



# The Positive Side

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## Forgive and Forget? Individual Forgiveness and Health

By Janet Madsen

*\* This article cannot begin to address forgiveness and reconciliation in regards to historical events related to groups of people, such as Aboriginal People of Canada. The omission of these historical events is not out of disrespect, but out of acknowledgement that the enormity of the events and the potential role of forgiveness or reconciliation are too large for the scope of this article.*

Betrayal can hurt, and when it happens within an intimate relationship, it can influence the course of your life. Parents, family, friends, lovers - the people who are closest to us and witness our deepest feelings - can hurt us badly, making us feel victimized and helpless. These feelings within us contribute to our sense of who we are. Over time, how we relate to negative events can impact not only on our mental health, but also our physical health. Considering forgiveness challenges us to think about how betrayals have shaped us and think about whether we want to change these shapes.

Researchers have found that when we have ongoing negative thoughts, it can cause higher blood pressure, muscle tension that can lead to chronic pain, a higher likelihood of injury, digestive problems, and more. Trying to avoid these physical discomforts can lead to self-harming behaviours or relationships, and using food, alcohol or drugs to escape. Forgiveness researchers examine how betrayal affects us. Frederic Luskin says forgiveness can improve your physical and mental health and

that forgiveness outcome studies show incredible emotional changes when people forgive. They experience decreases in anger, stress, depression, self-pity and hurt. They also show an increase in hope, compassion, optimism, and self-confidence. (January 2008).

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## Forgive and Forget? cont'd...



*So forgiveness can address negative thoughts, helping us to change our lives. But what does it really mean when it comes down to it. What do we want to forgive? Are there things that are unforgivable? Does forgiving excuse the betrayal?*

Forgiveness does not mean condoning unkindness or reconciling with an offender. It might, but it doesn't require it. An approach to forgiveness that acknowledges the complexity of the harms done to us as women (and often regarded as "normal") is important. Psychologist Sharon Lamb writes, "In the special case of women and forgiveness, of those who have been through rape, incest, battering and betrayal, learning to live with anger and resentment, even to embrace it, may be the healthier response [than forgiveness]" (Lamb, 2002, p. 168). It's about making peace with your past. Making that peace may involve forgiveness, but it might not.

Dr. Jeanne Safer is a New York therapist who works with people on forgiving... and not forgiving. "The whole Christian 12 step mentality has permeated our culture... for many patients, forgiveness is a double-whammy: first someone screws you, and then it's your fault you don't want to embrace them in heaven," Safer told journalist Melissa Healy last year (Healy, 2007). Safer challenges standard ideas in her book, *Forgiving and Not Forgiving*. She writes, "The definition of forgiveness should be broadened to include any state of mind that enables a person to reconnect psychically with the betrayer and to change the meaning and

impact of the trauma, even if considerable anger remains." (Safer, 1999, p. 52).

Safer makes a distinction between the damage caused by strangers, which "undermines one's sense of justice," and betrayal by those who are intimately connected to us, which "destroys faith in love, trust and honour." (Safer, 1999, p. 43). Everett Worthington, a forgiveness researcher and therapist, classes different kinds of forgiveness, citing emotional forgiveness as the "ultimate goal... in which negative emotions such as resentment, bitterness, hostility, hatred, anger, and fear are replaced with love, compassion, sympathy, and empathy." (Valeo, 2007).

*Forgiveness does not mean condoning unkindness or reconciling with an offender. It might, but it doesn't require it. "The key for me is shifting my perception of events. When I'm wounded, my focus is on protecting myself, so I can't go to empathy. But I can I look at things in a different light." - Willow*

Perception of events is key. "I have never hated the man who knowingly infected me," says Willow, a PWN member who has been positive for 14 years. At the time of her diagnosis, (in what she describes as "the shock of the moment") she called her partner Michael to tell him she had HIV because she wanted to protect him. He denied he had HIV, which Willow later realized was untrue. She had tested negative for HIV before, and Michael was her only sex partner since her negative test six months earlier.

Before seeing Michael again a year and a half later, Willow was able to work through some of



## Forgive and Forget? cont'd...

the steps of reconciliation and forgiveness: re-examining the betrayal, reassessing it and empathizing with the person who betrayed you. Willow says looking at the “what if?” scenarios are part of her working through to acceptance and moving on. “The key for me is shifting my perception of events. When I’m wounded, my focus is on protecting myself, so I can’t go to empathy. But I can I look at things in a different light.”



“After diagnosis, I went through shame, grief, anger, denial. I was able to go through a lot of healing by the time I met Michael again. I felt I’d been betrayed, because he withheld information that completely altered my life. But I don’t hate him. Living with a disease like HIV is crap, but living every day with the knowledge of my mortality and fragility of life is a gift.”

Changing how you look at a betrayal can change how you look at yourself, which is the biggest transformation. “Forgiveness is not about the other person, it’s letting go of the person,” confirms Willow. [Michael] doesn’t have any more control over me. I believe forgiveness is a skill and everyone has it in varying degrees.”

A shift in perspective allows you to move from feeling powerlessness and trapped to feeling powerful and you have choices. If you feel unresolved betrayals are affecting your health, maybe it’s time to look at them. Self-exploration through journal work or reading, a support group, or individual therapy can help you on your path. We can provide referrals if you wish.

Believe you have it in your power to be healthier through the process of change. You can figure out what kind of peace you want to make. Maybe it involves forgiveness or even reconciliation. Maybe you can’t imagine forgiveness, but are looking for the peace of acceptance. All are legitimate goals.

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## Overcoming Trauma With Love, Strength and Power: 16 Steps Towards Empowerment

### The 16-Steps

1. We affirm we have the power to take charge of our lives and stop being dependent on substances or other people for our self-esteem and security. Alternative: We admit/ acknowledge we are out of control with/ powerless over \_\_\_\_\_ yet have the power to take charge of our lives and stop being dependent on substances or other people for our self-esteem and security.
2. We come to believe that God/Goddess/ Universe/Great Spirit/Higher Power awakens the healing wisdom within us when we open ourselves to the power.
3. We make a decision to become our authentic selves and trust in the healing power of the truth.
4. We examine our beliefs, addictions and dependent behavior in the context of living in a hierarchical, patriarchal culture.
5. We share with another person and the Universe all those things inside of us for which we feel shame and guilt.
6. We affirm and enjoy our intelligence, strengths and creativity, remembering not to hide these qualities from ourselves and others.
7. We become willing to let go of shame, guilt, and any behavior that keeps us from loving ourselves and
8. We make a list of people we have harmed and people who have harmed us, and take steps to clear out negative energy by making amends and sharing our grievances in a respectful way.



Do you feel you depend on other people for your self-esteem and make choices you later regret? Are you feeling controlled by food, drugs or alcohol? If you have a voice inside saying you could be doing things differently, maybe it's time to listen. And a 16 step group could help you along the way.

Sixteen step groups focus on destructive behaviours that play out in substance use and/or in relationships. The 16 step model is a shift from mainstream 12 step groups. The 16 step model acknowledges the harm of dependence on food, substances or people for self-esteem and emphasizes the power people have to change their lives. But rather than finding that power in turning oneself over to God or a Higher Power as in the 12 steps, the 16 step model acknowledges the help a Higher Power could offer, but grounds the change in the person themselves. It's a small but significant difference: the power found outside the self vs. an internal discovery of the power we already have.

Charlotte Kasl, creator of the 16 step model, believes "At its core, this model is based on love not fear; internal control not external authoritarianism; affirmation not deflation; and trust in the ability of people to find their own healing path when given education, support, hope and choices." ([www.charlottekasl.com](http://www.charlottekasl.com)). The model has significantly changed addiction and substance use counseling.

Sangam has been facilitating a 16 step support group for a few months now, and says she thinks the 16 step model works specifically because it focuses on self-esteem and an individual's discovery of the authentic voice they already have. (Step 3:



We make a decision to become our authentic selves and trust in the healing power of the truth.). It is a more holistic approach to changing behaviour than the 12 step model, and includes harm reduction rather than only abstinence.

“Empowerment is about forgiveness and moving forward,” Sangam said at group recently. I was invited to attend so members could talk about their experiences for this article (thanks again everyone). Over dinner, I heard the ups (lots of laughter) and the challenges, although they came with benefits: “I like the steps- they offer a structure for stuff to look at.”

*“When I leave here,  
I’m in reality.”*

What’s apparent is that everyone appreciates the step process- “They prompt me to think about what I might want to avoid.” If avoiding stuff may be a pattern, looking at it is good: “We deal with dark stuff, but this group helps me better understand myself and my demons.” Everyone’s encouraged to participate, but no one is forced to share. I was told I must include that they use humour a lot, and that the group can be seen as a celebration: “We’re connecting to each other.”

“This group is about healing spiritually, and emotionally” was said by one and echoed by others. When Sangam asked the women to throw out words to describe the group, they included

- Thought provoking
- Loving

- Motivating
- Transitional
- Honour
- Resilience



If you want to be more empowered, maybe 16 steps are in order. Call Sangam to learn more. (604.692.3006)

9. We express love and gratitude to others and increasingly appreciate the wonder of life and the blessings we do have.

10. We learn to trust our reality and daily affirm that we see what we see, we know what we know and we feel what we feel.

11. We promptly admit to mistakes and make amends when appropriate, but we do not say we are sorry for things we have not done and we do not cover up, analyze, or take responsibility for the shortcomings of others.

12. We seek out situations, jobs, and people who affirm our intelligence, perceptions and self-worth and avoid situations or people who are hurtful, harmful, or demeaning to us.

13. We take steps to heal our physical bodies, organize our lives, reduce stress, and have fun.

14. We seek to find our inward calling, and develop the will and wisdom to follow it.

15. We accept the ups and downs of life as natural events that can be used as lessons for our growth.

16. We grow in awareness that we are sacred beings, interrelated with all living things, and we contribute to restoring peace and balance on the planet.

## Annual General Meeting and Election of the Board of Directors



The Annual General Meeting (AGM) will be held Thursday July 10 from 12 noon to 2 PM. Lunch will be served. We encourage all members to come out and vote for a Board of Directors! This year we are changing the voting system so that everyone, no matter where they are on AGM day, knows who is running and can make their vote count.

### What does the Board of Directors do?

The Board of Directors oversees the direction of PWN and is responsible for financial and legal management. They work closely with the Executive Director, who supervises staff to develop and maintain programs. The Board also represents PWN in the community and takes part in fundraising activities.

### How do I vote?

All PWN members and Board members can vote for the Board. You can vote for nominees in one of three ways:

- ✓ In person, at the AGM on July 10.
- ✓ If you can't attend the AGM yourself, you may vote by proxy.

A proxy vote is when you assign your voting privilege to someone you trust to vote on your behalf at the AGM only (no proxy voting by phone).

- ✓ New this year: By phone, in advance of the AGM.

Voters who choose this option must phone in by Wednesday July 9 at 3:30 PM. You may not leave a message with your vote- please ensure you speak to a PWN staff member directly.

You may only vote in ONE of these three ways. All members who get mail from us will receive a package. If you are not on our mailing list, call us to arrange pick up of your package.

### Why has the voting system changed?



Last year at the AGM, members voted to eliminate nominations 'from the floor.' In other words, no one can decide to put her name forward for election on the day of the AGM itself. This means that you won't have any surprise nominees, or have your proxy vote used for a nominee you're not aware of beforehand. Women interested in



being on the Board have submitted their interest to the Nominations Committee and gone through an interview to discuss how they might fit into the PWN Board and its goals.

## Nominees for the Board of Directors

There are 13 seats for the Board of Directors and each Member is asked to commit to a term of two years. Board members can run for two terms (a total of four years) if they wish. One woman is continuing to the second year of her term (Joni Devlin) and two are running for a second term (Kath Webster and Monique Desroches) This leaves another 10 spots open. The names of the women running for election appear below, but you can read their biographies in the voting package. If you have not received your voting package, please contact us.

See you July 10!

### Nominees:

- Veronica Bock
- Monique Desroches  
(running for re-election)
- Tamara Holdal
- Kerry Jacox
- Kendra Loewen
- Kath Webster  
(running for re-election)
- Julianne Wibe



## Aboriginal Women's and Children's Wellness Retreat

### **Bowen Island**

**June 6 - June 9, 2008**

*"I love the tools I have been taught to use in my journey of life" - Retreat Participant*

This year's Aboriginal Women's and Children's Wellness Retreat was held from June 6 - 8 on beautiful Bowen Island. The retreat was a great success and over 25 positive women attended. Children of positive women were invited to attend as well. Thank you to all the support staff for coordinating and to all the participants!

*"I miss being involved with my heritage, this brought it back." - Retreat Participant*

*"I'm glad I was able to bring my daughter." -Retreat Participant*

## Stigma Clings Stubbornly to Women Living With HIV/AIDS

*Washington, D.C.:* HIV-positive women in the United States face strikingly high levels of stigma, according to survey results released by amfAR, The Foundation for AIDS Research. The amfAR survey results were presented at a press conference on Monday, March 31, in Washington, D.C. and followed by a briefing in which panelists offered personal and professional perspectives on HIV-related stigma among women.

The results of the survey revealed pervasive negative views of HIV-positive women and a high level of discomfort in interacting with them. Many of the responses displayed a lack of knowledge of how HIV is transmitted and misplaced fear of contracting the virus that indicate a pressing need to scale up prevention education efforts.

Sixty-eight percent of respondents indicated that they would be somewhat or not at all comfortable with an HIV-positive woman as their dentist; 59 percent said they would be somewhat or not at all comfortable with an HIV-positive woman serving as their childcare provider; and 57 percent said they would be somewhat or not at all comfortable having a female physician who is HIV-positive. One in five respondents would be somewhat or not at all comfortable having a close friend who is HIV positive.

Only 14 percent of respondents felt that HIV-positive women should have children. Currently medication exists to prevent mother-to-child transmission of HIV. The survey also demonstrates significant differences in how Blacks, Hispanics and Caucasians perceive HIV/AIDS and the risk of

acquiring it. Of those who know someone with HIV or AIDS, Blacks (34 percent) and Hispanics (32 percent) are much more likely to have a family member with HIV/AIDS than Caucasians (13 percent).

Insights were also gained into public attitudes about HIV testing. Nearly 40 percent were sure they had not been tested for HIV. A majority (80 percent) of these respondents indicated that they did not need a test either because they “knew” they did not have HIV or because they didn’t think they needed to be tested.

However, respondents overwhelmingly supported expanded HIV testing and 65 percent support making HIV testing part of standard routine healthcare. This acceptance may be partially linked to the belief that HIV testing occurs more frequently than it does, with 67 percent mistakenly assuming that they are automatically screened for HIV when they are tested for other sexually transmitted infections. Fifty percent believed that women are automatically tested during prenatal exams.

The survey draws much needed attention to the plight of women living with HIV/AIDS. Forty-six percent of people with HIV/AIDS worldwide – about 15.4 million – are women and girls. In the United States, women account for 27 percent of new AIDS diagnoses, up from only eight percent in 1985. Both domestically and internationally, women continue to face widespread social and gender inequalities that can make it difficult for them to reduce their risk of HIV infection. In addition, women are biologically more susceptible to HIV infection than men.



“In the minds of many people, AIDS in the United States is no longer a crisis,” said Rear Admiral Susan J. Blumenthal, M.D., M.P.A., amfAR’s senior policy and medical advisor and former deputy assistant secretary for women’s health in the U.S. Department of Health and Human Services.

“Complacency has obscured the changing face of the epidemic and the dramatic rise in HIV infections in women over the past 25 years. These results should serve as a wake-up call for action across all sectors of society. We need to intensify efforts for science-based education and policy to shatter the stigma that has surrounded this disease for all too long.”



The online survey, conducted by Harris Interactive for amfAR, questioned nearly 5,000 respondents ages 18-44 and covered HIV risk and responsibility, impact of gender-based violence, and women’s access to healthcare and health information, as well as attitudes towards positive women.

The March 31 briefing featured presentations by international AIDS activist Marvelyn Brown; Regan Hofmann, Editor of POZ Magazine; Helen-

*“In the minds of many people, AIDS in the United States is no longer a crisis.” -Rear Admiral Susan J. Blumenthal*

Maria Lekas, Ph.D. , Assistant Professor of Clinical Sociomedical Sciences at Columbia University’s Mailman School of Public Health; and Laura C. Nyblade, Ph.D. , Senior Social Scientist, HIV and Stigma, at the International Center for Research on Women. The briefing was moderated by Dr. Blumenthal.

“Many women erroneously believe that they are not at risk for HIV,” said Hofmann, who is HIV positive. “This is why we are seeing the rate of new infections for women rise significantly in America. While many women accept that they could potentially become pregnant from even just one act of unprotected sex, they feel that they would have to do something ‘extraordinary’ to contract HIV, like be excessively promiscuous or be involved with people the likes of whom they don't think they would encounter in their everyday world.”

Brown said, “I take seven pills daily that make me sick to my stomach. I experience nausea, diarrhea, vomiting and the worst of all mood swings. But yet it is still not the worst part of having HIV. It is the stigma.”

Source: *The Body Pro*, Friday April 11, 2008  
Original Source: Amfar <http://www.amfar.org>  
March 31, 2008



## Harm Reduction Sites Have Met Goals: Ethics Official

Vancouver's supervised injection facility, Insite, has prevented overdoses from killing injection drug users (IDUs), according to the director of ethics at Atlantic Health Sciences Corporation.

Insite has "had over 600 overdose events in the site and no one has died," said Dr. Tim Christie. On the other hand, he said, law enforcement officials "say they want to stop drugs at the source, and they haven't made a dent."

Approximately three-quarters of federal drug strategy funding is spent on law enforcement while just 3 percent is spent on harm reduction, according to a 2006 HIV/AIDS Policy Law Review article.

"There's a cost to failing on the enforcement side and not investing on the other side, which is proven to work," Christie said. The cost to society of one untreated opiate addict is about \$45,000 (US \$44,400) a year, he said, far more than the cost of treatment. Hepatitis C treatment would run \$10,000-\$30,000 (US \$9,900-\$29,600), he said, while the lifetime treatment cost for HIV is an estimated \$240,000 (US \$237,000).

"Treatment is a lot cheaper and you'll have better outcomes," Christie said. "What we need to have is the hard ethical conversation about what do we value as a society and what values should public health policies be based on."

*Source: CDC HIV/Hepatitis/STD/TB Prevention  
News Update 06/05/2008*

*Original Source: Telegraph-Journal (New Brunswi)  
(06.04.08):: Andrew McGilligan*



## For Children with HIV, Growing Up Is a New 'Frontier'

During the late 1980s to mid-1990s, thousands of parents adopted babies with HIV/AIDS before the advent of antiretroviral drugs (ARVs) created the prospect of children surviving the disease. Before there were robust therapies, between one-quarter and one-third of HIV-infected infants died within the first two years of life, and half survived just nine years, according to CDC.

Between 1980 and 1998, US mothers who died of AIDS orphaned 20,715 HIV-positive children, according to a 2003 Journal of Acquired Immune Deficiency Syndromes study. Since the mid-1990s, several reports found that infants who began HIV treatment within the first six months of life were still living two to five years later. But there are no data on how many of the infected children are being raised by adults who are not their relatives.

"This is the frontier," said Diana Bruce, director of policy at AIDS Alliance for Children, Youth & Families in Washington. "We have never before dealt with these kids. They used to die and now they are not." "We don't know how long people with HIV will live," she continued. "There is still a lot we don't know." In 1989, the Illinois Department of Children and Family Services struggled to find homes for about 30 "AIDS babies," said Elizabeth Monk, specialty services administrator. Between 1986 and 1996,

191 wards were HIV-infected by their mothers and more than 40 children died. In the next decade, there were 42 infected wards and 17 deaths, according to state figures.

One adoptee, Lisa Robinson-Ross, now 22, dreams of becoming a nurse who works with babies and thinks about having a family of her own some day. A couple in Chicago, both 72, who used to worry about their adopted daughters' health now are making plans for when their girls - now ages 15 and 17 - outlive them. "My chances of giving them away at a wedding might not happen," the father says. "It would be nice to see them graduate from college."

*Source: CDC HIV/Hepatitis/STD/TB Prevention News Update 04/10/2008 Original Source: Chicago Tribune (04.06.08):: Ofelia Casillas*



## 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

**Our FOODBANK is no longer open every Tuesday. It will be closed the day before cheque day and the following week as well. See our calendar ([www.pwn.bc.ca](http://www.pwn.bc.ca)) for details or call for the schedule.**



### New PWN Website Now Up!

PWN unveiled its new website in June. The new website now has information on issues such as HIV and dating, relationships, treatment information, and more, along with program information and how to get in touch with us. Check us out and let us know what you think ! visit us at: [www.pwn.bc.ca](http://www.pwn.bc.ca).

### Staff News

Stacie is available for outreach visits Wednesdays, Thursdays and Fridays. Her number is 604.692.3005.

Krista Mullaney is taking over for Cara at Oak Tree this summer. You'll probably know Krista already, as she was our practicum student this year. Call her if you need a ride to your Oak Tree appointment: 604.313.7431.

### Newsletter by e-mail

If you would like to receive the newsletter by e-mail, please let us know at [pwn@pwn.bc.ca](mailto:pwn@pwn.bc.ca) or call 604.692.3000 (BC toll-free number for outside the Lower Mainland: 1.866.692.3001). All e-mail addresses are confidential, and the list is sent "blind copy" so others won't see your address.

**Do you have something to share? Deadline for submissions to the next newsletter is September 3. E-mail submissions to [janetm@pwn.bc.ca](mailto:janetm@pwn.bc.ca).**



## Events and Program Information

### Fall retreat: September 26, 27 and 28

Join us on beautiful Bowen Island for the fall retreat. All PWN members are welcome to apply. We'll be sending out registration packages by July 25, and completed applications need to be in by August 25. If you don't get mail from us, we can't send you the information! Call us with your current address arrange to pick it up .

### AIDS Walk: September 21

Put Sunday September 21 aside for the AIDS Walk. We'll be raising money for our housing subsidies, so put your walking shoes on and contact Donna about how to register. You must indicate you're walking for PWN when you register, or we won't benefit from your participation. Contact Donna for a "how to" at [donnat@pwn.bc.ca](mailto:donnat@pwn.bc.ca).

### WANTED FOR ACTION!

We are looking for persons with HIV/AIDS who are currently being treated with antiretroviral therapies and, as a result of antiretroviral therapy, has developed HIV associated facial lipoatrophy.

It is our intent to pursue financial coverage for facial lipoatrophy through our provincial health plan coverage. If you want to be part of this project and are comfortable with potential public exposure please contact:  
Advocacy BCPWA 604-893-2223

### VANCOUVER FOLK MUSIC FESTIVAL JULY 18, 19 & 20: Jericho Beach

PWN has limited reduced-priced tickets for members. Each ticket is \$23. per day, Saturday/Sunday. Kids are free. Call Sangam at 604-692-3000 if you are interested in purchasing tickets. Check out the line-up at [www.thefestival.bc.ca](http://www.thefestival.bc.ca)



**fax**

604.684.3126

**email**

pwn@pwn.bc.ca

**online**

www.pwn.bc.ca

**phone**604.692.3000 (local)  
1.866.692.3001 (toll-free in BC only)**in person or by post**#614-1033 Davie Street, Vancouver  
Vancouver, BC V6E 1M7**administration****Marcie Summers**, Executive Director  
604.692.3010 | marcies@pwn.bc.ca**Donna Tennant**, Director of Development  
604.692.3000 | donnat@pwn.bc.ca**Rose Busolo**, Clerical Assistant  
604.692.3012 | office@pwn.bc.ca**Nancy Hoo**, Bookkeeper  
604.692.3000 | nancyh@pwn.bc.ca**communications****Janet Madsen**, Communications Coordinator  
604.692.3009 | janetm@pwn.bc.ca**Kamal Arora**, Resource Coordinator  
604.692.3011 | kamala@pwn.bc.ca**support****Bronwyn Barrett**, Support Program  
Coordinator  
604.692.3008 | bronwynb@pwn.bc.ca**Sangam**, Support Worker  
604.692.3006 | sangamg@pwn.bc.ca**Stacie Migwans**, Support Worker  
604.692.3005 | staciem@pwn.bc.ca**Cara Moody**, Oak Tree Outreach Worker  
604.692.3007 | cmoody@cw.bc.ca**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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