

Learning to Forgive

When I first found out I was HIV positive in October 1991, I began to drown deeper in a world of bleakness, sadness and self-pity. The years of traveling through life on my own self-will was now crashing in all around me. I couldn't believe that this was happening to my family and me. Immediately my feelings overwhelmed me, I became angry, confused, ashamed, scared, embarrassed and humiliated. How could I tell my family? How could I go on? How long do I have to live? A million thoughts went through my head. It never occurred to me that I could probably learn to live with this illness called HIV.

I felt that people would reject me and I would die, at any time, at any moment. I didn't believe I could find the faith or have the courage to deal with my new-found truth, so I decided to go into hiding. I stepped into a closet of loneliness, darkness and fear and I remained there for six years. I didn't feel worthy of an intimate relationship. I felt dirty and contagious. I also emotionally disconnected myself from family, friends and my children because loving anyone was painful since I didn't see myself living much longer. The emotional pain overwhelmed me to a point where I felt that I was losing my sanity. Trying to hide the truth was becoming more complicated. I didn't talk about being HIV positive; nor did I visit the doctor to check on my health. I started to use drugs, more in combination cocaine, heroin, and pills—Valium and Xanax. I drank and used street methadone spit from the owner's mouth. I was mixing it all, and I would often find myself in a semi coma state of mind. My self-worth, what little I had was slowly dying and my spirit was broken. I kept everything buried deep in my soul for years because I had no idea how to deal with my



BY WANDA

emotions. The drugs helped me to be numb, every day, all the time. I later learned in my addiction that no amount of drugs could numb everything.

I had been in and out of jail since I was 18 years old, mostly for shoplifting. In 1996, at the age of 36, I was arrested for the last time and felt that something had to change. I was on a course of self-destruction, and my sanity was being gravely compromised. I was angry with God because I felt he had overlooked me with many of his blessings. What kind of God would allow me and my family to suffer this way? It was God who had taken my only brother away in a painful death.

There was nowhere else to turn, no one to talk to, so I set aside my anger with God and prayed, asking him to please help me. I was a torn little girl, filled with grief and spiritually disconnected, wearing a mask of lies, in an adult body. I was for the first time, uncomfortable in the jail environment because now I would be labeled as that girl with AIDS. I was baffled and afraid, but I knew in my heart of hearts that I didn't have the strength to continue to hide. No longer could I deny my truth. How could I move to a place of self-love and trust? A place of forgiveness?" It came to me that if anything were to change in my life, I would have to be the one to look at and deal with my past to move forward and deal with the future.

I needed help. I had to learn how to find the good in what I thought were bad and painful experiences. I remember one time, there was this dance director who came to my elementary school, we were told that he would choose four dancers to take back to Africa with him. I had a worn leotard, that thing was falling apart, I had safety pins everywhere but I danced anyway. I was one of the girls chosen, but I can remember my mother saying "I ain't got no money to send you to no damn Africa." Thinking back on it now, my mother was probably just afraid of her only daughter going halfway across the world. Nevertheless, my not going to Africa was

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painful, because it meant so much to me. But now instead of focusing on what could have been, I have chosen to embrace the little girl that found the courage to dance anyway, regardless of the fact that we couldn't afford a trip to Africa or even a new leotard. I have learned to find good, even in times of loss. My brother Skip, passed way in 1992 due to AIDS related complications. Skip was a very loving and giving person to all that knew him. From Skip I learned to recognize and accept compassion and to be compassionate to others. Skip died keeping his AIDS status away from his family. I began to understand what loneliness and fear he must have felt during that time and it's my wish that no human being ever dies that way—alone! I knew that I would have to reach out to others for the help I needed before I went crazy. I asked to see the counselor in my unit and told the officer it was an emergency. I knew if I didn't talk to someone quickly I would change my mind and remain in hiding.

The counselor came and after making sure no one else was in earshot I mumbled the words through tears of shame that I was HIV positive and needed someone to talk to. In one week I spoke with the counselor, a mental health supervisor and a female intern in mental health. They each asked the same question—was I going to hurt myself. I felt that they didn't understand what I was going through and I didn't want to share my shit with a man. So I agreed to see someone from Whitman-Walker Clinic. They would understand! When Greg came, he too was the wrong answer, simply because he was male. Never mind his impressive experience and compassion in the field, I couldn't get past him being a man. My having HIV was embarrassing enough. Greg referred my case to a female colleague. We talked for hours, she noticeably felt my pain, but she made it clear to me that she wouldn't return unless I saw a doctor and faced my health issues. I thought who in the hell does she think she is. I don't need her!

I saw the doctor despite my wariness because I desperately needed her to return to talk to me. After awhile I also entered a women's support group and received one-on-one counseling so I could talk about things that I couldn't share in a group. The many years of stuffing my feelings meant that I needed to do a lot of work. I started to read inspirational books to heal my damaged self-esteem. I started collecting quotes by other people, words of meaning and hope that touched my heart enormously.

For forty months I talked and I cried and I kept reading about people overcoming difficult situations in their lives. My attention shifted from being afraid of being found out to ridding myself of the pain. Day by day, slowly but surely, I began to notice a sparkle of light in the darkness of my life. One of my mentors told me that I had to look in the mirror, and say, "I forgive myself." At first I couldn't even look myself in the mirror. I would steal a glance kind of sideways and quickly look away. In the past I sought redemption from other things, and not from myself and that's where it has to start.

Since being released from prison, I find that my growth process is at a total different level. Now I must heal my family relations and be a positive example for my children, someone they can trust to be there for them. I am learning to live life openly, taking risks with each new day, which means often stepping outside of my comfort zone. I must continue to trust my spiritual self and inner qualities. I need to learn the art of acceptance and forgiveness. Staying focused I choose to take care of myself by attending AA/NA meetings, seeing a therapist, and going to church. I visit the doctor and the dentist on a regular basis through the Whitman-Walker Clinic. I take my HIV cocktail medications, a regimen I'm able to tolerate twice a day.

Whitman-Walker referred me to The Women's Collective for family-centered case management. Once there, I was received with open arms and provided assistance from their food bank. Their program also provides metro and/or bus tokens weekly for transportation to appointments. I receive child-

care assistance that helps me bond with my children, I was afforded the opportunity for my family to attend the circus together. My case manager referred me to the Carl Vogel Center for nutritional counseling, monthly acupuncture and massages that help me with my neuropathy in my legs and feet. She also referred me to Our Place, where I received clothing. I was also referred to the Women's Initiative Program where I receive a small stipend weekly for my participation in their HIV support group that is geared to empowering women with HIV/AIDS. I attend The Women's Collective coffeehouse where women of different backgrounds meet twice a month to share their concerns and hopes in a laid back environment.

My case manager assists me with any concerns I'm experiencing. She's also a good listener. At my request, she will accompany me to appointments that take me outside my comfort zone like a job fair and applying for housing. I also receive peer counseling at The Women's Collective, which helps me to remember it's okay to keep off the mask of my past. The Women's Collective is empowering me by allowing me to tap into my inner qualities, like my writing and communication skills. It's a place where I'm heard and hugged, plus reminded how special I am, how valuable I am to my community. It's a safe haven at a time when many of life experiences, being clean and sober, are new to me. I'm treated with dignity and respect and it's a blessing to be a part of their organization.

Deep in my heart I know that Skip is watching me and watching out for me. That he is proud that his big sister finally stepped out of that closet into the sunlight. Now I am working on the process of forgiving myself, spiritually and emotionally, inside and out. I'll close with my favorite quote.

*"Forgiveness is not an occasional act;
But a permanent attitude."*

Martin Luther King Jr. 

Still Here

Still here. I'm still here. I find myself saying those words in my mind and in my spirit constantly. In 1986 I was given less than two years to live, looking back almost fourteen years ago. I have had 0 t-cells, I never ever thought I would even see 1990, so you can imagine how I feel about being here in the new millennium. Trust me, I wasn't worried about the Y2K crisis. I was one of those people that right after my diagnosis I prepared for my death. I prepared by getting things in order for my children to live after I was gone. I bought my burial plot, decided who would take my children, and did a will—Year 2000—I'm still here.

I tossed and turned in the middle of the night waiting, aware of each breath, aware of each heart beat, praying that if God would let me live I would continue to help others and I would never take life for granted. With each illness, excruciating migraines, bouts of diarrhea, stomach pains, tingling in my feet, thinning hair, all of which I thought were signs that I wouldn't be here much longer. Of course, like most of us I never talked to anybody about death. I have dear friends and family but I wanted to spare them my pain and fear—its awkward for them because they can't do anything to help you. So much of life's journey, we walk alone.

He was my first love, we struggled through some hard times and just when we reached the happiest times of our lives he died. There are no words that seem fit to describe the pain, so for fear of minimizing it, I kept it to myself. I never ever thought of living without him. But the next morning I got up because there were children to feed and

take care of. I'm still here. She was my youngest daughter, my baby; I have no pictures of her where she is not smiling. She carried a Winnie the Pooh to all of her operations, and to each doctor's appointment, literally hundreds of doctors' visits. I buried my precious baby, a few months after my husband. I thought children are supposed to outlive their mothers and that mothers are supposed to protect their children. I felt so guilty, I still feel guilty that this all happened because I carried her inside my body. I hated God. I would have done anything to exchange places with her. There are no words, to describe a mother's feelings of passing this virus on to her child and the child then dying. I wanted to die. *I'm still here.*



BY PAT

My story is no different than thousands of other women across the country, around the world. In that you can find sadness, in that you can find strength and hope. We learn that life goes on even when we don't want it to go on—both the good and

bad of life. You think that AIDS might be the most devastating thing to happen to you but then your son is murdered, or you get HIV and a few months later you're diagnosed with breast cancer or your child is hit by a car. You think that AIDS might be the most devastating thing to happen to you but then you meet a person who loves you and you get married, or you buy a house, or you accomplish your life's dream. Through it all we survive.

We all hear it, mostly from our HIV negative friends, "take it one day at a time". Trust me, there have been times, when we have to take it one hour at a time, one minute at a time, to keep from breaking down, from going crazy, from giving up. Late nights, after you turn off the lights and discover that there is nowhere to run, you cry so hard you can hardly breathe, only to wake up the next morning ready for another day. *I'm still here.*

People ask me all the time how did you create this organization. I used to say it was easy I just wanted to meet other women, but I've come to realize that it wasn't easy, not then and definitely not now. This organization started out of sharing some food and inviting people to talk, out of it came hope, encouragement and a network of women helping each other to survive. Out of it came women who in many ways are like sisters. From these women came ideas for our programs and services. From my couch in my living room to an office on Dupont Circle and now into an even larger office space, on the U Street corridor. From me to a staff of seven. People have visited us from all over the world to talk to us about The Women's Collective's unique programs, hoping to duplicate our work in their homeland. And we have the wonderful opportunity to learn from them as well.

From then to now, we have created something good, wonderful and powerful. But the fact that we exist because so many of our sisters are living with HIV/AIDS is unacceptable, painful and heartbreaking. Every day we meet incredible women who may come to us for help but they also help us by sharing their love and support with other sisters. Sometimes we have really hard days, we lose someone we love, or there is a family in crisis, or someone is in the hospital. We work with a lot of newly diagnosed women and young women and in each I see myself thirteen years ago, and I see myself now. The fear, the anxiety and as each of us shares a bit of ourselves, both the tragedies and triumphs of our lives, we take from each other the lessons of life, of finding ways to get through the day unbroken, of finding ways to get through the night a little less afraid, of finding ways to embrace both the good and bad of life.

I never got to an undetectable viral load; my t-cells hover around 150, not much higher, not much lower. I'm still here. Took the genotype tests and I am resistant to most of the drugs out here but I'm still here. I never thought that I would see my daughter reach high school—she will be graduating from college soon, and my son will be graduating from high school. Do I dare dream about tomorrow, about grandchildren, and weddings and seeing my son graduate from college of course I do. Are there still days when I think that each day brings me closer to death of course I do. But most of all I think—thank you God, because today, for now through good and bad, *I'm still here.* 

Patricia Nalls is the founder and Executive Director of The Women's Collective.



We've Moved! The Women's Collective is now located on the U Street corridor in larger offices in order to better serve women and their families. We are located at 1436 U Street, NW, Suite 200 accessible via the Metro Green Line U Street-Cardozo station or the 50, 52, 54, 90, 92, 94, 95, & 96 bus lines. **Please visit us soon!** Our phone and fax number remain the same.



Hot Fun In The Summer Time!

The Women's Collective sponsored several fun events for children and families this summer. We took a vanload of moms and their children to Oxen Hill Farm where they were treated to a reenactment of a 16th Century wedding; afterwards the kids enjoyed a picnic with hotdogs and snacks. Also this summer the Mystics, Washington's WNBA team, gained fifty new fans, as women and their families cheered them on in adown to the wire battle against the Charlotte Sting. The D.C. Care Consortium donated the tickets.

Over twenty lucky children were able to attend a week of Summer Camp 2000 sponsored by Hillbilly Haven in Brandywine, Maryland. The Executive Director of Hillbilly Haven, Diana McConaty started the Christian summer camp as a way to make a difference, as she says, "There is plenty any ONE of us can do!! Now is the time to take back our children and give them hope and a future" The children enjoyed bible lessons, crafts, workshops for puppetry, step dancing and basketball. The last day of the camp is a celebration of step dancing, games, ponies, moon bounces and a barbeque. Thanks to Hillbilly Haven for welcoming our kids with open and understanding arms. We will end the summer with a big surprise, a trip to a local amusement park, where children will enjoy a full day of rides and food. Before you know it our children will be back to school.

We hope this summer of fun renewed their spirits!



THE WOMEN'S COLLECTIVE CASE MANAGEMENT PROGRAM

BY BELINDA ROCHELLE

"I need a doctor, where can I get medical care?"

"My child is having a hard time with my diagnosis, we need to talk to someone."

"I'm afraid to talk to my partner, he might hit me."

"I need help and I don't know where to turn."

One of the first steps to getting help for you and your family is to get a case manager. The purpose of case management services is to help you and your family, get all of the care you need. Our goal in providing these services is to empower women through education, by helping them to understand the who, what, where and how of the health care system. We help you to understand how you can get all of the care you and your family need. We provide peer support with a peer advocate (also referred to as an access advocate) who is another woman living with HIV/AIDS, whose job it is to walk this journey with you.

The Women's Collective case management program creates connections between you and service providers. We're your advocates, if you don't feel comfortable, or you're having problems with a service provider, we're there to represent your concerns. You need us to go with you to see an attorney, or to disclose to family members, or to intervene in a time of crisis -

then we're there with you. We understand the fear and negative attitudes from providers that can make you feel ashamed, we understand blaming ourselves, we understand all of the things that ultimately discourage women from seeking the services that could save our lives.

We understand because we are a unique organization, one created by a woman living with HIV/AIDS. We are run by and for women living with HIV/AIDS and their advocates. The core of our case management program is peer based which means the services are based on the lessons from our experiences as women living with HIV/AIDS. Our services are based on our intimate knowledge and understanding of women's lives, and women's life choices as individuals and as members of a family.

Our case management team has over twenty-five (combined) years of experience in the conceptualization and implementation of pro-

grams and services for women living with HIV/AIDS and their families. We assign you to a case manager who serves as your lead advocate and a peer advocate, a woman living with HIV/AIDS. Each case manager has experience working specifically with young people, women and families dealing with substance abuse, HIV/AIDS, homelessness and a wide range of other health and mental health issues.

An access/peer advocate is also assigned to you. She is there with you every step of the way, to provide emotional support. The access/peer advocates are women who have also dealt (and continues to deal) with the unique challenges and issues of being a woman living with HIV/AIDS. Our access/peer advocates meet with you to talk about your frustrations and experiences, share information, as well as encourage you to set personal goals for living with HIV not dying with HIV. Peer focused means that we place a priority on women with HIV/

AIDS helping other women with HIV/AIDS by providing encouragement and empowerment in a nurturing supportive environment. We deal with all matters of the heart, because they are just as important as other types of services and support. As a result our program has a set of guiding principles that include the key words: comprehensiveness, coordination, collaboration, and most importantly self-empowerment.

In essence when you walk into the doors of the Collective to get case management services you have “hired” us to be your partner in getting the care and services you need. The Women's Collective case management services are family-centered. What does that mean? It means that we provide services for the woman as a client, and also for her children and other family members. Why is that important? It's important because most of us don't feel well unless our “family” (however you define your family) is okay. Your emotional well being has a direct relationship to your physical well-being. Ask any mother how she's doing and within minutes she will tell you something about the kids.

If you don't have food or clothes for the kids, then you're probably not thinking about taking your medications. If you can't pay the rent, then you probably won't think about taking care of your health. So that's where Pat began when she started the organization and it's at the core of our mission. We wanted to change the status quo, we did not want to force women into a rigid program

model, that doesn't work for women and families, but to build a program out of what we know about women's lives as mothers, as caregivers for their partners, their parents and significant others.

Since many women's lives do not fit into the traditional model of care we provide services in our offices, a coffee shop, her home or any other place convenient for her. Our hours extend beyond the traditional hours of 9 to 5. Case managers are available on Wednesdays from 9:00 a.m. to 9:00 p.m. On the 4th Saturday of each month case management services are available from 12:00 p.m. to 4:00 p.m. If it is more convenient for a woman to meet with us outside these hours we do whatever we can to meet her needs.

In addition to experience, a committed staff and nontraditional hours, we also have collaborative relationships with other health and social services providers to help you and your family get the services you need. We do not limit our network to traditional AIDS service organizations. We provide referrals, linking women to culturally appropriate programs that provide the following types of services:

Family Support Services include services that respond to needs as identified by your family. These services may include parent networks; baby-sitting/daycare, parenting classes, respite care, tutoring programs, bereavement counseling and any other assistance that helps you and your family

handle day-to-day activities.

Primary Medical Health Care includes public and private health care professionals, services that support and/or deliver in-patient, ambulatory and community-based care to meet the health needs of you and your family. Our current network includes primary care centers, health maintenance organizations, private specialty care providers, hospitals, public clinics, neighborhood health centers, and home care and community health agencies. These health care professionals have expertise in areas such as child development, dentistry, treatment education, home health care, nutrition, and physical therapy among others

Psychosocial Care can help you and your family, manage the stress of living with HIV/AIDS. Our network of providers includes community psychological services for families. These folks can help you evaluate family dynamics and manage problems like depression and bereavement. We also provide one-on-one peer counseling and three peer support groups for women, lesbians and African women

Job Training and Education referrals can link you to training centers/schools and/or employment services.

Entitlement and Legal Services, if you've been denied benefits (including Medicaid, SSI, and SSDI) or you face other legal issues (i.e. helping to plan for who will take care of you children in case of illness or death and child support). Our case management

team can link you to organizations that provide legal services at little or no cost to you.

Our staff can also provide referrals for transportation, emergency financial assistance, treatment and referrals for domestic violence and other agencies including those that specialize in substance abuse treatment. We don't just hand you a piece of paper and tell you where you to go, at your request we will go with you, but whatever the situation we try to address barriers to access by linking you to respite care, childcare support and even transportation services so that you can get to appointments. Our case management team is aware of eligibility guidelines and waiting lists for programs so that you're not sent on a wild goose chase.

We provide several levels of case management services. Supportive case management helps those of us who require limited services for example entitlements assistance and information. We also provide intensive case management services to help those of us who have multiple issues that may include substance abuse, homelessness, being recently released from jail or prison and providing for children who are HIV positive and/or HIV negative. We also provide a short-term intervention that provides consultations and/or referrals for food, the AIDS Drug Assistance Program and other services. You may need a case manager for one thing that takes an hour, or you may need help and support over a long period of time, either way The Women's Collective case management team is ready and willing to help you and your family.



Do You Need Case Management Services?

- **Identify Your Needs**

Although we all WANT that vacation to the Bahamas, the first step is to identify what you really NEED to maintain your mental, emotional, physical and spiritual health. If you don't know how or where to turn to get these needs met then you might need a case manager.

- **Identify The Needs OF Your Family**

Next, identify your family's needs. Is your partner having a hard time dealing with your diagnosis? Are you having a hard time finding a doctor for your child? If your family is having a difficult time then, of course, it affects your mental and emotional health, family centered case management program will address your needs *and* the needs of your family members.

- **Access and Referral**

We all know that in this life, it's not what you know, but who you know. Sometimes it can be intimidating to call a physician's office. Sometimes it's hard to tell someone that you need a place to live or you don't have enough food. A case manager can help. They know whom to contact, where to go and the eligibility guidelines for services.

- **Coordination and Planning**

You have too many appointments, all at the same time and in different places. Your daughter has a dental appointment, you need to see an attorney because you've been denied disability and the food bank closes early. Our case management team can help you come up with a plan, or coordinate a schedule that makes it easier for you to access services.

- **Peer Support**

You need someone to talk to? As well meaning as most service providers are, no one can ever really know what it is like to live with HIV/AIDS, that's why a critical member of our case management team is a peer advocate, a woman living with HIV/AIDS who is here to provide emotional and other types of support.

- **Reaching Your Goals—Empowerment**

The Women's Collective case management program links women and their families to a comprehensive network of psychosocial, primary medical and peer-based support and services. We believe that the key to good health is empowering women with HIV/AIDS to make their own health care choices based on accurate, culturally appropriate education and services, peer support and advocacy. You don't have to do this alone that's what case management is all about, it is a program designed to help you to take care of you and your family.



CASE MANAGEMENT PROGRAM EXPANDS

One of the hardest things about establishing an organization is hiring good, committed staff people, its complicated and difficult, a little like finding pieces of a gigantic puzzle. It's a time consuming process. We are dedicated to finding people who not only "know the job" but are also committed to respecting and honoring the women The Women's Collective works with and for. The Women's Collective has been fortunate enough to hire two new staff members, Brenda Hicks and Kelly Jones to join our case management program. Antoinette Cash is also an important member of the team, serving as a peer advocate, a woman living with HIV/AIDS who provides emotional support and also expertise in helping women get into a system of care. The entire team, led by Pat, is driven by a passion to do whatever they can to be strong advocates for women and their families. The team's professionalism, commitment and dedication are obvious to anyone who has had the opportunity to meet our two newest team members. For the rest of you who haven't had the chance to get to know them, we provide the following profiles to share their journey to The Women's Collective.



Ask any case manager why they want to be a case manager and the likely answer is that they want to "help" people. For Brenda Hicks, a new case manager at The Women's Collective her answer is no different. Born in New York and raised in South Carolina, Brenda credits her grandmother and the close-knit neighborhood where she grew up as a child for her choice in a career. "There were many families working hard,

trying to raise their children. I was the kid in the neighborhood who would organize trips for the other kids, even to the point of making permission slips." she remembers.

She moved to the Washington, DC area in 1990 to attend the Doctoral Social Work Program at Howard University. With over 20 years experience as a social worker in the areas of mental health and health services, she has worked in numerous settings: hospitals and community based agencies, working specifically with young people, women and families dealing with substance abuse; HIV/AIDS and a wide range of other issues.

"I've seen discrimination against women and their families, where the system is not really interested in working with families, but working against them in very punitive and coercive ways, or without concern for the family as a unit. For example, making appointments for women without thinking she may need childcare

or transportation, without thinking that she may have a sick child at home, the focus is on the individual as a client, and for women that doesn't work."

She also acknowledges that many social services agencies are reluctant to deal with families' infected/affected by HIV/AIDS. She feels that many organizations don't know how to provide appropriate services and only apply for the grants because they need the money. For Brenda being a case manager is a hard job but a simple one—a case manager must be an advocate and must value the women and families that they work with.

"We're glad she's a part of The Women's Collective. She brings to the team a wealth of knowledge and experience, especially working with service providers outside of the AIDS network." Said, Patricia Nalls, "There are numerous resources available and the key is knowing where to go and whom

to contact, Brenda knows the community well.”

Brenda has worked with a lot of new case managers and social workers just out of school, as well as with social workers with many years of experience and she is often amazed that even they have a hard time defining case management.

“Say for instance a woman needs assistance, and she identifies her needs, then as a case manager it’s important that I am also aware of her family unit. She may have her mother living with her, serving as the caretaker of her children. We then have to ask ourselves, well what does that caretaker need or what do the children need also because that will have a direct impact on that woman’s health and well-being.”

One of the reasons Brenda decided to join The Women's Collective is to fulfill a desire to work for an organization that really wants to provide family-centered case management and she is excited about the success of The Women’s Collective’s programs.

“It’s different and very much needed.” She admits that the peer base and peer focus of the program is new for her, but that it is just another example of The Women's Collective emphasis on the importance of providing emotional support for women and their families. From transportation services, to respite care, to parenting classes to self-esteem building, to primary medical care or housing, the mission of The

Women's Collective family centered program is to identify, link and coordinate all of the services women *and* their family’s need.

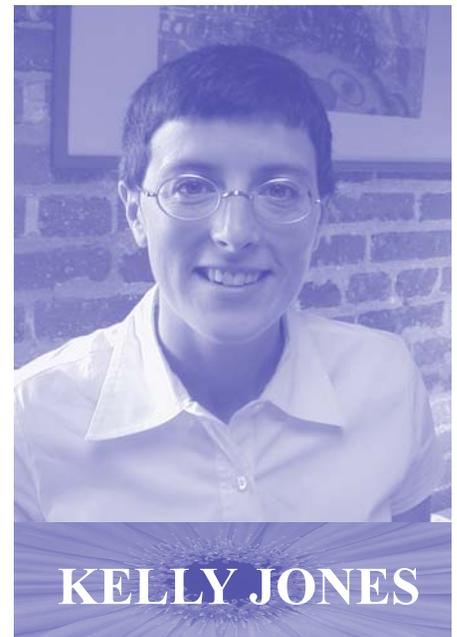
For someone who has been in social work for as long as Brenda, it would be understandable if she exhibited signs of burnout or skepticism, but she makes it a point to turn inward, and reflect on her motivation.

“I think that its important for a case manager to be aware of themselves, to truly understand their biases, it’s the only way to be objective and nonjudgmental. I need to be honest about the things that push my buttons, because you may project that onto a client and that would be unfair and get in the way of doing a good job.”

Brenda maintains strong connections with her own immediate family, taking the time to help raise her niece. She owns a home in South Carolina where she makes frequent trips to visit old friends and contemplates returning there to settle down and live.

“It’s a way to reenergize myself, reconnect to my grandmother spiritually who instilled in me that spirit to help others.” She says as a smile flickers across her face. “The Women’s Collective has the opportunity to do something incredible not just in the field of HIV/AIDS, but also in case management in general. We can try new things and we’re evolving to give women and their families the services they not only need, but they deserve. I learn a lot from the women we work with. Many come

here with a strong sense of determination and perseverance. I sometimes wonder if I could personally cope with many of the problems that they have to deal with day-to day. I haven’t met one woman who was ready to give up and I think that says a lot about each of them.” 



Kelly Jones is the newest member of the Women’s Collective case management team. In the past she has worked for several local organizations and agencies including, Bread for the City. In addition to working full time at The Women's Collective she is also currently attending Catholic University completing her Masters in Social Work. “When I learned about the work and everything that was going on here, the mission of the organization, I was excited about the possibility of working here. I liked it because it was a women’s organization and it was a small organization with innovative ideas and ways to provide services.” While her previous work and educational experiences are

beneficial to her in her current position as a case manager she knew from the beginning that the work would be difficult and hard for a lot of different reasons. Now almost six months later, Kelly's opinion about the job hasn't changed, the work is hard, but it's a job that she enjoys because it presents constant challenges.

"Although Pat hired me for this position I also feel that when a woman walks through that door she in affect has also hired me and because I've made a commitment to do this work I'm going to do everything that I can to help her." Kelly visits women at their homes. She advocates for them with different agencies. Whether its going to a meeting with a woman at the Department of Public Housing or filing the paperwork necessary for a woman to get entitlement assistance, Kelly is there to provide as much support as possible. While her work experience at Bread for the City prepared her for certain aspects of the work, she readily acknowledge that the AIDS arena is different and that the peer-based aspects of the case management services are so critical.

"I know I don't have all of the answers. Having Toni and Pat as a part of the team is important because they have a lot of experience both professionally and personally. They know what a woman may be going through in a way that I can't." In many instances women will share something with the peers that she wouldn't share with a case manager. That's why a team concept is vital in addressing the needs of women and their

families who may be dealing with multiple issues.

"Needing a case manager is not a bad reflection on a woman. It doesn't mean that she doesn't have the strength, the will, the intelligence, the ability or the time to find services for herself or her family. It just means that she needs someone to help her sort things out." Kelly says.

If you spend any time with Kelly the first thing you notice is her quiet enthusiasm for her work. She's on the go a lot. She's helped one woman to move, literally carting boxes and furniture; she met with another woman at a shelter to complete paperwork; or, sometimes she's on the telephone returning a call to just reassure a woman that everything is going to be all right. Either way, she's reaching out in ways and at times that women want and need. And, judging from their response to Kelly, it is not a stretch to say that women like to work with her.

"I'm always thinking about my work. I just try to focus on what we can do to help women and their families and I'm thinking about that all the time. And if I know deep down inside that I've done what I'm suppose to do, and everything that I could possibly do, then I feel that I am doing a good job."

And while the job can be very rewarding, Kelly is also aware that AIDS is a life-threatening illness and that losing a woman is a real possibility.

Less than two months on the job she lost one of the women she was working with. "While I knew coming into this work that there was a chance that death could happen. It was difficult in the sense that I wanted to do something. I tried to be there for her husband, helping him to get some things in place. It was so hard, when she was in the hospital I was so upset for him and when he called me up and told me that she died, he was so calm. While I know I helped in some ways, I learned a lot from him too." The emotional support is an important aspect of the case management team's work. Often women and their families need emotional support, hope and encouragement, throughout the continuum of this disease in order to fully benefit from other types of services.

Originally from New England, she moved to Washington years ago. Still practically a newlywed, Kelly and her husband, Peter, have been married for just a year. They live in N.E. Washington and share their household with two dogs, Lacy and Jasper. Ask her what she likes to do for fun, its not surprising that her answer is running. "People ask me all the time who do I work with and I tell them that I like my job because I work with six women, all of us are different, we come from different backgrounds and experiences and yet somehow we all find ourselves at this place—it sounds hokey to call it fate, but what else could it be. I feel like this is the right place and I'm supposed to be here."



Just a Sister Away

Washington, D.C. is one of the most diverse cities in the world. With a large predominately African American population, “Chocolate City” as it is known to some, is one of the most cosmopolitan cities in the United States. The nation’s capital is home to a large, diverse immigrant community. Walk down certain streets in the District and ask someone where they’re from and you’re likely to hear “Trinidad or El Salvador or Malawi.” And while there are many differences among cultures, there is often a common struggle—AIDS continues to touch the lives of people, especially women and children everywhere.

Coming through the doors of the Collective are women and families from around the world. They seek support, information and technical assistance about how The Women's Collective does its work. When Chatinkha Nkhoma walked through our doors, we met a strong activist living in Maryland but committed to working with women and families in her native country of Malawi. When Mark* came to us he was struggling to reunite his wife and daughter, both living with HIV but unable to join him in the United States because of their HIV status. We have met with a group of physicians, nurses, and advocates who shared the story of the port city of Odessa, in the Ukraine with over 25,000 HIV/AIDS cases. They talked about the experiences of families who face the stigmatization, discrimination and isolation of HIV. Sounds all too familiar doesn't it?

What is so disturbing is that the very issues we have dealt with in this country, ten years ago, people in other countries are still dealing with today. When people come to us about how to help their loved ones in their native countries we are painfully aware that we don't have all the answers to their

questions. We can't make pharmaceutical companies make medications affordable and available. We can't make the government disseminate AIDS prevention material. What we can share is The Women's Collective story of how to start a peer-based organization out of one's home. We can share how you can build a support network that isn't government sponsored or supported. We can share how AIDS education can begin with one person simply sharing what they have learned with another person.

So we decided to feature this new column—Just A Sister Away. We asked Dr. Chad Womack, a Staff Research Fellow, at the National Institutes of Health to chronicle his recent trip to India and Africa. In this column we hope to share similar struggles and lessons learned; this is an opportunity for all of us to become aware and educated about the lives of our sisters who are not as far away as you might think.

**Name has been changed*

It Takes a World Community

By Dr. Chad Womack: *Staff Research Fellow, at the National Institutes of Health*

If someone were to have told me, back in the fall of 1993, that I would be walking the streets of Mumbai (formerly known as Bombay), India in the red-light district, I would told them that they were crazy. But, that's exactly what I have been doing since 1996 when I traveled to India for the first time, exploring the myriad of HIV/AIDS clinics and hospitals in Mumbai in an attempt to understand what the disease has meant for India, it's society, the health care infrastructure, the doctors, and most importantly, the patients and their families. I have learned a great deal since then about this disease and how it manifests in the unfortunate loss of life, and how HIV positive individuals and their families struggle to cope with the dramatic effects of the end-stages of AIDS.

Perhaps the first thing I appreciated about HIV/

AIDS in India was the difficulty that physicians had in communicating what HIV infection meant to patients, many of whom were not formally educated. For many of these patients, the terms HIV/AIDS did not register, and had little to no meaning until the doctor explained what exactly HIV infection would eventually mean in terms of prolonged care, probable TB infection, and loss of vitality. I recall one mother who, upon learning for the first time that she was HIV positive (even though she had been at this particular infectious disease clinic for over 6 months), responded immediately by asking if her two children would be okay. Through a friend who was translating, I came to understand her situation and why she had come to Mumbai from her village. She had been widowed by her husband several years prior, and had been thrown out of her in-law's family home, her community and even village as she was blamed for her husband's untimely and mysterious death (due to AIDS)- the proof for them being the growing rash on her chest. So she left with her children, arriving on the doorsteps of this clinic by herself, homeless and without knowing where else to go. The doctors and counselors at this clinic treated her for the rash, but did not explain to her that she could be at risk for HIV infection. So there she was, a widow, a mother with two children in foster care, and just learning that she was HIV positive.

This was my introduction to HIV/AIDS in the developing world, and was an experience that fundamentally changed my life and gave me a different perspective on being an HIV/AIDS scientist. Because of this transforming experience, I began to appreciate how the complexities and imbalances that exist within Indian society were being impacted by an emerging HIV/AIDS epidemic—the striking contrast between what was available for private-paying versus public patients, the inherent cultural complexities of Indian society, the lack of effective and affordable medications for public clinic patients, the continued stigmatization of those af-

flicted with HIV/AIDS, and the list goes on, I sensed the growing frustration of those engaged in the fight against HIV/AIDS in India, including the doctors who work hard despite many obstacles, including the social stigmas associated with the disease, government bureaucracy, and difficulties in communication (there are over 400 different languages spoken in India).

It is ironic that in the developing world, where over 95% of the HIV infected world resides, there are little to no resources to deal directly with HIV infection.

Since my initial set of experiences with HIV/AIDS in India, I have traveled to South Africa where I have been fortunate to have met many people engaged in the battle against HIV/AIDS as clinicians, nurses, scientists, and most importantly people living with AIDS. I have been inspired by these individuals,

and by their heroic efforts against the spread of this virus. I have also learned a great deal about the definition of meaningful struggle, and how that translates into public health. Despite the ever advancing edge of the epidemic, and the rapid spread of HIV globally, I am left with a simple faith that our efforts are not in vain and that a cure or vaccine will be in sight soon. But it will require work, community and, ultimately, faith.

HIV/AIDS has challenged us to view the world as one community, one village comprised of many different huts. What affects one hut will eventually affect another. This understanding is no more poignantly exemplified than when one considers how this epidemic started. What started out as no more than a few hundred to a thousand cases of HIV infection reported in the world during the early 80's, has now blossomed to over 50 million cases of HIV infection world-wide. And the rates of infection are rising rapidly in most parts of the developing world including Sub-Saharan Africa, and Southeast Asia.

It is ironic that in the developing world, where over 95% of the HIV infected world resides, there are little to no resources to deal directly with HIV infection. HIV infected individuals and their families are desperate for antiretroviral medications, often

mortgaging their homes and possessions for access to care. This is in sharp contrast to the current situation here in the U.S. where, thankfully, most antiretroviral medications are paid for by our government. However, because most of the developing world economies are struggling, beleaguered by large international debt, their capacity to respond to epidemics like HIV/AIDS and TB are severely limited. This, of course, means that individuals and their families, are increasingly vulnerable to HIV/AIDS and, yet, do not have access to effective or affordable HIV/AIDS therapy or care.

I often hear the question: Why should we care about HIV/AIDS in the developing world when we have our own issues here in the U.S., particularly within minority communities? Despite the obvious humanitarian concerns that would inform an answer to this question, there are also some very practical issues that we face in developing new ways in which to treat HIV infection, and HIV/AIDS vaccine development. In addition, it is clear that our ability to develop a safe and effective HIV/AIDS vaccine will largely depend upon our ability to facilitate technology transfer from the developed world to the developing world, and increase the local capacity for HIV/AIDS care. In regards to the development of new therapies for HIV infection, it is in the developing world that the new treatment strategies will ultimately be tested and revised. This, in turn, means that we cannot isolate and convince ourselves that our concerns are national. Ultimately, our concerns about HIV/AIDS should be, out of necessity if not by choice, global in nature. It takes a village to raise a child, and it's going to take a world community to defeat HIV/AIDS.

Out of Africa (Part 2)

By Anonymous

In the last issue of the newsletter we shared the story of a mother living with HIV/AIDS. A new immigrant to this community she told the story of a committed husband and father, determined to bring and keep their family together,

determined that both she and their daughter will survive AIDS. In this issue we share their story from the perspective of her husband.

I once thought of AIDS or HIV as a disease that affects only others. I never imagined that any of my family members could have it because we were taught to believe that only people who are promiscuous could have this disease. My whole perception changed about two years ago when I got a reply from the INS in America telling me that I was selected to apply for an immigrant visa to come to America together with my wife and my daughter.

We were very happy after receiving this letter because we thought of America as a place where one can realize his or her dreams. I had to fill out some forms and send them back to the INS for them to approve the application. The application was approved a few months later and we were scheduled to go for an interview at the American embassy. Before the interview we were supposed to do an HIV test, I did not think the test was an obstacle for us to travel to the US because even though we had never done the test before we had never been promiscuous and I did not feel that we were at high risk. I remember my wife telling me that we should do a screening HIV test before the real test. I initially resisted and only agreed because the pressure was too much. We went for the screening test and they told us to come back for the results in about a week. I could not go for the results because I was working so I told my wife to go instead. When I came home that evening I knew something was wrong, my wife looked so sad. I was even afraid to ask her about the HIV test results. She then told me that the results came out and a technician told her she was HIV positive and I was HIV negative. I couldn't believe what I was hearing.

I told her that I was sure there was a mistake and that I had to speak to the technician. The technician informed her they had to do another test to confirm the first results. Again the results were the same, my wife was HIV positive. I was now afraid that my child might also be positive because she had always suffered on and off with fever ever since she was born. We never suspected anything apart

from malaria. My wife was very miserable after the tests so devastated that she even contemplated suicide. I had to encourage her that at least there was still hope since I was not infected and I had read that there were powerful drugs in America that could reduce the virus to undetectable levels. My wife had to do another test at another laboratory, which came out negative so we decided to take another test, this time with the embassy doctor.

My wife still had to collect these results because I was working. She got the same results, I was negative and she was positive. I still remember the humiliation my wife went through at that clinic, the doctor himself could not believe it. They even said my wife must have had the child with another man. I talked to an embassy staff person about my problem and he advised me that they would not give my wife and child a visa, that I should apply alone and as soon as I get to America I should look for a means to bring them to this country. I remember the night I was to leave my country and come to America, I was crying together with my wife. I made a promise to her that as soon as I got to America I would look for a means to bring her and my daughter there so that they could start treatment. I started working on this promise as soon as I arrived and through an act of God I got to know Patricia Nalls. She gave me all the encouragement I needed. When she told me she has been HIV positive for 12 years I was really encouraged. It made me realize my wife and child still had a chance. Most people in Africa have this belief that once you get diagnosed you are just waiting for your time to die. I shared my concerns and fears with Pat and Belinda until my wife finally came to this country last year. My child is still in Africa but I am still hopeful that she too will be here in time to start on her medications.

I would like to use this opportunity to thank Pat and the Women's Collective for all the support that they have given my wife and I through all of the difficult moments. I am using my story to appeal to the US government to modify their laws concerning HIV and immigration policies. I think HIV today is not as it used to be in the early 80's when there was no hope. Today there is hope and being diagnosed HIV positive does not mean you are going to die tomorrow. My child has been separated from us

because she is HIV positive which is no fault of hers. Nobody wants to get AIDS and yet people still get it. There are many immigrant families out here who have been separated from their loved ones just because of their HIV status. The one thing I have learned from this experience is that anybody can have AIDS. 

Contributors to The Women's Collective

Abbott Laboratories
Administration for HIV/AIDS, District of
Columbia Dept. of Public Health
Black Gay and Lesbian Pride
Broadway Cares/Equity Fights AIDS
Brother, Help Thyself
The Cafritz Foundation
The Community Foundation
DC CARE Consortium
Freddie Mac Foundation
Giant Food Foundation
John Lloyd Foundation
MEE Productions
Ms. Foundation, Women & AIDS Fund
Public Welfare Foundation
Washington AIDS Partnership
Whitman-Walker AIDS Walk Foundation
Women in the Life

*Thanks to the many wonderful individual
benefactors who also support our work.*



The Women's Collective's **drop-in resource room** for women and their families is now open complete with a TV/VCR and educational videos on many topics, as well as books, magazines, reference materials and a computer with an Internet connection. **Visit us at our new office at 1436 U Street, NW, Suite 200, Washington DC.**

ASK THE PHARMACIST

By
Anthony Ramdass

Just like your physician, your pharmacist is an important member of your health care team. We encourage you to get to know your pharmacist. They can answer your questions and in most cases they are usually more accessible and eager to take the time to answer your questions, (at least we know Tony is willing to take the time). If you have a question for the pharmacist, send it to us here at the Women's Collective or email us at womens@bellatlantic.net.

Sometimes I take my medication after the expiration date on the prescription bottle. Real deal—how long can I take the medicine after the expiration date?

All medications must be taken correctly and according to the doctor's directions. Usually medications are guaranteed for one year after it is dispensed from the pharmacy (ex. a prescription filled at the pharmacy on 4/15/2000 will expire on 4/15/2001). After a year, pharmacists, for liability purposes, cannot guarantee the accuracy, stability or potency of your medications. In the pharmacy the medication can last longer because it is kept in industry specified conditions. For example it is kept in

the original container it is shipped in by the manufacturer. It is protected from light and properly secured. Once the pharmacist places the medication in a vial (bottle) and gives it to you, the conditions of the medication changes. You might place it in a hot or humid place, you might not keep the vial cap on the bottle and you might even expose it to light. Hence, over a period of time, the potency will decrease. As a result, after a year, you may not get the full strength of medicine and the condition for which the medicine was prescribed may get worse and/or it may cause some side effects. One year is the usual and customary length of time to keep medications.

The real deal is that you should not use your medications after the expiration date!

What's the difference between generic and name brands? Is the generic as good as the name brand?

Brands are medications discovered, researched and patented by a drug company. Sometimes these drug companies spend over \$300-\$400 million dollars and take over fifteen years to discover a drug. Because of this investment of time and money the government gives the company a patent protection to recover their cost and they prohibit another company from making the same medication during the patent period. How much you pay for the brand name drug is totally determined by the drug company, it is not determined by the government, or the market-

place. Hence brand names are usually expensive. Once the patent protection period expires, many generic companies begin to manufacture the same product using the same formulation like the brand company. They too must submit studies and tests to the F.D.A. to prove that their generic product is similar to the brand name product. Only after they prove their case, that their generic drug is determined to be as safe and effective as the brand name, is the company able to sell the generic product to the public. Almost immediately you will see a drop in the price for the brand name drug to compete with the costs of the generic drug. This occurs because now that there is more than one company making the same product the price is now set by the marketplace and not by the brand name company.

There is absolutely no difference between brand name and generic medications. Insurance companies prefer to pay for generic drugs because they are generally less expensive than name brands.

What can I do if I feel that my pharmacist and/or his staff have breached my confidentiality? Do pharmacists have a code of ethics they must follow?

Pharmacists are medical professionals who must adhere to a strict code of medical ethics. We are governed by state laws and state boards. We take very serious the confidentiality of your illness and your medications and do not divulge any information unless

authorized. Pharmacists are the most trusted professionals according to a survey of the American public. By definition, every pharmacist must know by the type of drug(s) you are taking, what your medical condition is. It is important that we are aware of your illness so that we may be able to serve you better. This is important because we are trained to identify any potential drug interaction between medications and to counsel our patients. Pharmacists normally do not discuss your records, medications or illness amongst themselves or staff. However, should a breach of confidentiality occur you do have recourse. Identify the area, jurisdiction and state where the pharmacy is located and file a complaint with the State Board of Pharmacy. They will do an investigation and take appropriate action to solve and correct the problem.



Ramdass Pharmacy provides free home delivery and accepts all major health plans including: Washington D.C. and Maryland Medicaid, PCS, NY/Care, Aetna Unions, Capital Care, Blue Cross/Blue Shield, Optimum Choice, as well as other plans. You can also have your prescriptions faxed to them.

Ramdass Pharmacy is located at:

*4821 Annapolis Road,
Bladensburg, MD 20710*

Phone: 301.779.3237

Fax: 301.779.0596

*Open: Monday–Saturday,
9:00 am–8:00 p.m.*

Medications Currently Available through the District of Columbia AIDS Drug Assistance Program

Free medications are available through the AIDS Drug Assistance Program (ADAP) if you meet the program guidelines. ADAP provides medications, nutritional supplements and complementary therapies for people living with HIV/AIDS. ADAP is available in almost every state, but each state has its own eligibility requirements, and application process. Each states' drug formulary of approved and available medications may also be different and is subject to change.

Anti-Retrovirals

Abacavir (Ziagen)
Didanosine (ddI, Videx)
Efavirenz (Sustiva)
Hydroxyurea (Hydrea)
Lamivudine (3TC, Epivir)
Lamivudine/Zidovudine (Combivir)
Nevirapine (Viramune)
Stavudine (d4T, Zerit)
Zalcitabine (ddC, HIVID)
Zidovudine (AZT, Retrovir)
PCP Prophylaxis
Pentamidine Aerosolized (NebuPent)
Atovaquone Suspension (Mepron)
Dapsone
Trimethoprim/Sulfamethoxazole (Bactrim)

Antibiotics

Amoxicillin/Clavulante (Augmentin)
Azithromycin (Zithromax)
Ciprofloxacin (Cipro)
Clarithromycin (Biaxin)
Clindamycin (Cleocin)
Ethambutol (Myambutol)
Isoniazid (INH)
Ofloxacin (Floxin)
Pyrazinamide
Pyrimethamine (Daraprim)
Rifabutin (Mycobutin)
Rifampicin (Rifampin)
Sulfadiazine

Topical Steroids

Hydrocortisone cream 1%

Anti-Fungals

Amphotericin B (Fungizone Oral Suspension)
Clotrimazole (Mycellex, Lotrimin)
Fluconazole (Diflucan)
Isoniazid (INH)
Ketoconazole (Nizoral)

Protease Inhibitors

Amprenavir (Agenerase)
Indinavir (Crixivan)
Nelfinavir (Viracept)
Ritonavir (Novir)
Saquinavir (Invirase, Fortovase)

Wasting/Weight Loss

Dronabinol (Marinol)
Megestrol Acetate (Megace)

Anti-Cancer

Alpha Interferon
Doxorubicin (Doxil)

Antidepressants

Fluoxetine (Prozac)
Sertraline (Zoloft)

Anti-Diarrheal

Diphenoxylate and Atropine (Lomotil)

Analgesics

Acetaminophen with codeine (Tylenol I & III)
Fentanyl patch (Duragesic Patch)
Ibuprofen (800 mg)
Morphine Sulfate (MS Contin)

Anti-Virals

Acyclovir (Zovirax)
Cidofovir Injection (Vistide)
Ganciclovir (Cytovene)

If you are a District resident and you need information about ADAP in the District contact, 1.202.727.2500, Spanish 1.202.328.0697 or TTY 1.202.939.7814. • If you are a Maryland resident and you need information about ADAP in Maryland contact, 1.410.767-5685 or 1.800.205.6308. • If you are a Virginia resident and you need information about ADAP in Virginia contact 1.804.225.4844 or 1.800.533.4148.

OUR MISSION

The mission of The Women's Collective is to increase support and services for women living with and at risk for HIV/AIDS by utilizing a "sister to sister information highway." Our goal is to improve the lives of women and their families—giving them the hope, courage, and support they need to advocate for themselves and others.

The Women's Collective:

- Offers a wide range of **family-centered case management services** that include assisting women in accessing respite care, child care, housing, food, transportation, emergency financial assistance, etc., providing women opportunities to take care of not only their own primary medical and psychosocial needs but also the needs of their children and other family members and includes home visits;
- Conducts outreach to women living with and at risk for HIV/AIDS, with special emphasis on women who are new to care, via our **access advocacy** program. Our access advocates visit women in a variety of traditional and nontraditional settings that make it convenient for women, initiating that critical relationship that will support women to reach out and link up with other self-defined services;
- Implements **Sisters Helping Sisters to Survive**, our primary and secondary prevention program, is designed to bring women of diverse backgrounds together to promote access and linkages to care for women with or at risk for HIV/AIDS. **Sisters Helping Sisters to Survive**, trains women to work as peer counselors, helping women recently diagnosed with or at risk for HIV/AIDS by giving them hope and helping them to access services and make affirmative health choices;
- Implements **peer partners**, a program that links women who do not participate in support groups to peer advocates who support them one-on-one. For many women who remain isolated this is a mechanism through which women and their families receive hope, information, and education about services through phone calls and private, confidential meetings.
- Sponsors **information sharing meetings & treatment educational sessions** and quarterly **Sister Circles** on various topics including treatment and advocacy issues;
- Sponsors a **Coffee House support group** twice a month for women living with HIV/AIDS and their children. Also sponsors monthly support groups for **lesbians** and **African women** living with HIV/AIDS;
- Provides a **drop-in resource center** with a TV/VCR, educational videos, reading materials and computers with Internet service for women and their families;
- Publishes ***Sisters in the Struggle***, a newsletter dedicated to sharing information that is distributed to women living with or at risk for HIV/AIDS, their advocates, and to places where women seek services across the metropolitan area and other parts of the country;
- Provides **technical assistance** to local, national and international organizations and coalitions;
- Participates in numerous **local, national and international policy advocacy** activities such as the Mayor's Advisory Committee on HIV/AIDS, the Ryan White Planning Council, The DC Housing Planning Council and the Ms. Foundation for Women's Innovative Health Care Model Project advisory group for women living with HIV/AIDS.

Subscriptions to *Sisters in the Struggle*

(Our mailing list is confidential)

If you would like to have a subscription to *Sisters in the Struggle* or make a donation, The Women's Collective would love to hear from you. Subscriptions are free to women who can not afford to pay but we do ask that anyone who can afford to subscribe, please do so.

Enclosed is my yearly: ___ subscription ___ renewal ___ donation

___ \$0-20 low income ___ \$20-50 individuals ___ \$50-100 businesses, nonprofits, professionals

Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

SISTERS IN THE STRUGGLE

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By The Women's Collective

Sisters in the Struggle is a publication of The Women's Collective. It is published four times per year and distributed free of charge to women living with HIV/AIDS, local service providers and advocates. The opinions expressed in the articles in this newsletter do not necessarily reflect the opinions of the board and staff of The Women's Collective.

Want to photocopy an article out of the newsletter? Not a problem—we only require that you call us to get permission and to let us know how you want to use it. Out of respect for women coming forth and telling their stories we ask that you honor their right to share their stories in ways they see fit. Therefore, please do not photocopy the stories shared by women living with HIV/AIDS without first getting their permission (in writing) to reproduce their stories. Send your request to them in c/o of the Women's Collective, 1436 U Street, NW, Suite 200, Washington, DC 20009, fax 202.483.7330, or via email at womens@bellatlantic.net. All medical information is provided for information purposes only. We strongly urge you to consult a physician for *all* of your medical advice.

The Women's Collective is now located at 1436 U Street, NW, Suite 200, Washington, DC 20009. You can reach us by phone at 202.483.7003, fax at 202.483.7330 or email at womens@bellatlantic.net.



An Angel in Our Midst: Kathleen Stoll

We would like to thank Kathleen for her indomitable support of the work of The Women's Collective. Whether she is reviewing legal documents, providing invaluable advise or facilitating access to emergency financial assistance for women and their families, she is an incredible advocate! Thank you, Kathleen, for all your hard work and dedication!

SISTERS IN THE STRUGGLE

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