



The Positive Side

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Wise Women Speak: HIV Treatment

By Janet Madsen

Treatment decisions can seem intimidating, and rightly so. Once you start on treatment, you have to stick to it to make it work. In the early days of treatment there were lots of side effects that could be really discouraging. People felt worse before they felt better. Luckily these days, side effects are less intense than they used to be, and don't happen to everyone. The schedule of taking pills has become simpler, and the simpler the schedule is, the easier it is to stick to it. Treatment has changed but it can still be a leap of faith. But what is it like to take the leap?

Recently I asked women coming into the drop in to share some of their thoughts and experiences with HIV treatment. Here's the wisdom from women eating lunch (you're always wiser when you're well-fed!). Many thanks to the women who participated.

“What is great about treatment?”

We know treatment can improve your health by limiting HIV's ability to reproduce and allowing your immune system to regain strength. Viral load decreases and CD4 immune cells increase. One woman stated the simple power of it: “You stay healthier longer.” Another woman bluntly said, “As opposed to dying?”

Others mentioned the larger health benefits of being on treatment, saying flus and colds don't come as often or as severely. And another woman

mentioned the bigger picture piece: learning more about her health and about the treatments themselves. She enthusiastically said she has a chance to “focus on living again- yeah!”

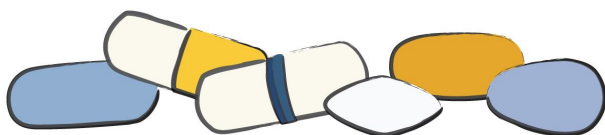
How did you feel after your first month on treatment?

The first few weeks of HIV treatment are about getting used to the schedule of taking the pills and possibly dealing with side effects. They can also be about figuring out how to maintain your privacy about taking them if you don't want other people in your life to know.

continued...

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Wise Women Speak cont ...

Women reported the ups and downs of that first month. On the up side of things, women said, “I felt much better,” and “My CD4 count doubled!” A couple reported feeling really tired, and “like crap.” Another woman was right in the middle: “I did great, no reactions, but not everyone is the same.”

Her point that everyone is different is really important- how you react to the medication will be about your body. And talking to your doctor about your experience is important too. He (or she) needs to know how the treatment is working, and not just in regards to the viral load and CD4 numbers.

Do you have any advice for women starting out?

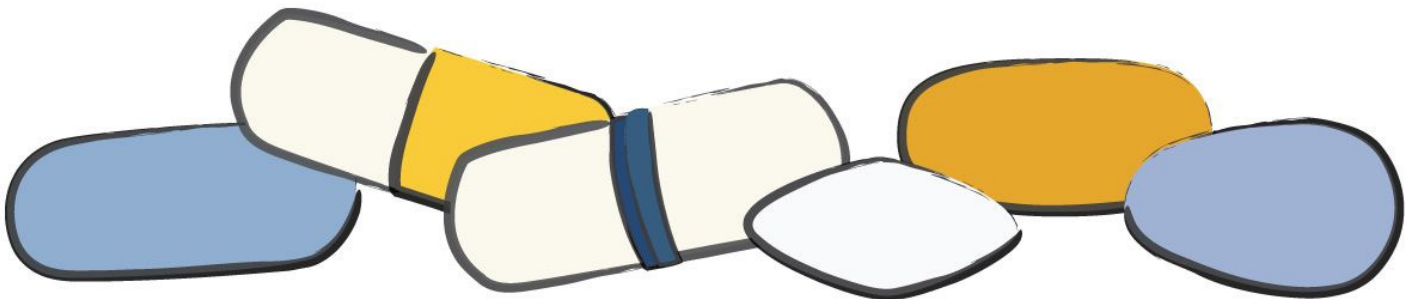
Making the leap can be scary, as the first piece of advice reflects: “Don’t be afraid. Another woman suggested, “Give it a chance to work.” Knowing how important adherence is made this woman say, “Stay on your meds! Take them properly for adherence.”

Being aware of how your unique body feels is key to success. One woman advised to “Monitor your meds, because sometimes the pharmacist or doc will over or under medicate.” Paying attention to changes in how you feel is part of the feedback loop for you and your doctor.

If you use drugs, women advise, “don’t use heroin, it will make you sick.” If heroin’s a regular part of your life, talk to your doctor about methadone or other options if you’re thinking about treatment.

There is always support when you start out. Peer support volunteers are available through PWN, as are support workers. Cara Moody, who is on the *Oak Tree Clinic* staff but has her office at PWN, can take you to medical appointments and help you get support. Give us a shout with questions.

Many thanks to the women who shared the experiences.



The Berlin Patient: HIV Cured for the First Time

By Katie Ralphs

You've probably heard about the first and only person to be cured of HIV. His name is Timothy Ray Brown, and in 2007 he received a stem cell transplant that effectively removed all HIV from his body. The transplant was primarily intended as a treatment for his leukemia (a type of cancer of the blood) which Brown had been diagnosed with earlier that year. This case is very unique, and the painful and risky procedure has not been replicated on anyone else since. It is certainly not a realistic cure for everyone with HIV, but the results are exciting in terms of the possibility for future research in the stem cell field.

Who is Timothy Ray Brown?

He was a US citizen living in Germany who had been HIV-positive for over ten years. He had been on antiretroviral drugs for the duration and his viral load levels were undetectable. In March of 2007, when he was 40 years old, he developed acute *myelogenous leukemia*. He was initially treated with standard drugs for this condition, but relapsed seven months later in September. This time Brown was given a stem cell transplant as treatment to cure his leukemia.

A Unique Donor

Bone marrow and stem cell transplants are relatively common procedures for patients with leukemia, replacing the cells that were destroyed by cancer treatment with healthier ones from a donor. This particular transplant was unique because Brown's surgeon, Dr. Gero Hütter, took an extra step when screening for the appropriate stem cell donor. There were 232 people with matching tissue-type who could have been a donor for Brown. The surgeon had each of the 232 donors screened for the genetic mutation "delta32 CCR5" – a mutation that



SOURCE: POZ.COM/PETERRIGAUD.COM

effectively makes the person resistant to getting infected with most forms of HIV. This mutation is not common; it exists in 1-2% of white Americans and Western Europeans, in 4% of people from Scandinavian countries, and is nonexistent in Africans, African Americans or people of Asian descent. It turned out that one donor, sample 61, had this highly uncommon genetic mutation.

Stem Cell Transplant

This procedure is intense, painful, and risky. Between 15 and 20 percent of people die within the first 100 days of the procedure. It is only performed if the person is at high risk of dying from their leukemia without the transplant. Brown was given radiation therapy to his whole body, put on immunosuppressive drugs, and given an antibody to kill off all his T-cells. He was given chemotherapy that killed his leukemia cells as well as his healthy cells. This essentially means that all of his stem cells and all of his bone marrow were



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The Berlin Patient cont ...

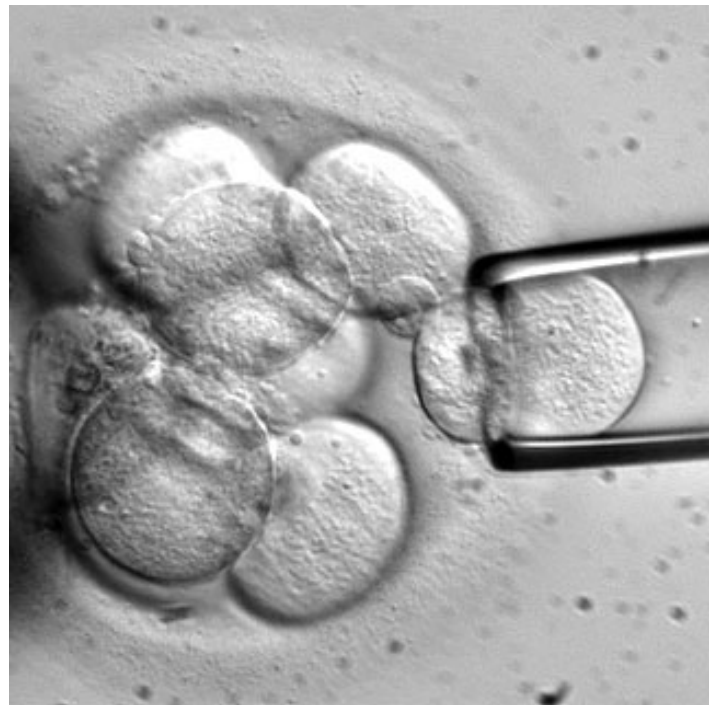
destroyed in the process. These blood-forming stem cells were replaced with cells from the donor, cells that had the delta32 CCR5 mutation that made them resistant to being infected with HIV. After the treatment, Brown did not resume taking his antiretroviral drugs, but continued to receive immunosuppressive treatment. His leukemia came back after a year, and he was given another round of chemotherapy followed by a second infusion of the HIV-resistant cells. During this second treatment, Brown suffered serious intestinal problems and was diagnosed with a neurological disorder.

Testing Negative

Brown has been tested regularly for HIV since the transplants and all of his tissues have tested negative. His anti-HIV antibody levels have also continued to decline, which is what led Hütter to believe that Brown is cured of HIV - if the HIV was still there, it would be stimulating antibody production. The presumption is that even if the virus was dormant in Brown's body, it would not be able to infect him again because his new cells are resistant to HIV. On a functional level, he has been cured because he no longer needs antiretroviral drugs and there has been no decline in his immune system. While there could still be HIV in some areas of his body that doctors have not been able to test, he is the closest example of a cure that doctors have.

A Cure for HIV

This does not mean that anyone with HIV could have chemotherapy and a stem cell transplant and be cured of HIV. As mentioned previously, these are not simple procedures. It would be undesirable and probably unethical to submit relatively healthy people to this treatment, especially considering the



Source: www.liveworldjournal.com/health

It would be both undesirable and probably unethical to submit relatively healthy people to this treatment, especially considering the risk factor for the surgery itself.

risk factor for the surgery itself. Instead, researchers are using this case as a jumping-off point to look at other possibilities for a cure. One of these approaches is to use a mild chemotherapy to create room for HIV-resistant stem cells to enter the body, with the hope that they would repopulate the immune system. A more promising approach that is being widely researched is to take a person's own cells and genetically engineer them to look like the CCR5 mutated cells. People with the delta32 CCR5 mutation are resistant to HIV infection because their cells lack a receptor called CCR5.



Most HIV uses the CCR5 receptor to enter and infect CD4 cells – so if cells could be genetically engineered to remove the CCR5 gene, the person would be nearly completely protected from infection. It is relatively simple to alter one cell, but to genetically alter millions of cells in someone's body is not possible at this time. However, it means that researchers are increasingly confident that if they could alter 100 percent of the stem cells, it would likely have the same effect that it did for Timothy Brown, effectively curing the person of HIV.

Another Obstacle to Making it Work Again

One reason that this procedure has not been replicated on another patient is identified by Jeffrey Laurence, Director of the AIDS Laboratory for AIDS Virus Research of Cornell University. He argues that it is a result of the difference between public and private healthcare. In Europe, the health care system is socialized, even more so than Canada's system. This means that Dr. Hütter was able to test all 232 donors for the unique genetic mutation, without the concern of who was paying for it. In the United States, there have been multiple patients identified who are in almost identical situations to Timothy Brown – they are in their early 40s with leukemia and HIV, requiring a stem cell transplant. But in the US, insurance companies foot the bill for healthcare. And they will only pay for 10 tests of donor samples. It is likely that one of those donors will be a match for the patient, in terms of the stem cells they need for their leukemia. So if a leukemia patient with HIV in the US needed this procedure, they would have to be incredibly lucky to find a donor with the delta32 CCR5 mutation in the first 10 tests. Dr. Hütter had to do 61 tests to find the right donor. Unfortunately, insurance companies will not pay

for tests after a stem cell match has been found. It is also highly probable that they would not pay for the procedure even if someone with the genetic mutation was found, because it is considered experimental.

Although this cure is not practical, it is still exciting! It has shifted the direction of researchers and provided motivation for companies to experiment with procedures similar to this one, minus the costs and risks. Funding for HIV research remains a challenge and unfortunately is not always a priority, but learning about these possible avenues for a cure has made me really excited about the future of HIV research!

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Women and Lipodystrophy: It's Not Just a Side Effect

By Janet Madsen

I recently read a paper by nurse advocates Marilou Gagnon and Dave Holmes called “Women living with HIV/AIDS and the bodily transformation process known as the lipodystrophy syndrome: a grounded theory study.” A mouthful, I know. But the message boiled down to this: women don’t experience lipodystrophy as a mere side effect of taking HIV therapy. They experience it as life-changing. It impacts their self-image, sexuality, social connections and work options. They felt the visibility of lipodystrophy stigmatized them and made them vulnerable to social scrutiny, comments and questions about their body shape.

Lipodystrophy is the term for changes in how fat is distributed in the body—more in some places, less in others. You might gain weight in your breasts, on the neck and back, and in the belly (lipohypertrophy). You may lose it from your face, arms or legs (lipoatrophy). Both men and women can have lipodystrophy, but it develops in a higher percentage of women¹. Some (not all) HIV treatments can contribute to the development of lipodystrophy. Treatment combinations have improved over time, with the added benefit that body changes are not as extreme as they used to be. But for women who have been living with HIV for along time and been on treatment, they may have lipo.

Gagnon and Holmes interviewed women who had been positive for a number of years, some as long as 20 years. A few had been on treatment since the early days, and others started as late as 2006. All experienced body changes as a result of lipodystrophy.

I know lipodystrophy can be a scary possibility for women. I’ve had a number of discussions recently

Women don’t experience lipodystrophy as a mere side effect of taking HIV therapy. They experience it as life-changing.

with members about it. Some say they’d prefer not to hear about it, because it bothers them and they don’t want to think about it happening. Others are noticing it’s starting to happen, and they want to know more about what to expect and what to do. Lipodystrophy won’t happen to everyone, but for those who have it, or those who may, Gagnon and Holmes insist there should be space to talk about concerns. That space needs to happen with nurses, doctors, peer supports, and organizations like PWN. The women in the study indicate that “[Lipodystrophy] is not a simple reconfiguration of fat tissue but rather a complete transformation of self.”² Gagnon and Holmes wrote with passion about how doctors and other health care providers need to be aware that while “[HIV] health is measured within clinical setting of CD4 counts and viral load, women... are continuously confronted with the image of a sick-looking body.”

Gagnon and Holmes also point out that lipodystrophy is not a “side effect” but is front and center in changing women’s experiences of themselves in the world, affecting sexuality, self-image, social choices, mental health and economic status.

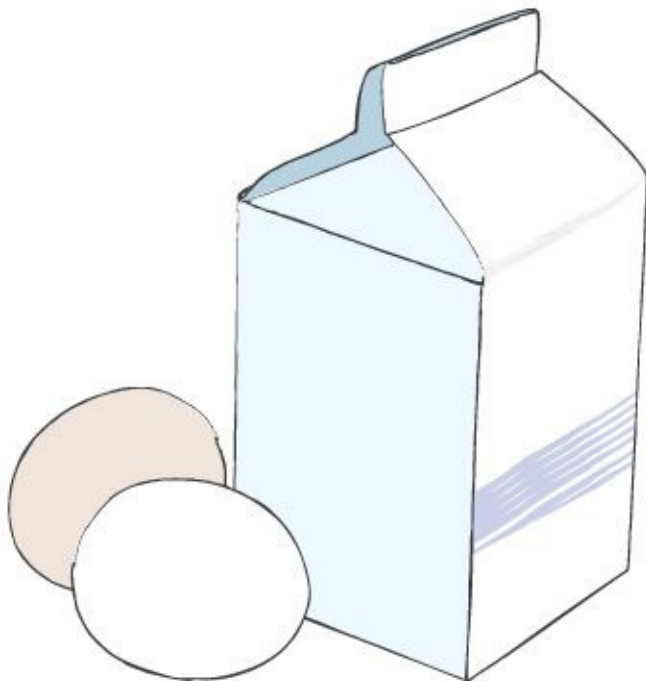
If you have concerns about lipodystrophy, we can provide support in various ways. We can support you in talking to your doctor about your treatment regime, or connect you with a peer who can relate. We can also help you get the most recent information. You might feel alone, but you’re not. Other women are dealing with this too. If you’d like a copy of the whole article, let me know: janetm@pwn.bc.ca via email or phone me with your address. I can be reached at 604-692-3009.

continued...



REFERENCES (for Women & Lipodystrophy):

- 1 Lipodystrophy and Women. The Body, March 2005. Retrieved from <http://www.thebody.com> March
- 2 Gagnon, M. and Holmes, D. (2010) Women living with HIV/AIDS and the bodily transformation process known as the lipodystrophy syndrome: a grounded theory study. Journal of Research in Nursing, December 3, 2010. Retrieved from <http://jrn.sagepub.com>



Best Before & Expiration Dates: What You Need to Know!

Compiled by Katie Ralphs

Best Before:

- The amount of time that an unopened food product, when stored under appropriate conditions, will retain its freshness, taste, and nutritional value.
- “Best Before” dates are not indicators of food safety, neither before nor after the date. They apply to unopened packaged products only.

Expiry Date:

- Indicates the shelf life and safety of the product.
- Required on fortified foods and drugs:
- Meal replacements (liquid formula)
- Liquid nutritional supplements
- Infant formula
- Medication

Can you eat food after the “Best Before” and “Expiry Date”?

Best Before: SOMETIMES!

- You can buy and eat foods after the “best before” date has passed. However, when this date has passed, the food may lose some of its freshness and flavour, or its texture may have changed.
- Consider “best before” dates as a guide only. If the food looks and smells as you would expect, it should be safe to eat.
- Health Canada says: “If in doubt, throw it out!”

Expiry Date: NO!

- It is illegal to sell a product after the expiry date.
- Food should not be eaten if the expiration date has passed, and should be discarded.
- Drugs degrade over time and some prescription medicine can be dangerous after their expiry date.

REFERENCES:

Canadian Food Inspection Agency. March 8, 2011. Retrieved from <http://www.inspection.gc.ca/english/fssa/concen/tipcon/date.shtml>



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Women and the BC HIV Care System

Reporting from the BC Centre for Excellence in HIV/AIDS's LISA study

By Jamie Forrest

As the HIV epidemic evolves and shifts to a more manageable chronic condition for those accessing treatment, new challenges have arisen for AIDS Service Organizations (ASO) in the province of British Columbia. The shift means that ASOs are increasingly tasked and balancing the delivery of prevention information with assisting clients in navigating the often-complex HIV care system. In addition to accessing HIV-specialized clinical care, it is now understood that optimal health outcomes for people living with HIV include access to supportive health services, such as housing assistance, food security and harm reduction practices.

Women represent 15% of people currently accessing treatment in BC... [but] women represent 26% of LISA study participants ... in order to better understand the unique needs of this population.

The Longitudinal Investigations into Supportive and Ancillary Health Services (LISA) study at the BC Centre for Excellence in HIV/AIDS (BC-CfE) was initiated in 2007 to examine experiences of men and women accessing treatment for HIV in British Columbia. The study team conducted 1000 interviews throughout all health authorities in the province. Interviews collected in-depth information regarding social determinants of health – factors such as income, education, ethnicity, gender, health services, and housing – which help to predict health outcomes. Information gathered also included demographic, socioeconomic, and behavioral information such as stigma, treatment perceptions, food security and quality of life. This article presents responses from a total of 264 HIV-positive women, including nine transgender women regarding access to, and experiences of, services related to HIV care captured in the LISA study.

Women represent 15% of people currently accessing treatment in BC. The LISA study oversampled women in order to better understand the unique needs of this population. Women thus represent 26% of LISA participants. The average age of female LISA participants at time of interview was 41, where the youngest was 20 and the oldest was 67. Almost half of women (49%) reported Aboriginal ancestry. Most women viewed their health positively – 59% reported their overall health as good, very good or excellent and 78% felt their health was the same as or better than the previous year.

Relationships With Care Providers Significant

There are many factors that may explain why nearly two out of every three women in our study reported their health positively. Importantly, highly active antiretroviral therapy (HAART) works. It stops HIV from replicating and allows the body's immune cells, particularly CD4 cells, to grow and function properly. As a result of HAART, people living with HIV can lead longer, healthier and happier lives. But, there are other reasons why the majority of LISA women may be reporting their overall health in a positive light. Our study has shown that BC women feel positive about their relationship with the HIV care system. This is true of the relationships with their physicians to women's access and utilization of social workers, case managers, harm reduction services, dieticians, and gynecological care.

Patient-provider relationships significantly shape one's experience with the healthcare system. Sixty-three percent of women in the LISA study have been seeing the same HIV doctor for more than three years. Women also reported having positive relationships with their HIV care provider. Ninety-



three percent said that their doctor is someone who listens to them, 97% felt confident in their doctor's ability to care for people living with HIV, and 95% of participants agreed or strongly agreed that their doctor had their best interest in mind when making decisions about their HIV care. This high degree of trust that participants have reported towards their HIV care provider speaks to the effort of BC physicians to provide the best possible quality care to people living with HIV and AIDS.

Support Services are Part of Good Care

Our study has shown that BC women feel positive about their relationship with the HIV care system.

In addition to the positive relationships that participants reported with their regular care providers, women are increasingly accessing other health services related to their overall health. Of 264 women sampled, 99 (38%) reported frequently accessing the services of a social worker and 42 (16%), a case manager. Social workers and case managers can help people living with HIV and AIDS better navigate the complex health care and other government systems and assist with improving mental, physical and emotional well-being. Additionally, 109 (41%) women regularly accessed methadone treatment and 32 (12%) frequented detox or recovery centres. Previous research has shown that adherence to methadone treatment and the practice of general harm reduction principles is associated with improved adherence to HIV medication- a necessity to prevent drug resistance and better overall health outcomes.

Furthermore, 107 (41%) women visited a dietician as part of their HIV care. Dieticians can help people living with HIV and AIDS adjust their food

intake to work better with their medication and can assist lower income individuals in creating healthy and inexpensive food options. This is particularly important in light of a recent BC-CfE study that found 71% of participants living with HIV and AIDS to be food insecure - i.e. unable to obtain sufficient or nutritionally adequate food. This finding prompted the creation of a national research program, which will launch in the coming months to help better explain food insecurity and compare BC's results to other provinces.

Women-Specific Care Essential

The LISA study also explored women-specific services. Women may face challenges in accessing gynecological and women-specific medical care, particularly in the context of HIV. Encouragingly, 73% of LISA participants reported regularly visiting a physician who specializes in women's care. 68% of women reported having a pap smear in the six months prior to their interview and, of those who had an abnormal pap smear, 83% were followed-up by their women's health care provider. LISA women also reported having conversations with their doctors about contraception in the context of their antiretroviral therapy and reproductive health concerns, such as fertility planning.

Despite the positive stories reported by many women with respect to their HIV care, women also spoke of challenges with accessing services. One hundred and six women reported missing care appointments because they reported not "wanting to deal with their health." Fifty-five women reported missing an appointment because clinic hours were inconvenient. Twenty-five women missed appointments because they could not get the time off work, and 93 women could not find transportation to the clinic. These barriers



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The LISA Study cont ...

to care mean that access to HIV-specific care still comes with challenges, even in an environment of universal health care. ASOs, in partnership with health service delivery agencies, are continuing to work with clients to improve patient navigation through the care system and help alleviate barriers to care.

In addition to care access issues, there are many

There are many unanswered questions about the specific needs and challenges of women living with HIV and AIDS in Canada.

unanswered questions about the specific needs and challenges of women living with HIV and AIDS in Canada. Previous research from across the country has shown differences in clinical outcomes and service delivery between provinces among women living with HIV and AIDS. This has prompted investigators from BC, Ontario and Quebec to launch a new study called the Canadian HIV Women and Reproductive Health Cohort Study (CHIWOS). The purpose of this new study is to bring together researchers and community members from across the country to learn from HIV-positive women what barriers and facilitators exist to accessing women-specific HIV and AIDS services. The CHIWOS study will also examine service use patterns and the impact of such services on sexual, reproductive and mental health outcomes among women. The study will employ peer research assistants to facilitate outreach, recruitment and conduct the interviews. The CHIWOS study is projected to begin enrollment later this year.

While the LISA study is no longer enrolling participants, our study team continues to design analyses that will help answer questions about the social determinants of health and access and utilization of support services. The study has published five articles in scientific journals on the topics of patient comprehension of drug resistance, neighbourhood perception, body image, stigma and food security. We continue to work on projects related to women and violence, housing, adherence support programs, and quality of life among people living with HIV and AIDS.

JAMIE FORREST has a Masters of Public Health from Simon Fraser University Faculty of Health Sciences. He is a researcher at the BC Centre for Excellence in HIV/AIDS in the Epidemiology & Population Health Program. Jamie works on the LISA project helping facilitate the study's knowledge translation and exchange with community partners. The author thanks study colleagues for their feedback on this article and participants for their research input. For more information visit our website at <http://www.cfenet.ubc.ca/our-work/initiatives/lisa> or email jforrest@cfenet.ubc.ca





Positive Women's Network presents:

SpringBoard 2011

Thursday April 28th, 2011 4:00pm

Century Plaza Hotel
1015 Burrard St, Vancouver

4:00 Registration

4:30-6:00 Concurrent Sessions:

Sessions will include an update from **Chee Mamuk**, and a presentation on **social networking** for individuals and organizations in the HIV community.

6:15 Dinner and Keynote:

'Aging Gracefully with HIV'

SpringBoard is FREE.

This event is open to all members of PWN and other interested participants, including service providers. Men are welcome.

For more information or to Register, contact PWN at 604-692-3000 or pwn@pwn.bc.ca



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Events and Program Information

	monday	tuesday	wednesday	thursday	friday
drop-in	11:30 - 3:30	11:30 - 3:30	11:30 - 3:30	11:30 - 3:30	--
lunch	--	12:00 - 2:00	--	--	--
office	9:00 - 4:00	9:00 - 4:00	9:00 - 4:00	9:00 - 4:00	9:00 - 4:00

PWN Grocery Schedule

****SCHEDULE IS SUBJECT TO CHANGE**

Regular Grocery Hours:

Tuesdays 12pm - 2pm

APRIL 2011:

April 5 (Open)

April 12 (Open)

April 19 (Food Bank Closed)

April 26 (Food Bank Closed)

MAY 2011:

May 3 (Open)

May 10 (Open)

May 17 (Open)

May 24 (Food Bank Closed)

May 31 (Food Bank Closed)

JUNE 2011:

June 7 (Open)

June 14 (Open)

June 21 (Food Bank Closed)

June 28 (Food Bank Closed)

JULY 2011:

July 5 (Open)

July 12 (Open)

July 19 (Open)

July 26 (Food Bank Closed)

Skill Development Weekend

The PWN Skill Development Weekend is taking place **May 27th to 29th at Loon Lake**. Be sure to get your application and medical forms in by April 18th to be considered. Find more information online at www.pwn.bc.ca or call Melissa at 604 692 3007.

Farewell Tea for Dr. Burdge & Dr. Forbes

PWN and Oak Tree Clinic will be co-hosting a Farewell Tea for Dr. David Burdge and Dr. Jack Forbes, both of whom are retiring as Co-Directors of the Clinic. Please join us to celebrate the great work these two committed physicians have accomplished over many years. Oak Tree patients, service providers and community partners are welcome to attend. **Friday, April 29th at 4:00pm at Children's and Women's Hospital** (watch for details about the exact location, or call PWN at 604 692 3000 for details.)

2011 AGM

Positive Women's Network's 2011 Annual General Meeting (AGM) will be held on **Wednesday, June 22nd**, from **5:00pm to 7:00pm** at the **PWN office**. The AGM is an opportunity to hear about PWN's work and elect a new Board of Directors.



Events and Program Information

Connect with Peer Support

We're thrilled to announce that PWN just finished training 8 more peer support volunteers in March 2011. This diverse group of women living with HIV received training on confidentiality, disclosure, treatment information and more. They are eager and excited to connect with YOU!

Finding out you have HIV is usually a life-changing experience whether you suspected it or not. Learning about HIV, health care changes, and treatment decisions are all part of the deal. But you need support too. Talking about the changes in your life can be an important part of adjusting to them.

Meeting other women with HIV is a natural step when you're ready. You can meet a peer volunteer in-person (if you're in Vancouver), or talk to her on the phone, or via email. You decide when and how you want support. For more info, contact a PWN support worker at 604 692 3000 or toll-free 1 866 692 3001, or by email at pwn@pwn.bc.ca.

Thank You Tamara!

In the last few months, you may have met **Tamara Landry**, a PhD student from University Without Walls, who has been conducting interviews for our 20th Anniversary Narrative project. We're not sure exactly what form the project will take, but it has been wonderful to connect with long-time PWN members, supporters, community and staff, to talk about our amazing history. Some of the information gathered from these interviews will be featured in our Women-Centred HIV Organizations are Needed poster for presentation at the upcoming CAHR conference.

Literacy Lives Program

Working with Simon Fraser University, PWN will be recruiting program learners from our membership to participate in an exciting 6 month course, where participants will receive a *Certificate in Community Capacity Building* from SFU. It's an intensive course with classes 2 days per week, beginning in September. If you are interested in learning more about group projects, computers and community engagement, AND if you have completed some peer support or leadership training already, we want to hear from you! Want more information or wondering how to apply? Contact Bronwyn at bronwynb@pwn.bc.ca or 604 692 3008.

PWN Broadcasting Live from CAHR

PWN will have a very visible presence at the 20th annual *Canadian Conference on HIV/AIDS Research (CAHR)*, **April 14th-17th** in Toronto.

We are presenting three posters, to share our experience and expertise in peer support training, Aboriginal women's retreats, and providing women-centred HIV services.

We will also be "Broadcasting Live" through Twitter through the conference and the pre-conference Women's Research satellite Meeting! You can find and follow us on Twitter at www.twitter.com/pwn_bc or on our website at www.pwn.bc.ca/pwn-broadcasting-live.

Good Luck Katie!

Thanks to **Katie Ralphs**, our BSW practicum student from UBC, who has been with the PWN support team since October 2010. Katie has assisted in the support program, as well as worked on various projects at PWN (see her article about the Berlin Patient on page 3). It's been great to have you around Katie, all the best with your studies and your next practicum in Bella Coola.



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Positive Women's Network, a partnership of women living with and affected by HIV/AIDS, supports women in making informed choices about HIV/AIDS and health.

We provide safe access to support and education/prevention for women in communities throughout British Columbia. The Positive Women's Network provides leadership and advocacy around women's HIV/AIDS health and social issues in the national and local health care communities.

Thanks to our Supporters!

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Unless otherwise noted, all materials and graphics in this newsletter are written and produced by the PWN Health Promotion Team (janetm@pwn.bc.ca).