NOV 1998 ISSUE 2

WISE words

HIV/AIDS TREATMENT INFORMATION AND ADVOCACY FOR WOMEN

Gynecological Issues for Women with HIV

All women, at some point in their lives, experience an unwanted gynecological (GYN) condition. For women and doctors alike, common GYN conditions like yeast infections are usually no cause for alarm. Viewed as such, we learn not to be particularly concerned about them. When confronted with these conditions, we just want them to heal painlessly and quickly. And that's that.

But GYN conditions in women with HIV can sometimes take on a different, more troublesome, course. Often the very first signs of HIV infection, gynecological conditions in HIV-positive women can become painful, recurrent and difficult to treat. Researchers have long known that the female genital tract (diagram, pg. 2) plays a significant role in acquiring or transmitting HIV and other infections. Yet, they are only just beginning to understand how HIV interacts with the genital tract and how this may give rise to a range of GYN conditions. This article, the first in an ongoing WISE series, reviews some of what we know about the impact of HIV on GYN health and

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205 13th Street, Suite 2001
San Francisco, CA 94103
TEL 415.558.8669 FAX 415.558.0684
EMAIL WISE@projinf.org WEBSITE www.projinf.org

National HIV/AIDS Treatment Hotline
800.822.7422
San Francisco and International
415.558.9051

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A Word from WISE

After a brief hiatus and soul searching, I'm pleased to present this issue of *WISE Words*, with content changes and a brand new look! *WISE Words* is the publication of Project WISE, an interdepartmental program of Project Inform focused on HIV/AIDS treatment information and advocacy for women. I am honored to be its new coordinator!

One new feature of *WISE Words* will be an ongoing public policy forum on issues affecting HIV-positive women's lives. It provides a means of action for women to get involved in current policy debates. Another new feature is opening up *A Word from WISE* to our readers who wish to share informative treatment related experiences. Finally, each issue will include a glossary of key concepts and terms (noted in bold italics).

In this issue we feature an overview of some gynecological (GYN) complications associated with HIV disease. It's important to consider that GYN health may be telling us something about the status of our immune system. When conditions become more difficult to treat, it probably means the immune system is weakening. The need for regular exams and prompt treatment of problems cannot be overstated.

For women currently taking or considering an indinavir (Crixivan®) twice daily regimen, new study results show that an experimental twice daily dosing regimen is not as effective in keeping viral load "undetectable" as the three times daily regimen. People using a twice daily regimen are encouraged to switch to a three times daily regimen or at least to discuss the issue thoroughly with their doctors.

Finally, information on viral load results and women are starting to come to light. Two studies suggest that women progress to symptoms of HIV disease with lower viral load levels than men. It's unclear what this preliminary information means for women, but we are contacting researchers for further exploration of this issue. The next issue of *WISE Words*, arriving in early 1999, will review the information to date. For now, remember that CD4+ cell counts, not viral load tests, are the primary means of predicting the immediate risk of acquiring opportunistic infections.

As we refine and make *WISE Words* as useful to you as possible, we hope you'll share your thoughts and ideas with us. Our goal is to make this a valuable newsletter for YOU.

Angela Garcia
Information & Advocacy Associate/Project WISE Coordinator

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Gynecological Issues for Women with HIV, continued

discusses issues in evaluating and treating common complications.

HIV and GYN Health

Efforts to understand the relationship between HIV and GYN health have led to as many questions as answers. Some studies have shown that high levels of HIV in genital secretions (also called cervicovaginal secretions or CVS) correlate with high plasma blood levels and/or GYN infections or swelling and tenderness. HIV interacts with other viral infections, such as herpes simplex virus (HSV) and human papilloma virus (HPV), the virus that causes genital warts. HIV may also promote or worsen infections, particularly vaginal candidiasis (yeast infections) and chlamydia. HIV has also been shown to lead to chronic vaginal inflammation and may lead to increased vaginal discharge.

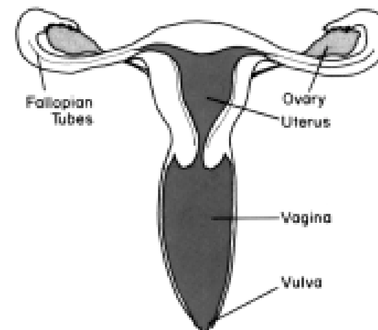
Gynecological conditions in women with HIV can sometimes take on a different, more troublesome, course. Often the very first signs of HIV infection, gynecological conditions in HIV-positive women can become painful, chronic, and difficult to treat.

These and other GYN complications women with HIV experience range from being mild and easily treatable to painfully debilitating. Information on some of the most common GYN complications is listed below.

Common GYN Complications

Vaginal candidiasis is a fungal infection common in many women. It causes itching and swelling of the vulva, thick white-yellow discharge (some women describe it as looking like cottage cheese) and burning upon urination. Women with HIV are particularly susceptible to vaginal candidiasis. In fact, recurrent vaginal yeast infections are the most common initial symptom of HIV infection disease in women. As immune suppression becomes worse, the frequency and primary location of the infection may shift from the vagina to the mouth (for more information, consult Project Inform's *Candidiasis Fact Sheet*). Recurring yeast infections are a symptom of an already weakened immune system. Intervening to protect the immune system from further damage by HIV and allow the immune system to repair and heal is critical. As the immune system is further weakened and damaged, yeast infections will occur more frequently, be more aggressive and respond less well to therapy.

Female Genital Tract



Fortunately, there are several effective forms of treatment for vaginal candidiasis, including topical creams and suppositories such as clotrimazole (GyneLotrimin®) which are available over-the-counter and by prescription. If the candidiasis is unresponsive to these treatments, the antifungal drug fluconazole (Diflucan®) may be necessary. For women not responding to fluconazole, the antifungal ketoconazole (Nizoral®) may be an effective alternative. Modifying diet by decreasing sugar and alcohol, and adding lactobacillus-containing yogurt (stated on the label) or acidophilus capsules may help prevent recurrences of candidiasis.

Herpes simplex virus (HSV) type II and syphilis may take a more aggressive course in people with HIV. For instance, the painful sores in and around the genitals and/or anus caused by herpes tend to be more frequent, persistent and require higher doses and longer courses of treatment than what is needed in someone whose immune system is intact. Herpes sores persisting over one month are associated with severe immune suppression and are considered an AIDS-defining illness.

Acyclovir (Zovirax®), an oral pill, is used to treat herpes. For women with frequent HSV outbreaks, daily acyclovir therapy may be helpful in preventing future outbreaks. If herpes stops responding to acyclovir (e.g. sores don't go away within two weeks after starting acyclovir therapy), a number of other therapies are available to treat acyclovir-resistant herpes. These include: intravenous foscarnet (Foscavir®), topical cidofovir and oral famciclcovir (Famvir®). Like herpes, syphilis in people with HIV may require a higher doses and longer treatment of penicillin, the standard therapy for syphilis.

Diseases such as chlamydia, gonorrhea, trichomonas and bacterial vaginosis are common among women with HIV. Currently, standard treatment regimens are advised to treat these conditions. These include antibiotics such as azithromycin, ceftriaxone or doxycycline to treat chlamydia and penicillin and/or tetracycline to treat gonorrhea. Both bacterial vaginosis and trichomonas are treated with metroidazole.

An important point to remember is that when these diseases occur, the vaginal acid level changes, making the GYN environment more welcoming to other infections (including HIV infection). Furthermore, untreated GYN complications, particularly chlamydia and gonorrhea, are the common cause of pelvic inflammatory disease (sometimes called "PID") and cervicitis (tenderness and swelling of cervix).

Pelvic inflammatory disease (PID) is a term to describe a range of GYN inflammatory disorders including swelling of the fallopian tubes, the uterus, ovaries and, in advanced stages, the abdominal lining. Common symptoms of PID include constant moderate-to-severe pain, tenderness in the abdomen, irregular menstrual cycles, non-menstrual bleeding and/or painful and frequent urination. Like other GYN conditions, PID may be more prevalent, severe and resistant to antibiotic treatment among women with HIV, especially women with AIDS. Indeed, the Centers for Disease Control recommends hospitalization and intravenous antibiotics in the treatment of PID in women with HIV.

Inflammation of the cervix, known as cervicitis, is also a symptom of PID. A number of conditions can lead to cervicitis. Chlamydia and gonorrhea infections can result in swelling of the cervix. Cervicitis may also result from untreated trichomonas or bacterial vaginosis. Cytomegalovirus (CMV), a virus in the herpes family which is also the leading cause of blindness among people with AIDS, can also be a GYN complication and may cause cervicitis as well. Cervicitis is often present without symptoms. When symptoms do occur, they include non-menstrual bleeding, bleeding after penetrative intercourse, painful urination and lower back pain. The treatment for cervicitis depends on the identified cause of the condition.

Human papillomavirus (HPV) is a sexually transmitted disease which primarily affects the cervix and is a leading cause of cervical dysplasia (abnormal cells) and cervical cancer. HPV also causes genital and anal warts. While warts may be the most visible way that HPV presents itself, people can have warts inside their vagina or anus and not be aware them. HPV is also a major cause of anal cancer.

Recent studies have demonstrated that women with HIV, particularly those with low ***CD4+ cell counts***, have an increased frequency and severity of HPV-related cervical dysplasia. Cervical cancer, the most severe form of cervical dysplasia, is more aggressive and difficult to treat in women with HIV compared to HIV-uninfected women. However, if detected early, less severe dysplasia (e.g. grades CIN I or II) are fairly easily treated, stressing the need for regular (e.g. at least every 6 month GYN exams) and timely screening for GYN health.

Many types of treatment are available when symptoms of HPV do occur including surgical removal, electro-cautery (removal by electric current), chemical removal and laser removal. Unfortunately, treatment can be painful and recurrence of HPV related warts is common. Recent studies caution against the use a common treatment option called cryotherapy, which involves freezing off the wart or abnormal cells. Cryotherapy can cause normal tissue to heal over deeper areas of dysplasia, causing future genital screenings to appear normal while abnormal tissue grows undetected beneath the surface. Also, many women report that the aftermath of cryotherapy can be very painful.

> While the Pap smear is relatively non-invasive and the easiest GYN screening procedure, its usefulness is beginning to be called into question—especially when used as a screening tool for cervical cancer in women with HIV.

ABNORMAL GYN SCREENING TERMS

Term	Definition
Atypia	These cells show minimal changes. May be "atypical" due to the presence of a vaginal infection, the use of oral contraceptives or because the person doing the Pap smear may have not handled the cells properly.
Dysplasia	Means "abnormal development." Dysplasia is a pre-cancerous condition. Dysplasia is categorized as mild to severe by using CIN 1-3 and CIS to represent the extent of the problem.
SIL	*Squamous Intraepithelial Lesions.* SIL is another way to describe dysplasia by identifying lesions in the thin cellular layers of the vaginal tract. Again, SIL suggests a pre-cancerous condition.
CIN 1	*Cervical Intraepithelial Neoplasia.* CIN means abnormal growth or tumor in the tissue covering or surrounding the cervix. CIN 1 means that one-third of the sample has dysplasia or pre-cancer. It is mild dysplasia.
CIN 2	CIN 2 means 2/3 of the sample has dysplasia. It is moderate dysplasia.
CIN 3	CIN 3 means the entire sample shows cells with dysplasia. It is severe dysplasia.
CIS	*Carcinoma-In-Situ.* On a Pap smear, this report means the same thing as CIN 3, the entire sample shows dysplasia. However, the sample shows no sign of invasive cancer.

Screening

Since women with HIV have high rates and generally more severe cases of GYN complications, it is important to screen frequently and regularly. Screening is normally done with one of two diagnostic tools, the ***Pap smear*** and/or ***colposcopy***. While the Pap smear is relatively non-invasive and is the easiest GYN screening procedure, the usefulness of the test is beginning to be called into question—especially when it is being used as a screening tool for cervical cancer in women with HIV.

The problem with Pap smears as a useful diagnosis procedure lies in the fact that 15 to 30% of Pap smears results that come back as "normal"are found, after using more sensitive tests, to be abnormal (called

false negative results). In other words, about 15 to 30% women who are told that their Pap smear results are normal actually have something wrong that may require further examination or immediate treatment. This problem has lead some health care providers to suggest colposcopy (with a biopsy when something is found to be abnormal) as a more accurate screening procedure, particularly among HIV-positive women where early detection of GYN abnormalities is critical. Colposcopy is not without drawbacks, however. Not only does it require a specialist to perform the procedure, it can also be painful with some risk of infection and bleeding. At this point, it is difficult to say whether or not colposcopy screening is a necessary screening procedure for HIV-positive women without signs of an abnormal Pap smear. One of the reasons why Pap smears are recommended more regularly (every 6 months) for women with HIV is the hope that a 'false negative' result would be caught with frequent screening.

Standard GYN Screening for Women with HIV

EXAM	RESULT	FOLLOW UP
Pap Smear	Normal	Pap every 6 months.
Pap Smear	Inflammation	Pap every 3 months.
Pap Smear	Dysplasia	Colposcopy, biopsy. Pap every 3 months.

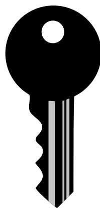
A promising new screening tool called ***Pap Plus Speculoscopy (PPS)*** has recently gained FDA approval. It is almost as sensitive as a colposcopy plus biopsy, is less invasive and painful, and does not require a specialist to perform the procedure. The new technology is starting to become more widely available in STD, Planned Parenthood and other GYN health providing clinics.

In the End, It's the Beginning that Counts

There is still a great deal to be learned about gynecological complications in women with HIV/AIDS and more precise and less invasive screening procedures like PPS need to become more widely available. At the same time, an overwhelming amount of information points to what is perhaps the most critical step in preventing and treating potentially fatal GYN complications: early and regular screening.

A study presented at this year's World's AIDS Conference found that women who were in early and mid stages of HIV disease were less likely to follow through with regular GYN screening compared to women with more advanced-stage disease. Yet it is precisely those earlier stages where detection and treatment can prevent a situation from getting out of hand and becoming life-threatening. No woman likes to be screened. It is uncomfortable, sometimes even painful, and can cause considerable anxiety. But when you look at the facts, isn't it worth it?

Tell us what you think. For more information, ask for the *Gynecological Conditions in Women with HIV Fact Sheet.*



Glossary of Key Concepts and Terms

ANTIBODIES Antibodies are part of the immune response against infections. They play a key role in destroying copies of a virus in the bloodstream.

CD4+ CELLS CD4+ (CD4 positive) cells are a type of white blood cell that have a marker on them called the "CD4" receptor. These cells play a critical role in managing the human immune response. Sometimes called "T-helper cells," or "T4 cells," or, less accurately, just "T-cells."

CD4+ COUNT CD4+ count is the number of CD4+ cells found in a particular blood test. This count is the most commonly used measure of immune health, but is by no means the only one. HIV infects and leads to a gradual loss of the body's CD4+ cells. A significant drop in CD4+ cell count (e.g. to below 500 or lower) reflects damage to the immune system, and a drop below 200 usually indicates damage sufficient to lead to the risk of opportunistic infections.

CLINICAL TRIAL A clinical trial is a structured effort to measure the results of using a drug or treatment strategy in living beings, rather than laboratory dishes or cultures.

COLPOSCOPY An examination of the vulva, vagina and cervix by means of a flexible magnifying tube (called a colposcope) which is inserted into the vagina. The tube allows a specialist to examine the surface of the cervix for signs of cancerous growth. While insertion of the colposcope may cause discomfort, the actual procedure usually isn't painful. It is more accurate at detecting cancerous growth that the Pap test.

FALSE NEGATIVE Results from a test (such as a Pap smear) that falsely report a normal or negative finding, when in fact something is abnormal.

PAP SMEAR A test for detecting cervical cancer and standard part of the routine gynecological examination. The Pap involves inserting something that looks like a long cotton swab into the vagina and "swabbing" cells from the cervix which are then examined under a microscope. Often this test causes a sensation that feels like pressure on the cervix. It can feel painful if the cervix is inflamed and sore for other reasons (e.g. an infection or pregnancy, etc.).

PAP PLUS SPECULOSCOPY (PPS) A new screening procedure for cervical cancer that involves a standard Pap smear and the lighting of the cervix with a chemical light called a Speculite after a vinegar wash. The Speculite whitens abnormal tissues so that a clinician may detect potential disease. This procedure feels like a regular Pap plus a tingly, sometimes stinging sensation due to the vinegar wash. The PPS is more accurate than the traditional Pap.

HIV RNA The early form of the genetic material of HIV. RNA = Ribonucleic acid.

VIRAL LOAD The amount of virus measurable in blood or other fluid or tissue. The viral load number has been shown to be a good predictor of the rate of HIV disease progression.

VIRAL LOAD BELOW THE LIMIT OF DETECTION A viral load measurement below the lower limit to which a particular form of viral load test can reliably count (for the most standard tests, the lower limit of detection is around 400–500 copies per cubic milliliter per blood). It does not mean the virus is not there, just that it is too low to measure in the bloodstream with the standard test. "Supersensitive" or ultra-sensitive versions of the viral load tests are available which can measure accurate as low as 20–50 copies of virus. Suppressing viral load below the limit of detection is one of the most important ways of making sure that the benefits of therapy last as long as possible.

TREATMENT NOTES

Indinavir (Crixivan®) Twice a Day? No Way!

New information from a study of indinavir (Crixivan®) has shown that a twice daily dosing regimen is not as effective as the three times daily schedule. As a result, Merck, the manufacturer, is stopping the part of the study which uses twice daily dosing and has notified activist groups, information providers and physicians of the new findings. Based on these findings, Merck is encouraging everyone using twice daily dosing to switch back to three times daily dosing schedules. The new findings are contrary to a previous, smaller study which suggested that twice daily dosing was at least equivalent to the standard three times daily dosing.

Percent of people with *viral load below the limit of detection.*

Study arm	at 16 weeks 287 patients	at 24 weeks 87 patients
3 times daily	78%	91%
2 times daily	72%	64%

The study included people who had never previously taken a protease inhibitor, or 3TC (lamivudine, Epivir®) and the regimens used included twice or three times daily dosing of AZT (zidovudine, Retrovir®), 3TC and indinavir. After 24 weeks of study, 91% of those receiving three times daily dosing had reached or maintained HIV levels below the limit of detection, whereas only 64% on the twice daily regimen had experienced the same level of viral suppression. What's most important is that after only 16 weeks, the twice daily dosing schedule appeared equivalent. By six months, however, the superiority of three times daily dosing became very apparent.

Another regimen under study which might still permit twice daily indinavir dosing is the protease inhibitor combination of ritonavir (Norvir®) and indinavir (Crixivan®). Preliminary, short-term studies of this regimen appear to show indinavir quite suitable for twice daily dosing, while also eliminating the requirement that the drug not be taken with food. However, it's important to recognize this is based on early data, covering a short period in two small ***clinical trials***. Another study using twice daily indinavir dosing is in combination with nelfinavir (Viracept®).

Caution About Regimen Changes

It's possible that more people than ever are currently using the indinavir twice-daily dosing regimen as news from the smaller study preceded the announcement of a shortage in supply of another protease inhibitor, ritonavir (Norvir®) capsules. When the supply problem was announced, some people may have begun re-thinking their anti-HIV regimens and may have made regimen changes, possibly to an easier-to-use regimen using indinavir twice daily dosing.

The lesson learned here is something Project Inform has been cautioning about for some time with regard to simpler and easier regimens using current available therapies. When these drugs were approved, the reason they were dosed according to schedules in their label instructions (e.g. three times daily) is because studies demonstrated these schedules were necessary to maintain optimal blood levels of drugs. While certainly people want, need and deserve simpler regimens, simply changing a regimen from three times to twice daily dosing is not the solution.

Nevirapine for Kids

Nevirapine (Viramune®), a non-nucleoside reverse transcriptase inhibitor, has recently been approved for use in children.

Dosing

The recommended dose of nevirapine for children aged 2 months to 8 years is 4mg/kg once a day for the first 14 days followed by 7mg per kg given twice a day thereafter. For children 8 years or older, the recommended dose is 4mg/kg once a day for fourteen days followed by 4mg/kg given twice a day thereafter.

Side Effects

Children generally experience the same side effects seen in the adult studies. Rash, usually mild to moderate in severity, is the most common. Other side effects include fever, nausea, headache and abnormal liver function tests. One side effect only seen in children was an anemia called granulocytopenia which is a reduction in granulocytes, a type of white blood cell).

WISE Words Policy Notes

Making it Mandatory: Women, Testing and Telling

As public policy decisions are being made, elected officials hear from "experts," public health officials, campaign supporters, industry and advocates. However, the voice frequently unheard or underestimated is the voice of the people most affected by the policy, system or program under debate.

The Rise of Mandatory Testing

One example of this is the issue of mandatory testing of newborn children and pregnant women. Those in favor of mandatory HIV testing of all newborn babies whose mothers have not had a recent HIV test claim that it is necessary to identify and treat HIV-positive children and their mothers. Those opposing mandatory testing feel it is coercive and expensive, and it could drive pregnant women away from the health care system. They also rightfully point out that immediate HIV testing of newborns tells very little about the child's HIV status, although it does reveal the mother's status. This is because a newborn child carries the mother's HIV antibodies and therefore all children born to HIV+ women will test HIV+ on a traditional test. After a period of time, a child that is not infected will lose their mother's HIV ***antibodies***. Those children infected with HIV will develop their own response to HIV as well as evidence of other signs of infection, such as detectable HIV on more sensitive tests to measure for virus (called ***HIV RNA*** or ***viral load*** tests).

> Secretary of the Department of Health and Human Services, Donna Shalala, needs to hear from HIV-positive women, people who serve positive women and women at high risk of contracting HIV.

Opponents also believe that women, given the opportunity to make a voluntary decision with appropriate counseling, will choose to test themselves and their children for HIV. Several studies have shown this to be true among women who have access to health care and who are offered appropriate HIV counseling and education.

What Is Happening Now

The Ryan White CARE Act (the federal legislation that authorizes and funds many HIV/AIDS programs across the country) contains an amendment requiring the Secretary of the Department of Health and Human Services, Donna Shalala, to decide whether mandatory testing of newborns has become "routine practice" in the U.S. by October 1998. This decision is important because if Secretary Shalala determines that mandatory testing is currently "routine," states that don't have mandatory testing could lose some of their federal HIV/AIDS funding. The loss of this funding would greatly impact states, making it even more difficult to provide drug assistance and other support programs to people living with HIV.

We are calling for Shalala to make her determination now because there are very few states that have mandatory newborn testing programs. A decision made now will likely state that these testing programs are not routine, eliminating the possibility of states losing funding.

What You Can Do

Secretary Shalala needs support and urging to make her determination before the end of the year. She particularly needs to hear from HIV-positive women, people who serve positive women and women at high risk of contracting HIV. Personal stories about experience with testing programs and explanations of the factors that encourage testing will be important, as will information about what practice is common in your state or area. You can write Secretary Shalala at:

The Honorable Donna Shalala, Secretary
U.S. Department of
Health and Human Services
200 Independence Avenue, SW, #615F
Washington, DC 20120

Partner Notification

Another issue of importance to many women is partner notification of possible HIV exposure. Some politicians claim women are demanding mandatory partner notification of possible HIV exposure. Mandatory partner notification means you would be obligated by law to give a public health official the names of your sexual partners. While it is untrue that all, or even most, women support mandatory or coercive partner notification, the issue of partner notification is an important and complex one for women. There is a debate underway among HIV-positive women about how partner notification is best done, when it is appropriate and what additional support people need to deal with revealing their HIV status.

Many women report they were infected by a person who chose not to disclose their HIV-positive status directly to them. If that person chose to use a voluntary, anonymous partner notification system, those women would discover their risk of HIV exposure. On the other hand, some women may face the threat of domestic violence if their partner is notified of possible HIV exposure. Others could face emotional abuse or abandonment.

There is a strong argument that mandatory or coercive partner notification simply doesn't work. People who are dis-

trustful of revealing their partner's names to a public health officials are unlikely to give truthful information. The most effective partner notification systems are voluntary, confidential and include appropriate counseling and support systems.

In spite of the public health arguments for effective voluntary systems, a bill has been introduced into Congress which requires states to implement a partner notification system (H.R. 4431, the "HIV Partner Protection Act"). If approved, health providers or other HIV testing entities are required to confidentially report the names of HIV-infected individuals and their partners to the state. The state would then be required to contact the partners of HIV-positive individuals.

It is unlikely H.R. 4431 will move forward in this session of Congress, given all the other issues currently facing the government. Following the November election, there will be an opportunity to educate new and older members of Congress about this issue.

When elected officials hear directly from women who give their own perspective, it is harder for them to exploit a debate to support legislation with which we may not agree. If you would like continuing information on this and other policy issues, consider joining **Treatment Action Network** (TAN). Members receive monthly action alerts and policy updates by mail or email. There is no membership fee. Contact Project Inform's Public Policy Department at 415-558-8996x224 or by email at TAN@projinf.org.

You Don't Have to Go It Alone

Project Inform's National HIV/AIDS Treatment Hotline is the nation's leading hotline for AIDS treatment information. The hotline currently fields over 40,000 calls a year from HIV-positive individuals, their families, friends and supporters, and health care and service providers. The trained volunteer operators (most of whom are HIV-positive) can help with questions about HIV treatment issues, research, or access to therapies, and can send written information on a variety of treatment related topics. All services are confidential and free of charge. The hotline also accepts collect calls from incarcerated persons.

Over the years, the number of hotline calls from women have increased, reflecting the growing number of women facing HIV. Currently, women make up 20% of HIV-positive callers and over 1/3 of total calls. Half of the hotline calls are from first-time callers. A first-time call can be tough, but remember, it's confidential.

Here are some tips to consider before making a call:

- Think about what you want to know about. Prepare and write down some questions in advance.
- Ask a friend or support person to help you with the call.
- If you have internet access , check out Project Inform's treatment information at *www.projinf.org.* It may give you some thoughts about things you'd like to discuss.

The operator will probably ask you some questions to better understand your situation. If the operator uses words you're unfamiliar with, ask her or him to explain them. Be persistent in getting the information you need. Request written information. It will come in a simple envelope with Project Inform's name and return address on it. If you prefer, it can be sent with no identifying return address.

When I call the Hotline, will I be able to speak to a woman?

Many women volunteer at Project Inform and regularly answer hotline calls. At any given moment, depending on the day or time you call, there may or may not be a woman available to answer your questions. However, be assured that anyone on the hotline should be able to help you.

If you are uncomfortable discussing your question with a man and there are no women available to speak with you, the hotline volunteer who answers your call can give you a date and time of a shift when a woman should be available. He can simply take your name and number and have a woman return your call as soon as possible. If you have any special concerns about confidentiality or receiving a return call from Project Inform, be sure to mention it to the hotline volunteer. Our volunteers can help you come up with a solution.

Help Someone, Help Yourself

While there's a growing number of women hotline operators, we need more. If you're in the San Francisco Bay Area and interested in AIDS treatment information, think about becoming a hotline volunteer. The training is excellent. Serving on the hotline is one of the best ways to keep up with the ever changing information. Call Mark Owens at 415-558-8669 x218 for information. Hope to hear from you soon!

WORLD and ***Women Alive*** are newsletters for, by and about women facing HIV disease. Both strive to break the isolation of HIV+ women by providing a forum for communication and information of interest to women. For more information, call WORLD at 1-510-658-6930 and Women Alive at 1-213-965-1564.

PROJECT INFORM CALENDAR OF EVENTS

Consult the Project Inform website for updated calendar information.

NOVEMBER

12 — **HIV Treatment Update**; 5:30pm, St. Joseph's Medical Arts Building, Tampa, FL. Martin Delaney, David Evans presenting. For information, contact St. Joseph's-Baptist Health Care, 813-870-4760.

16 — **Case Manager Treatment Education Training**, 3:00pm, Glades Community Development Corporation, North Belle Glade, FL. David Evans presenting. For information, contact Angela Gaetano, Community AIDS Resource, 305-751-7775 x206.

17 — **HIV Treatment Update**, 6:00pm, St. John's Episcopal Cathedral, Jacksonville, FL. Martin Delaney David Evans presenting. For information, contact Northeast Florida AIDS Network, 904-356-1612 x45.

19/22 — **AIDS, Medicines, & Miracles**; DFW Lakes Hilton, Grapevine, TX. Martin Delaney presenting. For information, call 800-875-8770 or email amm@inspirational.org.

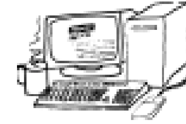
DECEMBER

5/8 — **National AIDS Treatment Advocates Forum**, Philadelphia, PA. Martin Delaney, David Evans, Judy Leahy, Anne Donnelly, Ben Cheng, and Angela Garcia presenting. For more information, contact National Minority AIDS Council, 202-483-6622 x343 or lwilliam@nmac.org.

1999

MAR — **11th National HIV/AIDS Update Conference**, March-26, 1999, 23Bill Grahame Civic Auditorium, San Francisco, CA. For more information, contact KREBS Convention Management Services, 415-920-7000.

OCT — **1999 National Conference on Women & HIV**, October 8–12, 1999, Los Angeles City Convention Center. For information, call toll-free 877-266-3966.



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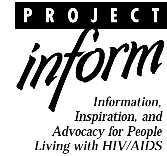
Project Inform's
Treatment Website!

Visit us at **www.projinf.org**



Project Inform, established in 1985, is a national, nonprofit, community based HIV/AIDS treatment information and advocacy organization, serving HIV-infected individuals, their caregivers and their healthcare and service providers. We serve our constituents through the toll-free National HIV/AIDS Treatment Hotline, *PI Perspective, WISE Words* and other informational treatment publications, educational Town Meetings, online services, and research and drug access advocacy programs. All information is available free of charge. All programs depend on individual, foundation and corporate grants. Your support is strongly encouraged.

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As a Pledge Partner, you can spread your tax-deductible gift into monthly payments. Pledge Partners and Partners in Hope receive *"What's New?,"* our monthly treatment newsletter.

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Yes, I want to help Project Inform remain at the forefront of providing important HIV/AIDS treatment information!

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WWRD

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