their partners would do anything to please them, including engage in unprotected sex. A Pittsburgh study of 156 HIV-positive gay and bisexual men found that participants who engaged in unprotected anal sex were younger, were less educated, had less anxiety about their HIV serostatus, had a greater feeling of control over their lives, used less active behavioral coping mechanisms (for example, they did not try to educate themselves about HIV), and reported more use of alcohol and poppers.

A study of 50 HIV-positive injection drug users found that while 86 percent of participants reported that they planned to use condoms if they were going to have sex, only 42 percent had acquired condoms in the previous month, and only 18 percent currently had a condom. In addition, participants who shared drug injection equipment were significantly less confident that not sharing drug paraphernalia reduces HIV risk and scored significantly lower on tests of self-efficacy to negotiate safer needle use with others. Engaging in sex or drug use is often a way for people to cope with difficult situations. In a study of 73 injection drug users who tested for HIV antibodies within 20 weeks of enrolling in a drug treatment program, those who tested HIV-positive were less compliant with program guide-

to disclose their HIV status to their partners. Non-disclosure of HIV infection is associated with having a high number of sex partners, more casual sex, and lower perceived levels of social support. According to a study of 266 sexually active HIV-positive people in Atlanta, 41 percent had not disclosed their serostatus to any sex partners in the previous six months, and 48 percent of these were in monogamous relationships for at least six months. Among men who had not disclosed, 25 percent had HIV-positive sex partners, 41 percent had HIV-negative partners, and 36 percent had partners of unknown serostatus. Compared to men who had disclosed their HIV status to sex partners, men who had not disclosed had lower rates of condom use during receptive and insertive anal intercourse and scored significantly lower on questionnaires measuring the ability to properly use condoms and negotiate for safer sex. Emotional distress was greatest among people who had not recently disclosed. Women had lower scores than men on questionnaires measuring ability to communicate with partners about HIV status.

A study of 350 HIV-infected people between the ages of 14 and 23 in four U.S. cities found that participants disclosed their serostatus to only 54 percent of their partners. Eighty-one percent of participants were sexually active in the prior three months, mostly with multiple partners, and 82 percent of these reported consistent condom use during this time.

Mixed status couples often struggle with maintaining sexual satisfaction and trust. Some couples consider the risk of losing commitment and intimacy in a relationship to be more threatening than the risk of transmitting HIV. Power dynamics in a relationship—such as fear of rejection, desire to please, and possible threat of violence—may reduce a person’s ability and willingness to disclose infection status and communicate prevention concerns.

Disclosing HIV infection to a partner can be a way to begin a discussion about safer sex or safer drug use, but this is difficult for many people, especially women, who may fear stigma, rejection, or violence from their partners. Studies show that between 30 percent and 50 percent of HIV-positive people do not disclose their HIV status to their partners. Since the risk of HIV transmission is associated with having a high number of sex partners, more casual sex, and lower perceived levels of social support, non-disclosure is common.

Further Harm

Many people with HIV who have sex with other HIV-positive people choose not to use condoms...
or other protection, often rationalizing that no further harm could result from unprotected sex. For example, a Florida study of 267 gay and bisexual men found that participants who were in seroconcordant relationships used condoms least, while couples in mixed status relationships used condoms most. But people with HIV are not invulnerable to the detrimental effects of unprotected sex.

STDs are a significant concern for people with HIV because co-infection with syphilis, gonorrhea, intestinal parasites, hepatitis, or herpes can weaken the immune system and accelerate progression of HIV disease. Co-infection with HIV and another STD often causes an increase “viral load,” the concentration of HIV in the blood, and a decrease in CD4+ cell count. Also, STD infection in people with HIV can be more severe, painful, and difficult to treat if the immune system is compromised.

Research also indicates that the presence of some STDs increases the amount of HIV “shedding,” thus increasing the likelihood of transmitting HIV during unprotected sex or needle sharing. An STD that produces lesions or sores provides routes for HIV to exit or enter the body. Chlamydia, gonorrhea, trichomoniasis, non-gonococcal urethritis, and yeast infections all destroy the outer layers of mucous membranes, allowing HIV easier access to white blood cells. In Tanzania, a 38 percent decrease in new HIV infections was associated with improved STD treatment.

Another possible risk for HIV-positive people who have unprotected sex is becoming reinfected with different strains of HIV. “Reinfection” refers to being infected with HIV a second time through exposure to a different strain of virus, which could result in a higher viral load, leading to faster disease progression. However, researchers have not proven that reinfection is more than a theoretical risk. Although there is definitive evidence of dual infection with different subtypes of HIV, it is unclear whether this occurs from simultaneous infection by two different strains of HIV or through repeated exposure and reinfection.

The term “superinfection” has been recently used to describe reinfection with another person’s “drug-resistant” strain of HIV, which has mutated and become resistant to certain HIV antiviral medications. Studies have shown that transmission of drug-resistant strains of HIV from an HIV-positive person to an uninfected person occurs, but there are no known cases of transmission of drug-resistant virus from one HIV-positive person to another.

**Intervention Programs**

In 1998, the Centers for Disease Control and Prevention (CDC) funded five health departments to create pilot projects for providing HIV prevention to people with HIV. The state health departments of California, Maryland, and Wisconsin, and the local health departments of Los Angeles and San Francisco have begun programs targeting a wide range of HIV-positive people, including women, men of color who have sex with men, injection drug users, young people, female sex and needle-sharing partners of injection drug users, and incarcerated men and women. The interventions include: HIV and other STD counseling, testing, and treatment; referral and linkage to care; prevention case management; outreach through social networks; mass media and Internet marketing; partner counseling and referral services; HIV-positive peer support; skills building; and community forums and social services.

The AIDS Action Committee in Boston created an advertising campaign that targets HIV-positive gay men with messages aimed at helping initiate discussions of transmission and promoting responsibility. The campaign involved placing posters over urinals in gay bars and sex clubs with messages such as “Let’s stop new infections now,” “If you’re positive, think about transmission,” and “Ask. Tell.” A survey of men leaving the bathrooms found that 70 percent could recall two or more of the messages.

Follow-up counseling for people who recently tested HIV-positive can be beneficial for a number of reasons. The HIV test result disclosure session is usually not an optimal time to discuss issues such as access to medical care and treatment or the importance of safer sex, primarily because clients are often still in shock.

One approach to follow-up counseling that has proven successful at numerous San Francisco anonymous testing sites is “linkage” counseling. Upon receiving an HIV-positive test result, clients meet a confidential linkage counselor who provides assistance in the initial case management stages. Clients may reach the linkage counselor to discuss feelings or ask questions by calling a pager. A follow-up appointment is usually scheduled two to seven days later to discuss medical care, provide support, explore any substance use, and make referrals to necessary social services.

For clients who test HIV-positive and are in relationships, couples counseling can help facilitate safety and boundaries. In a study of 144 heterosexual mixed status couples in a California program who received counseling and risk assessments every six months, condom use increased significantly, and no new HIV infections were reported among the couples.

In a study of 255 HIV-positive men, regular preventive counseling and support group attendance increased frequency of HIV disclosure to sex partners. The study also found that HIV-positive men disclosed less often to HIV-negative partners or partners of unknown HIV-status than to HIV-positive partners.
Implications for Counseling

It is becoming increasingly common for HIV counselors to address prevention with clients who test HIV-positive. Prevention for people with HIV is usually more appropriate in confidential test sites or other settings that, unlike most anonymous test sites, have the capacity to provide follow-up counseling sessions and to develop ongoing relationships with clients. In anonymous settings, counselors often do not discuss these prevention issues because during disclosure sessions it is difficult for many clients who test HIV-positive to discuss issues other than their new infection status and what to do about it. If a test site does not offer post-disclosure counseling, provide referrals to agencies where clients can obtain these services.

Upon receiving an HIV-positive test result, many clients are emotionally and psychologically unable to absorb much of what happens in the session. But in some instances, clients who are prepared to receive a positive antibody test result may be able to discuss prevention with the counselor. Being empathetic and client-centered helps counselors assess whether or not clients are ready to discuss prevention during the disclosure session. For example, if a client is withdrawn, crying, angry, upset, or unresponsive, it is not an optimal time to bring up such an important issue as prevention. However, it is appropriate for counselors to utilize opportunities that clients present to explore feelings about disclosing HIV status and preventing transmission to other people.

**Disclosing HIV Infection**

Disclosing HIV infection is the first and one of the most important steps in HIV prevention. Disclosing to sex partners may be complicated by stigma, shame, fear of rejection, the limitations of the client’s communication skills, and, for male clients who have sex with men, internalized homophobia. In addition, former injection drug users may feel shame about disclosing this past behavior as the reason for their HIV infection. Normalize this experience by explaining that difficulties with disclosure are common among people who test HIV-positive. Develop and maintain referrals to support groups where clients can listen to peers discuss similar concerns and apprehensions about disclosure.

The ramifications of disclosure can be overwhelming for clients newly diagnosed with HIV. In addition, clients who are not in primary relationships may believe that it is unnecessary to disclose HIV infection if they are practicing safer sex.

Explain that they may not need to disclose in every situation, and help them develop criteria for determining when it is most important to disclose. It is important for counselors to avoid making judgments if clients choose not to disclose their HIV infection to all of their partners. Some clients want to evaluate the need for disclosure on an individual basis, some want to make strict rules or guidelines for themselves, while others prefer a combination, maintaining flexibility within clear guidelines. Work with clients to clarify their values for disclosing and prepare for the unexpected outcomes of disclosing in different situations.

Fear of rejection by potential partners is a common concern for clients who have recently tested HIV-positive. A counselor might address this fear by saying, “Yes, you may experience rejection. How do you think you will deal with it? How have you dealt with rejection in the past?” Explain that some people do not want to date HIV-positive people out of fear of infection or fear of loss, but that there are also people who do not care and even those who want to date HIV-positive people.

To facilitate disclosing a client’s HIV status to past partners, provide referrals to the local partner counseling and referral service, if such a service is available. This service contacts a client’s former sex or needle-sharing partners, without identifying the client, to inform them that they may have been exposed to HIV. With this knowledge, former partners may be more likely to test for HIV antibodies and pursue medical help if they are infected. To learn about this important service, contact the local county health department.

**Responsibility and Unprotected Sex**

Receiving an HIV-positive test result does not necessarily change a client’s sense of responsibility for preventing HIV transmission to his or her partners. The issues a client faced prior to testing HIV-positive and which led to infection usually remain after the client receives the test result.

A person’s capacity to take responsibility for behaviors that may place partners at risk may be influenced by anger, substance use, and sexual desire. Each of these can be explored.
with supportive open-ended questions or statements. For example, “It’s clear to me that you’re concerned about infecting your partners. I’m wondering how your use of alcohol may contribute to your partners’ risks. What do you think?”

To avoid infecting other people, some clients choose to have sex only with other HIV-positive people, and they may or may not use protection. The risks of infection with other sexually transmitted diseases (STDs) may seem insignificant in comparison with HIV, but these risks may significantly affect the long-term health of people with HIV. For many HIV-positive clients, however, quality of life issues take precedence over concerns about STD infection, and some of these clients consider engaging in unprotected sex to enhance their quality of life.

Encourage clients to make informed decisions before abandoning condom use, taking into account the risks and medical complications of STD co-infection and the theoretical risks of HIV re-infection. Refer clients to HIV knowledgeable health care providers for information and counseling regarding these issues, and encourage them to include primary partners when screening for STDs so that they can make well-informed decisions about condom use in their relationship.

Mixed Status Couples

The issues couples face after one partner tests HIV-positive can seem overwhelming. Counselors can help clients focus and organize a list of needs and tasks that might provide structure to an otherwise chaotic situation. They can also help HIV-positive clients discuss prevention strategies with their HIV-negative partners.

In many cases, it may be effective to offer couples sessions. If the test site does not offer couples counseling, provide a referral for these services. Couples sessions provide a supportive forum to discuss prevention strategies unique to each couple’s relationship and are especially helpful for couples who disagree about the extent of prevention measures they want to implement.

Sometimes, the uninfected partner expresses the least interest in prevention. For example, the HIV-positive client may identify prevention correlates. AIDS Education and Prevention. 2000; 12(4): 340-356.

References


8. Semple SJ, Patterson TL, Grant I. Partner type and sexual risk behavior among HIV positive gay and bisexual men: Social cogni-
Joe is a 28-year-old gay man who just tested positive for HIV antibodies at an anonymous testing site. In the disclosure session, he is sad but lucid. Although his immediate concern is for obtaining medical help, he is open to discussing HIV prevention. Joe’s main HIV risk behavior is unprotected anal sex, and he has a history of alcohol and marijuana use with sex.

**Counseling Intervention**

After providing Joe with medical referrals to service providers who are knowledgeable about HIV, ask him what he can do to prevent transmitting HIV to his partners. If he says that he will always use condoms during anal sex, ask if he thinks this is feasible and what might get in the way. Ask Joe if the possibility of lapses into unprotected sex might increase with alcohol or marijuana use. If so, suggest a referral to a local counselor with whom Joe can discuss unprotected sex and substance use.

If Joe is dismayed by the prospect of always using condoms and asks about having unprotected anal sex with other men who are HIV-positive, explain the risks of STD co-infection and the theoretical risks of HIV reinfection and superinfection, clarifying that there are no documented cases of reinfection or superinfection. Provide referrals for Joe to gain further information about the medical risks of having unprotected sex with other HIV-positive men. Let him know that some people with HIV stop using condoms with HIV-positive partners after exploring all the latest information, while other people continue to use condoms. Make sure to emphasize the importance of making an educated decision.

Bring up the topic of disclosing HIV status to sex partners, and explore how Joe would disclose, perhaps utilizing a role-playing exercise. Ask under which circumstances he feels it would be important to disclose his HIV status. If he has difficulty answering, help him, such as by saying, “Having to deal with these issues now can feel overwhelming. You can take your time with this. I’m going to give you a referral to a support group for HIV-positive gay men, and this may be a good place to explore disclosing your status. I’ll also give you the number for a partner counseling and referral service, which can help you by contacting the people in your past for whom it may be important to be tested. In the meantime, is there someone supportive you can talk to tonight?”

Help Joe identify a person or two with whom he can talk for immediate support. Also, help him decide where he will go after he leaves the clinic and how he will get there.

As a priority, but the HIV-negative partner may feel that the intimacy of unprotected sex outweighs the risk for infection. In some cases, the uninfected partner may feel compelled—perhaps subconsciously—to also become infected in order to share his or her partner’s experience. If this comes up during a couples session, the counselor might comment on the love and caring that motivates each partner’s desire to use or not use condoms and provide the HIV-negative partner with referrals for individual counseling. Explain that partners of HIV-positive people often need support to help them work through their feelings and accept their partner’s HIV status.

Counselors can help clients in mixed status relationships understand that it often takes time to work through solutions and that infection can occur during this time. Work with clients to develop a short-term HIV prevention contract. For example, clients may agree to temporarily abstain from high-risk behaviors, even though these behaviors may have deep meaning and intimacy for the couple. The counselor can help clients express feelings about loss and anger and look at other ways to increase intimacy. These contracts for safer sex often provide a structure of safety for the partners involved. Although these can be verbal agreements, writing and signing a contract can help clarify and reinforce the contract’s importance.

**Risk Reduction Contracts**

Without interventions that help clients break the cycles of habitual risk behaviors that led to their infections, the behaviors will likely continue. When counseling such clients, provide referrals to resources, such as residential drug treatment, that can address these issues.

If clients are interested in such referrals, counselors who can offer post-disclosure counseling sessions can create weekly risk reduction contracts while clients are waiting to enroll in a program. For example, a contract may stipulate that the client will utilize needle-exchange programs rather than continuing to share needles. Another contract may involve attending 12-step meetings.

In follow-up sessions, review client successes or challenges related to adhering to the contract. Supporting successes and resolving difficulties, or even altering the contract can go a long way to helping HIV-positive clients change behaviors that may also place others at risk for HIV.
Test Yourself

Review Questions

1. True or false: Many studies indicate that people with HIV tend to report lower levels of risk-taking behaviors compared to people who have tested HIV-negative, but they still take significant risks.

2. Which of the following factors commonly influence HIV-positive people to engage in unprotected sex? a) alcohol and drug use; b) negative feelings about condoms and the inability to use them properly; c) difficulty communicating with partners about their HIV status and fear of rejection; d) all of the above.

3. True or false: Studies show that HIV-positive people and mixed-status couples who receive follow-up counseling demonstrate no reduction in sexual risk behaviors.

4. Which of the following is a health concern for HIV-positive people who engage in unprotected sex? a) possible reinfection with another strain of HIV; b) compromised well-being due to the physical strain of sex; c) risk of infection with STDs that weaken the immune system and accelerate progression of HIV disease; d) a and c.

5. Which of the following is a reason that people with HIV have rarely been the specific target population for HIV prevention campaigns? a) people with HIV engage in lower risk behaviors upon notification of their infection; b) the fear that such prevention programs will be perceived as blaming infected people for the epidemic; c) most people with HIV are unwilling to change unsafe behaviors in order to protect others; d) there is no federal funding for such prevention programs.

6. True or false: There is evidence of HIV-positive people becoming reinfected with strains of virus that are resistant to antiviral medications.

7. True or false: Some mixed-status couples consider the risk of losing commitment and intimacy in a relationship to be more threatening than the risk of transmitting HIV.

8. Studies show that most people with HIV feel a sense of responsibility to prevent spreading the disease to other people, but some people with HIV are unsure about how to lower their risks.

Discussion Questions

1. What are some of the reasons an HIV-positive person would not want to disclose his or her HIV status to sex partners?

2. What are some of the issues to consider about the optimal time to bring up prevention for clients who test HIV-positive?

3. What are some of the thoughts and feelings counselors may have about prevention for people with HIV that could interfere with client-centered counseling?

4. What are some useful referrals for clients who test HIV-positive?

Answers

1. True.

2. d.

3. False. Research examining the effects of HIV counseling and testing on sexual risk behavior indicates that HIV-positive study participants and mixed status couples who received counseling reduced unprotected intercourse and increased condom use.

4. d.

5. b.

6. False. Studies have shown that transmission of drug-resistant strains of HIV from an HIV-positive person to an HIV-negative person occurs, but there are no known cases of transmission of drug-resistant virus from one HIV-positive person to another HIV-positive person.

7. True.

8. True.
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