



## HIV Disclosure and the Law: It's often about Sex, but it isn't Sexy

By Janet Madsen

One significant challenge to living with HIV has nothing to do with the physical realities of the disease, but the emotional: the ongoing issue of disclosure. You don't just say "I am living with HIV" once in your life post-diagnosis, you say it many, many times. To a lover, to a new doctor, a dentist, a friend, to family, to children...you get the idea. And while disclosure can get more familiar over time, it might not get easier. A big question a lot of women have is when are you obliged to tell someone your HIV status and when is it okay to let it go?

*... the law says that if there is a "significant risk of serious bodily harm" (in other words a risk of exposure to HIV, whether infection takes place or not), then a person with HIV has a legal obligation to disclose.*

I recently attended a workshop on HIV Disclosure and the Law to explore that question. Glenn Betteridge from the HIV/AIDS Legal Network was at the Pacific AIDS Network meeting (PAN) to share some information. The answers aren't as clear as you might think, but here is some of what I learned. (Anyone seeking information on her specific circumstances should talk to a lawyer, because this is just general information).

An essential piece of information Glenn stressed? Like life, the legal implications of HIV disclosure (or non-disclosure) change over time. Things evolve because we don't know which way the law will go until something is decided in a case that goes through the courts. But a completed court case sets a precedent that other court proceedings may use in the future, so each court decision is a stepping stone in others.

### Contents

- 1 HIV Disclosure and the Law**
- 4 HAART and cervical abnormalities**
- 5 HPV Vaccine for Positive Women**
- 6 Report from SpringBoard 2009**
- 7 High-dose tenofovir microbicide completely protects monkeys**
- 8 International Women's Day 2009**
- 9 ART and Breastfeeding**
- 11 The WISER project**
- 12 Events and Program Information**

## HIV Disclosure and the Law ... cont

We do know that the law says that if there is a “significant risk of serious bodily harm” (in other words a risk of exposure to HIV, whether infection takes place or not), then a person with HIV has a legal obligation to disclose. But “significant risk” has not been entirely defined in the law. Unprotected vaginal or anal intercourse is considered a significant risk, so disclosure is necessary according to the law. What about other sex acts? Is disclosure necessary if a couple uses a condom (safer sex)? What if disclosure doesn’t occur because a condom is being used, yet it breaks? What if a person with HIV is at risk for harm to herself if they disclose (in the case of someone in an abusive relationship, or a sex worker)? These scenarios have not yet been tried, so we really don’t know what the law would decide.

It gets murkier. If a person is charged, pleads guilty, and is sentenced without ever going to court, we don’t know how a similar set of circumstances might be decided in the future. Glenn cited a difficult 2006 case in Ontario as an example. A positive woman was pregnant with her second child. During her first pregnancy, she had access to HIV care, had taken ARV treatment and ensured her child had it too. But during her second pregnancy, she went off her HIV meds. Instead of giving birth at the hospital where she had received prenatal care, she went to a different hospital and told care providers she’d had no prenatal care. She also didn’t tell the health care team she had HIV. At several months of age, the baby tested positive for HIV. Because there was proof that the mother knew her HIV status at the time of the baby’s birth, three charges were laid against her. She pled guilty to one (failing to provide the necessities of life, in this case, provid-



ing the baby access to ARV once he was born), and the case didn’t end up going to court. But she lost both her children (and any access to them). We don’t know what might be decided if a case like this goes to court in the future, but the message seems clear: disclose your status to health care providers when you’re pregnant, or you might lose your child. It’s scary, but possible.

Another important piece of information I took away is that you shouldn’t make any assumptions about what your sex partners may know.



Saying “I have HIV” may not be enough if your potential partner doesn’t know how HIV and AIDS are related (it’s more common than you think). It’s wiser to say, “I have HIV, the virus that causes AIDS.” Be as clear as you can to make sure your partner understands your HIV status before you have sex. If you wait until after you have sex, it’s too late.

*Saying “I have HIV” may not be enough if your potential partner doesn’t know how HIV and AIDS are related.*

One way of disclosing to a new sex partner is to do so with a witness there to back you up. While this may sound unrealistic, it is a way of ensuring that you’re covered if they decide to press charges later on. Glenn suggested telling a new lover, then having a friend follow up- “So you do know Midge is HIV+, right?” to confirm and acknowledge your status. Awkward, perhaps, but certainly effective.

Claiming ignorance of the law is not a sufficient defense, so disclosure is always going to be your responsibility. The Crown has argued (R vs. Cuerrier) that placing legal implications on HIV disclosure will encourage people living with HIV to disclose their status to avoid prosecution. Activists on the other side of the fence argue that mandatory disclosure creates a false sense of security that could undermine prevention education and safe sex responsibility for everyone. (“I don’t need to worry about safer sex, cause she’ll tell me if she has HIV”). It also criminalizes people with HIV unnecessarily and could discourage people from getting tested for HIV at all.

It’s safe to assume that this is a legal issue that is not going away soon, so knowing your rights and responsibilities is important. The majority of cases before the courts have involved men with HIV not disclosing their status and exposing women to the virus, but charges have occurred against women. Disclose whenever appropriate. If you have questions in general, contact a support worker. If you have specific questions, contact a lawyer. For more information, check out the Canadian HIV/AIDS Legal Network website: [www.aidslaw.ca](http://www.aidslaw.ca).





## HAART and cervical abnormalities — a long-term study

By Sean R. Hosein (CATIE)

Like HIV, the human papillomavirus (HPV) is also sexually transmitted. As a result, many HIV positive men and women are co-infected with both viruses. Infection with HPV can cause warts in or around the genitals and anus. More troublingly, HPV can also cause abnormal growths on the cervix, vulva, penis and inside the anus. In some cases, these abnormal growths can transform and become pre-cancerous and can even form tumours. As HIV weakens the immune system, HPV infection tends to persist; therefore, co-infected women can have high rates of abnormal cervical growths and cervical cancer compared to HIV negative women.

In high-income countries, highly active antiretroviral therapy (HAART) is generally widely available. This therapy reduces the production of new HIV, allowing the immune system to begin to rebuild itself. Consequently, life-threatening infections—the hallmark of AIDS—are uncommon in people who are engaged in their medical care and treatment in these countries.

In one study, researchers in the United States have been closely monitoring the gynecologic health of HIV positive women, in some cases for up to seven years. They found that in some women the use of HAART might enhance the ability of the immune system to control HPV.

### Study details

The team of researchers began recruiting hundreds of HIV positive women and other women at high risk for HIV infection in 1993. Study clinics were

located in the following American cities:

- Baltimore
- Detroit
- Bronx
- Providence

Women were seen twice yearly at study clinics where they were extensively interviewed, underwent physical and gynecologic examinations and had blood and other fluids collected for analysis. During these visits, Pap tests were performed and women with abnormal results received further gynecologic care as necessary.

The study team focused on 537 HIV positive women, about half of whom had never used HAART. The average profile of these participants at the time they entered the study was as follows:

- age – 35 years
- 50% had injected street drugs
- main ethno-racial distribution: 60% Black, 22% White, 16% Hispanic
- 71% currently smoked cigarettes
- 60% of the women had detectable HPV on their cervix using high-tech PCR tests
- most women had CD4+ counts between 200 and 499 cells
- only 6% of women had a viral load below the 50-copy mark

### Results

Women who had moderately abnormal Pap test results and who used HAART seemed mostly





likely to clear HPV cervical infection. But in women who had mildly abnormal Pap test results, HAART did not seem to help their immune systems clear HPV. Overall, women taking HAART were 30% less likely to have worsening Pap test results. Moreover, HAART users were 30% more likely to have Pap test results improve over the course of the study.

### Don't miss the Pap



The study authors caution that while HAART appears to help the immune system clear HPV and reduce the severity of HPV disease, these effects do not happen quickly nor is cervical health fully restored. Therefore, HIV positive women continue to need regular and close gynecologic care so that abnormal growths can be caught early in their development.

### REFERENCE:

1. Paramsothy P, Jamieson DJ, Heilig CM, et al. The Effect of Highly Active Antiretroviral Therapy on Human Papillomavirus Clearance and Cervical Cytology. *Obstetrics and Gynecology*. 2009 Jan;113(1):26-31.

*From Canadian AIDS Treatment Information Exchange (CATIE), February 5, 2009. For more information visit CATIE's Information Network at <http://www.catie.ca>*



## Testing, testing: HPV Vaccine for Positive Women

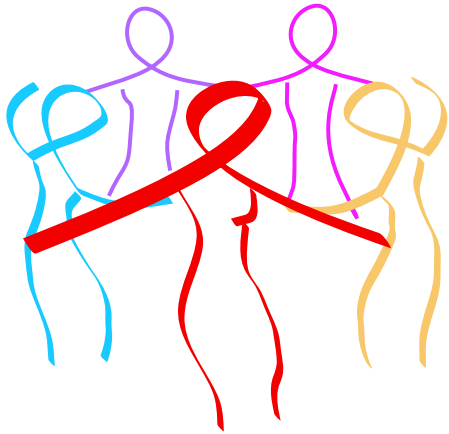
*from the PWN blog at [www.pwn.bc.ca](http://www.pwn.bc.ca), Jan. 23, 2009*

You may have heard about the relatively new “cervical cancer vaccine” to protect against four strains of Human Papillomavirus (HPV). One of the most common sexually transmitted infections, HPV will infect 3 out of 4 sexually active women at some point in their life, and can lead to cervical cancer if it's not treated. Studies of the vaccine have demonstrated a benefit for girls and women with healthy immune systems, but no study has tested it on immune-compromised women. Dr Deborah Money of Oak Tree Clinic is leading research to change that, hoping to benefit women internationally.

Women with HIV tend to experience more severe HPV infection than women without and it can be more difficult to treat. The “gold standard” for tracking cervical health and possible HPV infections is the Pap test. In Canada Pap tests are a standard of care, but this isn't the case the world over and treatment can be painfully invasive.

Sixteen sites across Canada are enrolling HIV positive girls and women age 9 and over to be part of this ground-breaking study. Being vaccinated against HPV wouldn't remove the need for regular Pap tests, as the vaccine protects against only four of the many strains that can be transmitted sexually. But it could cut down on the rates of infection with the two types that contribute to cervical cancer and the types that cause genital warts. If the results of the study demonstrate a benefit, the impact could be felt internationally. Offering the vaccine in regions where women don't have access to regular Pap tests and follow up care could dramatically reduce cervical cancer rates.

If you're interested in learning more about the study, you can contact Oak Tree's Evelyn Maan.



Positive Women's Network's 5<sup>th</sup> annual conference, SpringBoard, was a roaring success. Service providers, women living with HIV, and community members came together for an afternoon and evening of learning and discussion in regards to this year's theme "space for health."

Participants were offered a relaxing yoga/stretch class in the early afternoon, followed by a workshop on workplace wellness, entitled: "In the Thick of it: Staying Balanced at Work," facilitated by Shayna Hornstein. This workshop focused on how to prevent burnout and lessen the impact of cumulative workplace stress on the body. Two concurrent sessions occurred in the late afternoon: "Forum Theatre Troupe Workshop" and "Positive Action: Women Living with HIV Discuss their Political Activism." The Forum Theatre Troupe Workshop, facilitated by the YouthCo AIDS Society Forum Theatre Troupe, elicited laughter and thoughtful discussion while participants engaged in "a dress rehearsal for real life." The "Positive Action" panel gave participants an opportunity to hear about the amazing work three women living with HIV are doing at home and abroad; their testimonies of political activism in the face of adversity were moving and inspiring.

## 2009 SpringBoard conference a Roaring Success!

During dinner, the evening's keynote speaker, Dr. Susan Burgess, who has advocated ending the spread of HIV/AIDS in Vancouver's Downtown Eastside for almost a decade, discussed her work with women living with HIV in Vancouver and in Lesotho in relation to housing and healthy living.

Throughout the conference, participants were able to view the walk through photo exhibit, "Giving Women Power Over AIDS" from the Global Campaign for Microbicides, as well as peruse Positive Women's Network's resource table and contribute their ideas to an interactive medicine wheel.

SpringBoard continues to provide a unique opportunity for service providers, women living with HIV, and community members to come together, learn and dialogue about the diverse and multifaceted issues facing women living with HIV while celebrating International Women's Day. We look forward to SpringBoard 2010!



## Microbicide News: High-dose tenofovir microbicide completely protects monkeys

An animal study has found that a single dose of a microbicide gel containing tenofovir and FTC completely protected six out of six monkeys given a twice-weekly vaginal challenge of a combined human/monkey virus called SHIV. No monkeys were infected after 20 challenges with the virus whereas monkeys not given the microbicide were infected after an average of four challenges. Unexpectedly, however, the study also found that a gel containing tenofovir alone was just as effective and also protected all the monkeys. This contrasts with previous studies, which have found lower rates of efficacy for single-drug microbicides.

To test the effectiveness of the 1% tenofovir intravaginal microbicide gel and a combination gel including 5% FTC and 1% tenofovir, the investigators designed a four-arm study including a total of 21 pigtail macaques. In order to simulate human sexual exposure more accurately than other studies, the investigators gave lower doses of SHIV than in previous studies, but gave them more frequently – twice rather than once a week. In addition, the monkeys were not treated with progesterone. Previous studies have dosed monkeys with this hormone because it stops the animals' menstrual cycle, which is monthly like the human cycle, and keeps the vaginal wall thin, creating a state where the monkeys are permanently at their most vulnerable point of the cycle to infection. This

study left the monkeys to menstruate and more accurately imitates women's changes in vulnerability. Protection was measured over ten weeks or two complete menstrual cycles.

The study used gels containing high doses of antiretrovirals. In particular there was 30mg of tenofovir in each dose compared with 40mg in microbicide trials that are currently taking place in humans – weight-for-weight a much larger dose. Presenter Charles Dobard of the Centers for Disease Control said that trials with lower doses were being contemplated, saying that “we wanted to aim high and scale back.”

There were eleven controls, nine of whom received a placebo gel and two no gel. The 1% tenofovir and 1% tenofovir/5% FTC arms contained six monkeys each. The gels were applied intravaginally 30 minutes before exposure to SHIV. Infection with SHIV was checked using both antibody and viral load tests. The investigators also measured drug absorption 30 minutes after administration.

Of the eleven macaques in the control arm, ten were infected with SHIV after a median of four exposures to the virus. Both of the animals that received no gel became infected. After 20 exposures to SHIV, none of the macaques that were treated with either the tenofovir gel or the FTC/tenofovir gel were infected. The investigators comment that this demonstrates that “both tenofovir alone and when combined with FTC provided very significant protection ( $p < 0.005$ ).” Drug-level monitoring demonstrated that low levels of FTC (median, 67ng/ml) or tenofovir



## International Women's Day 2009

Each year around the world, International Women's Day is celebrated on March 8. Hundreds of events occur not just on this day but throughout March to mark the economic, political and social achievements of women past, present and future.

To celebrate International Women's Day, Positive Women's Network invited community members to join us at in the main concourse of the Vancouver Public Library on March 9, 2009 between 10am and 4pm. Our theme for this event was "Strong Women Strong World." We had the Global Campaign for Mircobicides "Giving Women Power Over AIDS" walk-through photo exhibit on display, as well as Positive Women's Network's resource table set up. We were thrilled to have staff and volunteers from

## Microbicide News ... cont

(median, 22ng/ml) were consistently detected in blood after these drugs were administered. It was estimated that this represented just 0.029% of the total tenofovir dose and 0.026% of the FTC.

### REFERENCE:

1. Dobard, C. et al. Complete protection against repeated vaginal seminal HIV exposures in macaques by a topical gel containing tenofovir alone or with emtricitabine. Sixteenth Conference on Retrovirus and Opportunistic Infections, Montreal, abstract 46, 2009.

Source: *AIDSMAP.com*, Sixteenth Conference on Retroviruses and Opportunistic Infections, February 10th 2009: Gus Cairns & Michael Carter

YouthCo AIDS Society and Women Against Violence Against Women Rape Crisis Centre (WAVAW) set up resource tables alongside ours. Passers-by were able to visit all three organizations' resource tables and receive information on women and HIV, youth and HIV and violence against women; issues facing women and youth in regards to violence and HIV are often intersecting.

During our event we honoured the role women play in society. We also reflected on the many challenges women continue to face; women do two-thirds of the world's work but receive only 10% of the world's income and own less than 1% of land. Thank you to YouthCo AIDS Society and WAVAW staff and volunteers for joining us to pay tribute to all of the amazing women the world over on International Women's Day!



## ART use in mothers with low CD4 cell counts reduces breastfeeding transmission fivefold: Malawi

The use of antiretroviral therapy (ART) by breastfeeding mothers greatly reduced the risk of HIV transmission to their infants after a 14-week course of infant HIV prophylaxis was stopped, according to a study performed in Malawi and presented to the Sixteenth Conference on Retroviruses and Opportunistic Infections (CROI) on February 10th, 2009. However, ART use did not significantly reduce transmission risk in mothers with CD4 cell counts above 250 cells/mm<sup>3</sup>.

The best means of preventing mother-to-child transmission of HIV (MTCT) during breastfeeding is currently the subject of much research and discussion. Formula feeding is not a viable alternative to breastfeeding in most resource-poor settings, as lack of clean water presents essentially as great a risk to infants as the risk of HIV transmission through breastfeeding. The PEPi-Malawi study had previously found that a 14-week course of daily infant antiretroviral prophylaxis, initiated at birth, can reduce infant HIV infection rates from breastfeeding by upwards of 65%. Other studies such as the Kisumu Breastfeeding Study (KiBS) have found that ART use by breastfeeding mothers reduces MTCT. This new study, reported to CROI by Taha Taha of Johns Hopkins University on behalf of a US/Malawian research team, investigated the effects of ART use by breastfeeding mothers on MTCT after infant HIV prophylaxis was stopped.

The researchers identified 2318 infants who were HIV-negative at 14 weeks of age, and monitored their HIV status until they reached 24 months of age.

The researchers also defined three categories for the mothers' use of ART:

- ART-eligible and untreated (CD4 cell count < 250 cells/mm<sup>3</sup> but no ART);
- ART-eligible and treated (CD4 cell count < 250 cells/mm<sup>3</sup> and received ART); and
- ART-ineligible (CD4 cell count = 250 cells/mm<sup>3</sup>).

Although 624 women were eligible for ART at some point postpartum, only 310 (13%) received it. All regimens were the standard first-line ART regimen used in Malawi: nevirapine, d4T (stavudine) and 3TC (lamivudine).

One hundred and thirty of the 2318 infants (5.6%) acquired HIV between the ages of 14 weeks and 24 months. MTCT occurred at an incidence rate of 10.6 per 100 person-years (p-y) in ART-eligible, untreated women (95% confidence interval [CI], 7.9 - 13.8), but only 1.8 per 100 person-years (p-y) in ART-eligible, treated women (95% CI, 0.6 - 4.2) - an adjusted hazard ratio [AHR] of 0.18 (95% CI, 0.07 - 0.44). In other words, ART use represented an 82% reduction in MTCT among ART-eligible women.

MCTC was also significantly less likely in women who were ART-ineligible - in other words, women with CD4 cell counts of 250 and above - compared to ART-eligible, untreated women (incidence rate, 3.7/100 p-y (95% CI, 2.9 - 4.6), for an AHR of 0.35 (95% CI, 0.25 - 0.50). (The lower likelihood of MCTC in healthier women

## Antiretrovirals and Breastfeeding ... cont

with higher CD4 counts is consistent with other existing data.) There was no significant difference in MTCT between ART-ineligible women, and ART-eligible women who were on treatment.

The health benefits of ART for the women themselves, also an essential part of the overall picture, were not presented at this session but are currently being analysed. The researchers concluded that, due to the 82% reduction seen in MTCT, eligible breastfeeding women “should start ART early for their own health and to reduce postnatal HIV transmission to their infants.”

### PMTCT during breastfeeding: what works best?

In a plenary presentation to CROI on Wednesday morning, Jeff Stringer of the Centre for Infectious Disease Research in Zambia discussed current knowledge, knowledge gaps and practice recommendations regarding breastfeeding and HIV. Some of the key questions and issues include the following:

### Should ART be used as PMTCT (Preventing MTCT) in women with higher CD4 cell counts?

While the Taha study found no significant effect of ART in such women, the KiBS study did

find that maternal ART reduced MTCT during breastfeeding, regardless of whether the mothers' CD4 counts qualified them for treatment. Nevertheless, women with lower CD4 cell counts – below 350 cells/mm<sup>3</sup>, and most especially below 200 cells/mm<sup>3</sup> – are at much higher risk of transmitting HIV to their infants, as well as risk of disease themselves – than women with higher counts (as demonstrated by the ZEBs and other studies.) The cold realities of practical constraints might argue for the strategic use of treatment where it will have the most effect. However, this should not be used as an argument for failing to treat as many people as resources permit.

### How should the twin PMTCT tools of maternal ART and infant prophylaxis be used during breastfeeding?

Stringer and Taha both argued that, for healthier women with higher CD4 cell counts, current evidence points to infant prophylaxis as the better intervention during breastfeeding – at least until there are more data from controlled trials. As described above, Taha found no

significant prevention effect of maternal ART in these women. He also argued that, since antiretroviral drugs are absorbed into infant's bodies by way of breast milk, there is the potential for excessive drug levels if infant prophylaxis and maternal ART are used simultaneously.



Several larger prospective trials are currently examining these questions. The BAN (Breastfeeding, Antiretrovirals and Nutrition) study is a three-arm trial comparing extended infant prophylaxis and maternal ART to a control arm of short-course infant prophylaxis. The PROMISE study, a complex protocol with multiple randomizations, is comparing several pre-partum ART regimens, postpartum HAART and infant prophylaxis, and continued versus terminated treatment for both mothers and infants after weaning. The results of these studies should provide needed evidence for breastfeeding recommendations in resource-poor settings.

#### REFERENCES:

1. Taha T et al. Effect of maternal HAART on postnatal HIV-1 transmission after cessation of extended infant antiretroviral prophylaxis. Sixteenth Conference on Retroviruses and Opportunistic Infections, Montreal, abstract 92, 2009.
2. Stringer J. Prevention of breast-feeding transmission of HIV-1. Sixteenth Conference on Retroviruses and Opportunistic Infections, Montreal. Plenary presentation, abstract 127, 2009.
3. Thomas T et al. PMTCT of HIV-1 among breastfeeding mothers using HAART: the Kisumu breastfeeding study, Kisumu, Kenya, 2003-2007. Fifteenth Conference on Retroviruses and Opportunistic Infections, Boston, abstract 45aLB, 2008.

Source: AIDS MAP News, February 12, 2009: Derek Thaczuk & Kelly Safreed-Harmon



## So, what is WISER anyway? Let's let Sharon tell us ...

My name is Sharon Milewski, and I've been the WISER project co-ordinator at YouthCO AIDS Society for almost a year now.

Through a fantastic partnership between Positive Women's Network and YouthCO, the WISER project was born. WISER stands for Women's Initiative for Support, Education and Re-entry. WISER is a support project with the main goal of giving young women (under 29 years old) who are HIV and/or Hep C positive a space to increase their life skills, and be engaged and empowered in their own wellness.

The WISER project includes an annual 3-day retreat for young HIV and/or Hep C positive women as well as monthly activities. We have a young women's group which is open to whatever the group feels like doing (going for lunch, nature walks, bowling ... the possibilities are endless), and we offer one to one support in and out of the YouthCO office (to deal with housing issues, appointment accompaniment, treatment centre visits, just to talk, etc).

To become a member in the WISER project, you must be a self-identified woman between the ages of 15 and 29 living with HIV and/or Hep C. To inquire about the WISER project, contact me by email ([sharonm@youthco.org](mailto:sharonm@youthco.org)), by phone (604-688-1441 / 1-877-youthco toll free), or stop by the YouthCO office (900 Helmcken St, @ Hornby, first floor).

Check out YouthCO's website [www.youthco.org](http://www.youthco.org) for more information about YouthCO.

## Events and Program Information

	MON	TUE	WED	THU	FRI
drop-in	11:30-3:30	11:30-3:30	11:30-3:30	11:30-3:30	-----
lunch	-----	12:00-2:00	-----	-----	-----
office hours	9:00-4:00	9:00-4:00	9:00-4:00	9:00-4:00	9:00-4:00

### Alison's Wellness Series – Massage Night!

As we head into Spring, practicum student Alison has some special wellness events in the works. In partnership with Friends for Life, she's arranged a free massage clinic for PWN members. The clinic will take place on Wednesday, April 8<sup>th</sup> at Friends for Life (1459 Barclay St, Vancouver) with 1 hour time slots beginning at 4:30, 5:45 and 7:00pm. Call Alison or Rose at 604-692-3000 to book a massage for yourself. If you need help getting there, we will do our best to assist you.

### Infectiousness explained (thanks to Evelyn)

We recently played host to Evelyn Maan from Oak Tree Clinic when she came to discuss HIV viral load and infectiousness. Thanks to Evelyn for a great session, and to Tibotec for sponsoring. More lunchtimes sessions will be offered- stay tuned.

### PWN Support Group

Whether you come for laughter, healing, recovery, or all of the above, Sangam's Thursday evening Support Group could be for you. You can expect to be treated with respect, share some good food, connect with other women, and maybe even reconnect with yourself. The next group nights are:

April 2<sup>nd</sup> and 16<sup>th</sup>  
May 7<sup>th</sup> and 21<sup>st</sup>  
5:30 to 7:30pm

Please call Sangam at 604-692-3006 to confirm the details.

### Did you know that Stacie does Outreach?

Outreach Support Worker Stacie has been traveling around Greater Vancouver and the Fraser Valley to meet with and offer support to women who can't normally make it in to our office. On Wednesday, Thursday and Friday, she visits women at the hospital, in prison, at AIDS service organizations, and in their own homes. She is also available to accompany members to medical and other appointments. For more information about Stacie's work or to make an outreach/accompaniment request, just call her at 604-692-3005.



## Events and Program Information

# Members' Retreat to Beautiful Bowen Island!

Positive Women's Network is pleased to announce our upcoming retreat:

**Friday, May 22nd to Sunday, May 24th 2009\***  
on beautiful Bowen Island!

**This retreat is open to all HIV+ women living in BC.**

Priority will be given to women who have never before attended a retreat and/or live outside the Lower Mainland.

You will need to register as a member of Positive Women's Network in order to apply for the retreat (membership is free!).

**Space is LIMITED so apply early!**

**The retreat is FREE** - PWN covers all retreat and transportation costs!

Applications are being mailed out and will also be available on our website [www.pwn.bc.ca](http://www.pwn.bc.ca).

**Application deadline is Friday, April 17th 2009.**

\*There is an option of joining us just for the day on Saturday, May 23<sup>rd</sup>.

For more information, please contact Melissa at 604-692-3000 / 1-866-692-3001 toll-free, or by email [melissam@pwn.bc.ca](mailto:melissam@pwn.bc.ca)



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## connected with us



**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.

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**Merck Frosst Canada Ltd.** for supporting our food program.



**RBC Foundation** for supporting our Health Enhancement Program



**Vancouver Foundation** for sponsoring Leadership, Engagement, Action and Dialogue (LEAD).



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