Behavioral Interventions for STD/HIV Prevention

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Relevance of HIV Prevention Interventions for STD Prevention and Vice-Versa

- HIV is an STD & other STDs may enhance the transmission of HIV – biological connection

- Similar behavioral goals
  - Sexual behavior change
    - Reduce number of partners
    - Condom use
  - Getting tested & getting partner(s) tested
  - Treatment & treatment adherence

- Many interventions developed for HIV prevention impact STD outcomes, e.g.,
  - Condom use
  - Mutual monogamy with HIV & STD tested-negative partner
  - Healthcare seeking, including HIV & STD routine testing
Behavioral Science-based Interventions for STD/HIV Prevention

- **Historical Perspective**
- **Behavioral Intervention – Levels**
  - Individual-level approaches – one client at a time
  - Group-level approaches – small groups of people with similar life experiences & circumstances
  - Community-level approaches – neighborhoods, cities, schools – broadly reaching persons with similar life experiences & circumstances

- **Structural Interventions – another type of community-wide approach – addresses components of behaviors that could affect public health**
  - Availability,
  - Accessibility
  - Acceptability

* Blankenship, KM et al. (2006). *Journal of Urban Health: Bulletin of NY Academy of Medicine*, 83 (1)
Behavioral Science-based Interventions for STD/HIV Prevention

- National HIV/AIDS Strategy (NHAS)
  - Includes biomedical, behavioral, & structural approaches

- Resources – information about
  - Training
  - Technical Assistance
  - Tools for working with clients & communities
  - Behavioral Interventions
  - Epidemiology

* www.effectiveinterventions.org
* www.cdc.gov
* www.cdcnpin.org
### Historical Perspective

#### Before HIV
- Main focus was identification & treatment of bacterial STDs – *secondary & tertiary prevention* – which also helped reduce spread – *primary prevention*
- Prevention messages were given as an “add-on” in the form of education & even “orders”
- Partner services

#### After HIV – initially – education & later – other behavioral influences
- Increased emphasis on behavioral interventions to prevent acquisition of (incurable) infections – *primary prevention*
  - Approaches were based in giving knowledge in hope of leading to safer & healthier behavior
  - Later – it was recognized that social & behavioral science-based interventions addressed much more than knowledge alone ~ & ~ they were effective

* [www.cdc.gov](http://www.cdc.gov)
**Historical Perspective**

**From Orders to Education—Alone to Behavioral**

- **Traditional STD prevention messages were “orders”** – just do not have sexual contact ~ or ~ use a condom
  - Intuitively a good thing to do – “An ounce of prevention is better than a pound of cure”

- **HIV – during 1980s – there was urgency & fear** –
  - Most of the prevention response came from affected communities
  - Delivered in the form of educational messages, e.g.,
    - Reduce the number of partners
    - Use condoms

- **HIV & other STDs – during 1990s & 2000s**
  - Scientific evidence supports behavior science-based interventions
  - Community involvement continued & there was an embrace of the behavioral science-based approaches – researchers & communities joined forces, including study of “homegrown” interventions

Behavioral Interventions for STD/HIV Prevention

- Behavioral science-based interventions with other health behaviors had shown effectiveness.

- Due to this experience & a recognition that STD/HIV prevention needed to improve – application of behavioral science to STD/HIV prevention & behavior change was recommended by the CDC, NIH, & others – for nearly 20 years.

- Cost-benefit analyses have had variable results:
  - D Cohen et al (RAND)
  - D Holtgrave et al has conducted many of these studies.

(continued)

* Holtgrave, DR et al. (1994). *Archives of Internal Medicine, 153* (10), p 1225-30
Behavioral Interventions for STD/HIV Prevention

STD/HIV Prevention researchers base their studies in several behavioral science theories, e.g.,

- Health Belief Model
- Social Cognitive Theory
- Stage of Change/Transtheoretical Model of Behavior Change Theory
- The HIV epidemic led to new models, e.g., Kelly’s AIDS Risk Reduction Model, or Fisher & Fisher’s Information, Motivation, Behavior Model
- Many interventions use elements from various & different theoretical approaches, or combinations of different theories

Several meta-analyses have been conducted to determine utility, e.g.,

- R DiClemente et al
- L Weinhardt et al
- CM Obermyer & M Osborne
- JS Lin et al

* DiClemente, RJ et al. (2005). Seminars in Pediatric Infectious Diseases, 16 (3)
* Lin, JS et al. (2008). Annals of Internal Medicine, 149 (7)
CDC Efforts and Projects

- Prevention Research Synthesis Project
- Compendium of HIV Prevention Interventions with Evidence of Effectiveness
  - Original – 1999 (listed 24)
  - Updated – 2009 (listed > 70)
  - Newest Chapter – 2010 – Medication Adherence Interventions (currently lists 8)
- Replicating Effective Behavioral Programs Project – many of these interventions were replicated in “real world” settings by partnerships of researchers & community settings
- Diffusion of Effective Behavioral Interventions (training, materials, & technical assistance)

* www.cdc.gov/hiv/topics/research/prs/index.htm
* www.effectiveinterventions.org
* www.cdc.gov/hiv/topics/cba/index.htm
* www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* www.cdc.gov/hiv/topics/prev_prog/rep/resources/qa/
Behavioral Interventions – Individual Level

- Client-centered, one-on-one intervention
- Science-based interventions with
  - Research findings that show efficacy
  - Program evaluation that shows effectiveness in the “real world”
- Individual Level Interventions (ILIs) should be evidence-based & if not, then science- or theory-based, e.g.,
  - Stage of Change/Transtheoretical Model of Behavior Change Theory
  - Health Belief Model
  - Theory of Gender and Power
  - Theory of Reasoned Action
  - AIDS Risk Reduction Model
  - Information-Motivation-Behavioral Skills Model (IMB)

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs
* www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* www.effectiveinterventions.org

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ILIs – Client-centered Counseling

- These are client-centered, i.e., based on the client’s individual circumstances & experiences
  - Thus can be tailored to each person

- This client-centered approach was recommended by the CDC for HIV pre- & post-test counseling to be
  - “Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs…” This requires an “understanding of the unique circumstances of the client …” through “the use of open-ended questions and active listening”. *

- Since then, many ILIs have been developed, studied, & implemented
  - Effectiveness has been shown with only have 1-2 sessions with the client, while others might include several sessions

Elements of Client-Centered Counseling

- Personalized risk assessment – thus useful for any/all target populations
- Facilitates & supports client-initiated behavior change
- Helps client recognize barriers to risk reduction
- Negotiates an acceptable & achievable risk-reduction plan – to identify a possible “first step” by the end of the counseling session; these could be simple or more involved, e.g.,
  - “I’ll start carrying condoms with me.”
  - “I’ll call the Drug Treatment Center for an appointment.”
  - “I plan to talk with my partner about getting HIV/STD-tested – tonight.”

- Refer client to other specialized services, if needed

* CDC. (2009). Procedural Guidance for Community Based Organizations
* Kamb ML et al. (1998). JAMA, 280 (13)
Client-Centered Counseling Challenges

- Providing counseling that truly reaches the client
  - History of risk behaviors as well as risk reduction successes
  - Knowledge and attitudes & beliefs about STDs, HIV, Viral Hepatitis, & the client’s own sense of vulnerability to these infections

- Identifying the best way to take that gathered information & using it to help the client work towards safer &/or healthier behavior by *letting the client do most of the talking*
  - Which is guided by the counselor’s questions & comments – this often presents a challenge, since it is a shift from the traditional HIV/STD prevention educator approach

- Assisting the client with identifying next steps that are reasonable & achievable

* CDC. (2009). Procedural Guidance for Community Based Organizations
* Kamb ML et al. (1998). JAMA, 280 (13)
Client-centered Counseling – the Approach

- Research has shown some common themes
- Use a combination of open-ended & close-ended questions
  - Open-ended examples
    - Are STDs something you worry about for yourself?
    - What’s been your experience with condoms?
    - What’s the difference between the times you use condoms & the times you don’t?
    - Who decided to introduce condoms the last time you used them?
    - What do you think you can do to reduce your risk for STDs?
  - Open-ended questions yield information about the client’s risk & safety history as well as attitudes & beliefs related to his/her risk

* CDC. (2012). *Program Operations Guidelines for STD Prevention*
* CDC. (2009). *Procedural Guidance for Community Based Organizations*
* Kamb ML et al. (1998). *JAMA*, 280 (13)
Client-centered Counseling – the Approach

- Use a combination of open-ended & close-ended questions
  - Close-ended questions provide clarifications & specifics – used to get “the facts” besides the big picture
  - Close-ended examples
    - Are your partners males, females, or both?
    - How many partners would you say you’ve had over the past 3 months?
    - When was the last time you had sex?
    - When was the last time you had sex without a condom?
    - Have you &/or your partner been STD-tested? HIV-tested?

- Use the principle of “Ask – Don’t Tell!”

* CDC. (2012). *Program Operations Guidelines for STD Prevention*
* CDC. (2009). *Procedural Guidance for Community Based Organizations*
Examples of Evidence-based ILIs

- **Project RESPECT**
  - Studied & implemented in STD Clinics
  - In DEBI Project – for variable settings

- **Personalized Cognitive Counseling (PCC)**
  - Studied MSM who with histories of repeat HIV testing – in publicly-funded Anonymous HIV CTR Programs
  - Recent addition to DEBI Project

- **Choosing Life: Empowerment! Action! Results!**
  - Studied persons living with HIV & those at high risk with HIV – to reduce risk behaviors
  - In DEBI Project

2. Dilley, JW et al. (2007). JAIDS, 30 (2); 44 (5) – 2 citations
3. Lightfoot, M et al. (2007). Behavior Modification, 31 (2)
Behavioral Interventions – Group Level

- Most evaluated type of intervention (GLI)
- Because GLIs work with a group – typically 6-12 people/group – the group members need to have enough in common for the intervention to be relevant
- Have been shown to be effective in many risk groups
  - Youth – Out-of-school & In-school
  - Men who have sex with men (MSM)
  - Injection drug users (IDUs)
  - STD clinic patients
  - Persons living with HIV
  - Heterosexual women & men (women more studied/implemented)

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs
* www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* www.effectiveinterventions.org
Behavioral Interventions – Group Level

As with the Individual, GLIs

- Focus on behavioral influencers such as knowledge, perceived risk, intentions, outcome expectancies, self-efficacy, perceived norms
- Are behavioral science-based & theory-based, e.g.,
  - Social Cognitive Theory
  - SOC/TTM
  - Theory of Reasoned Action
  - Theory of Innovation
  - AIDS Risk Reduction Model
  - Information-Motivation-Behavioral Skills Model (IMB)

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* PHR, III (1999) Entire Issue
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs
Behavioral Interventions – Group Level

- GLIs use the dynamics of a facilitated group to provide
  - Modeling & practicing behavioral skills
  - On-going reinforcement
  - Instruction on social pressure
  - Reinforce clear values/norms regarding unprotected sex

- Usually, these interventions involve multiple sessions – generally delivered over a few weeks to a few months – in various intervals, e.g.,
  - Daily or weekly sessions
  - Follow-up sessions – weeks to months later

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs
Examples of Evidence-based GLIs

- **Focus on Youth with Impact**
  - Studied in youth – to reduce HIV/STD risk behaviors; also has parent-focused part
  - In DEBI Project

- **Many Men, Many Voices (3MV)**
  - Studied Black MSM with STD/HIV risk behaviors
  - In DEBI Project

- **¡Cuídate! (“Take Care of Yourself”)**
  - Studied 13-18 year-old Latino females – to reduce HIV/STD risk behaviors
  - In DEBI Project

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Behavioral Interventions – Community Level

- Community is the target of the intervention, rather than the individual or a group
  - Obviously, the reach is very extensive
- Like with Group, CLIs must be directed to a specific target population so that the prevention is relevant
- Goals include changing community norms, reaching those that do not come into agencies/clinics for care, & empower community members, which are met through carefully designed strategies

(continued)

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs
* www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* ww.effectiveinterventions.org
Behavioral Interventions – Community Level

- Reach & relevance is also accomplished by conducting these interventions through outreach using community members in venues/geographic areas where high-risk groups congregate.

- Like Individual & Group, CLIs use concepts from a number of behavior change theories, particularly:
  - Diffusion of Innovation
  - Empowerment
  - SOC/TTM
  - Theory of Reasoned Action

- It is essential to identify the Messenger & the Message

* Guenther-Grey, C et al. (1996). *Public Health Reports, 111* (S1)
* Kelly, JA (1991) *AJP H, 81* (2)
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
* Valente, TW & Davis, RL (1999) *ANNALS of the AAPSS, 566* (1)
* [www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm](http://www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm)
* [ww.effectiveinterventions.org](http://ww.effectiveinterventions.org)
Behavioral Interventions – Community Level

- **Messengers – community members who**
  - Have full buy-in to the message & are fully prepared to pass on to others in community
  - Model the behavior change
  - Have access to community – particularly to the high-risk individuals who may be less likely to access prevention services
  - Have good connecting skills inside ~ & ~ outside of their own networks & are persuasive
  - Are recognized & respected as informal leaders who are “in the know” – they’re credible & believed – opinion leaders

- **Message – content & “packaging” developed with**
  - Community input through formative research

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* Guenther-Grey, C et al. (1996). *Public Health Reports, 111* (S1)
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
* [www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm](http://www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm)
* [ww.effectiveinterventions.org](http://ww.effectiveinterventions.org)
Examples of Evidence-based CLIs

- **Mpowerment Project**
  - Studied in young MSM (gay & bisexual) – to reduce HIV sexual risk behaviors; has a newer version for persons living with HIV
  - In DEBI Project

- **PROMISE**
  - Studied in many communities with different target populations for STD/HIV risk behaviors
  - In DEBI Project

- **Popular Opinion Leader (POL)**
  - Initially studied MSM in gay bars; has since been adapted to many other target populations – Black MSM: **d-up: DEFEND YOURSELF**
  - In DEBI Project

Structural Interventions

- Health is promoted by working to change the social context in which STD/HIV risk activities occur, & this is accomplished by changing one or more of the following (often in combination):
  - Changing laws, e.g., legalizing needle exchange
  - Changing physical environment, e.g., improving sidewalks, street lighting, & safety – to facilitate taking walks as exercise; or improving healthy & affordable food choices in neighborhood stores
  - Changing organizational structures, e.g., integration of HIV, STD, Viral Hepatitis, & TB services – to provide “one-stop shopping” that can facilitate & improve prevention & care of these overlapping infectious diseases & epidemics
  - Changing usual operating procedures, e.g., having walk-in services rather than by appointment only – making it easier for the clientele to access services

* Blankenship, KM et al. (2006). *Journal of Urban Health: Bulletin of NY Academy of Medicine, 83* (1)
### Example of Structural Intervention
**Condom Distribution – Soon to Be Available**

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Organizational</th>
<th>Environmental</th>
</tr>
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<tbody>
<tr>
<td><strong>Availability</strong></td>
<td>• Condom bowls</td>
<td>• 100% condom-use policies</td>
<td>• Increasing public funds for making condoms available</td>
</tr>
<tr>
<td></td>
<td>• Providing low cost condoms</td>
<td>• Condoms in jails &amp; prisons</td>
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<td></td>
<td>• Providing condom coupons</td>
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<tr>
<td><strong>Acceptability</strong></td>
<td>• Distributing promotional items (flyers to youth)</td>
<td>• PSAs</td>
<td>• Social Marking campaigns</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>• Wide-spread distribution of free condoms</td>
<td>• TV campaigns</td>
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<td></td>
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<td>• Community mobilization</td>
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<td></td>
<td>Adapted from: Charania, MR et al, p 2</td>
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* See [www.cdc.gov](http://www.cdc.gov) & [www.effectiveinterventions.org](http://www.effectiveinterventions.org)

See [www.effectiveinterventions.org](http://www.effectiveinterventions.org)
Behavioral Science-based Interventions for STD/HIV Prevention

While there are these various approaches – combining them has been shown to be even more effective:

- Individual-level – working on the behaviors of individuals
- Group-level – working with small numbers of individuals
- Community-level – working with larger sectors of a community
- Structural – working towards broad change

It is also clear that a variety of interventions can likewise have an even larger synergy:

- Biomedical
- Behavioral
- Public Health Strategies

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
Newer Challenges – Viral STDs Including HIV

- **Bacterial STDs are curable** – medicine can eradicate them
  - However – some of the bacterial infections have become resistant to several antibiotics – particularly gonorrhea, as previously noted

- **Viral STDs are treatable** – but not curable
  - So, in addition to medical treatments – prevention of viral STDs involves behavior change, including
    - Protected sex
    - No sexual contact
  - This is true for all the viral sexually-transmitted infections
    - HIV
    - Viral Hepatitis (A, B, C)
    - Herpes Simplex Virus (HSV)
    - Human Papilloma Virus (HPV)

- **Some viral STDs are vaccine-preventable** – these vaccines are both highly effective & safe
  - Hepatitis A & Hepatitis B (HAV & HBV)
  - Human Papilloma Virus (HPV)

* Bolan, GA et al. (2012). *NEJM*, 366 (6)  
* CDC. (2010). STD Treatment Guidelines, *MMWR*, 59 (RR-12)
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
Newer Challenges – Viral STDs

- In the past 10 years, rising concern about increased risk behaviors among persons with HIV have arisen
  - Incident STDs (syphilis, gonorrhea) have increased among populations that also have high rates of HIV – many of whom were aware of their status – showing that the sexual risks have risen, which has contributed to increases in new HIV infections
    - This pattern has been seen in different populations, particularly MSM
  - The causes for these increases in STD rates have been attributed to various reasons, including
    - Compared to HIV, the perception of risk for STDs is generally much lower
    - Many STDs are perceived to be “curable” which means treatment is as simple as a “shot” or a “pill”
    - HIV Harm Reduction perspectives

* West, GR et al. (2007) *AIDS Education and Prevention*, 19 (4)

(continued)
Newer Challenges – Viral STDs

- Other causes for these increases in STD rates include
  - The reduction in perception of risk or of the severity of HIV
  - Improved treatment & survival as well as quality of life for those living with HIV, related to
    • Antiretroviral medications (HAART) & less side effects,
    • Greater knowledge & technology for assessing patients (viral load & resistance testing, better understanding of immune status)
      o Undetectable Viral Load confusions
    • Those with HIV feel better than in past – life can continue including school, work, family, sex, &/or substance use
  - Prevention burn-out – often called “condom fatigue”

* CDC. (2003). *MMWR*, 52 (15)  
* CDC. (2007). *MMWR*, 60 (11)  
Newer Challenges – Viral STDs

- Other causes for these increases in STD rates include
  - Reluctance to disclose status – still associated with stigma, but is also associated with loss of relationships or sex
  - Perception that if a partner wanted condoms to be used – s/he would ask or insist
  - Younger at-risk individuals not being reached by old messages or the experiences of those in the early days of the HIV epidemic

- There is an increased need for effective behavioral interventions for persons with HIV inside & outside the clinical care setting

* CDC. (2003). MMWR, 52 (15)  
* CDC. (2007). MMWR, 60 (11)  
* Gilliam, PP & Straub, DM (2009) JANAC, 20 (2)  
Newer Challenges – HIV
“Prevention with Positives”

- Several interventions for persons living with HIV have been developed & implemented – particularly for sexual risk reduction
  - These interventions address these changes in risk perceptions associated with advances in HIV care
  - The focus on those with HIV is consistent with traditional public health infectious disease approach
- DEBI menu now lists several for persons living with HIV
  - Effective behavioral interventions – e.g., WiLLOW, CLEAR, Healthy Relationships, Partnership for Health
  - Public Health Strategies – e.g., CRCS, ARTAS
  - Several can be delivered to clients regardless of HIV status, e.g., Project START, SAFETY COUNTS

* [www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm](http://www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm)
* [www.effectiveinterventions.org](http://www.effectiveinterventions.org)
“Prevention with Positives” Examples
All in the DEBI Project

- **Women Involved in Life Learning from Other Women (WiLLOW)**
  - Studied women living with HIV – to improve support, coping skills, & to reduce sexual risk behaviors – a GLI

- **Healthy Relationships**
  - Studied men (MSM & heterosexual) & women living with HIV – to improve coping & decision-making skills – GLI

- **Partnership for Health**
  - Studied men (MSM & heterosexual) & women in HIV Care clinics – to reduce sexual risk behaviors – an ILI – to be delivered by medical providers

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3. Richardson, JL et al. (2004). *AIDS, 18* (8)
STD/HIV Prevention Behavioral Interventions

- Proven effective behavioral interventions are available at Individual, Group, & Community Levels
  - HIV & STD prevention
  - Healthcare seeking behaviors
  - Prevention for Persons Living with HIV

- CDC continues the process of supporting the dissemination of selected interventions to clinical settings, community-based organizations, & other providers of prevention services, with increasing focus on working with those living with HIV

- Training offered by the NNPTC is part of this process

* www.stdhivpreventiontraining.org
National HIV/AIDS Strategy for the United States

“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.” www.whitehouse.gov/onap
The National HIV/AIDS Strategy (NHAS) is an aggressive approach to changing the HIV epidemic – 4 goals

- Reducing New HIV Infections – by 25% by the year 2015
- Increasing Access to Care and Improving Health Outcomes for People Living with HIV
- Reducing HIV-Related Health Disparities

In order to achieve these goals – we need to work together in all service areas – NHAS objectives include

- Achieving a More Coordinated National Response to the HIV Epidemic in the United States
  - Integration of STD/HIV Care & Prevention is clearly a way to help reach this important goal – using combined behavioral, biomedical, & public health approaches

* [www.whitehouse.gov/onap](http://www.whitehouse.gov/onap)
Resources

- **Websites that can help you obtain more information about interventions & training, materials, & technical assistance (TA)**
  - CDC – general [www.cdc.gov](http://www.cdc.gov)
    - National Network of Prevention Training Centers (NNPTCs) – [www.STDHIVpreventiontraining.org](http://www.STDHIVpreventiontraining.org)
    - “DEBI Interventions” – [www.effectiveinterventions.org](http://www.effectiveinterventions.org), which also has information on training & TA
    - National Prevention Information Network (NPIN) – [www.cdcnpin.org](http://www.cdcnpin.org)
    - AIDS Education & Training Centers (AETCs) – [www.aidsetc.org](http://www.aidsetc.org)
    - AIDS Info – [www.aidsinfo.org](http://www.aidsinfo.org)