

**this
edition**

Mid-July to Mid August, 1996
Volume III Number IV

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THIS JUST IN !!!

Carol LeBlanc,
TAP's Director of Support Services
announces

**A SOCIAL SECURITY
INFORMATION SESSION**

Ted Herrock,
Director of the Portland
Division of Social Security,
will speak and answer
questions.

Also, it is likely someone from
the City of Portland's social services
will be on hand to talk
about filing Social Security
claims and grievances.

*So Come On, Clients.
Here's a great opportunity!!!*

**Thursday, August 15, 1996
at 1:15 p.m. - 2:15 p.m.
(following the regular
free Thursday lunch)
at The AIDS Project.**

MAKE IT A DATE !!!

**in the
Affirmative**

THE AIDS PROJECT

A NEWSLETTER FOR MAINE'S HIV/AIDS COMMUNITY

**our cover
story**

**THE AIDS PROJECT HIRES
NEW EXECUTIVE DIRECTOR**

The AIDS Project's Board of Directors voted to hire Stephen T. Moskey of Cape Elizabeth as its new Executive Director at its June meeting. Mr. Moskey will officially begin working on July 22nd. Mr. Moskey was chosen after an extensive national search which began last October upon the resignation of Deborah Shields.

Mr. Moskey holds a B.S., M.S. and Ph. D. from Georgetown University. Most recently he worked for Aetna Life and Casualty out of their Hartford offices as Director of Consumer Issues in their Corporate Affairs Division. He has had extensive contact with AIDS issues and organizations. Until 1990, he was Aetna's chair of their Corporate Task Force on AIDS. He serves or has served at the Maine Community AIDS Partnership, the National Health Council, the Consumer Federation of America, the National Leadership Coalition on AIDS, the CDC's Business Responds to AIDS program and the Gay Men's HIV Prevention Outreach Advisory

Group in Hartford, Connecticut. He has an extensive background in issues like AIDS, women's issues, managed care and health care reform, life and health insurance, and corporate social responsibility and philanthropy.

The Search Committee and the Board of Directors are pleased to have Mr. Moskey coming on board.

Paul Draper has done a great job as the Acting Executive Director, as well as Development Director, since last October and will continue on as the Development Director now that a permanent Executive Director has been hired.

In a recent story about the hiring, the Portland Press Herald erroneously reported that the job of Development Director had been cut in January due to a budget shortfall. That is just dead wrong and no amount of press releases seems to be able to get the Press Herald to realize their mistake.

**PEABODY HOUSE REVISITED;
THEY, TOO, HAVE A NEW EXECUTIVE DIRECTOR**
by Bethany Roma

Peabody House opened its doors to clients on February 14, 1995. It provides a home-like environment for up to six people in the advance stages of AIDS. Originally conceived of by five people, it is now a non-profit organization run by an Executive Director who reports to a Board of eleven people. Its mission is to enable people in the advance stages of HIV to live with dignity, independence (as their wellness allows) and, as much as possible, to enable residents to direct their own care.

Residents of Peabody House have their own private bedrooms. These rooms were decorated by interior designers who donated their time and talent. There is also a shared living room, kitchen, dining room, and a basement recreation room where smokers are able to indulge. The house is on the Western Promenade of Portland and

overlooks the water. The grounds are well maintained with pathways meandering through a tranquil garden.

Currently, Peabody House has a staff made up of an RN, Clinical Director, CRMA's (who are licensed to dispense medications), a Social Worker and a Doctor (who is the medical director of the house). Clients may also have their own private physicians. Skilled nursing is provided by HomeCare, CHS, or VNA/Hospice. In addition, Peabody House utilizes volunteers for everything from direct support to gardening and domestic assistance.

Tom Cathcart has been the Executive Director of Peabody House since June 3rd of this year. Tom was previously the Chief Operating Officer at Mercy Hospital and also held a position with Blue Cross prior (see pg.7)

NEWSBRIEFS

FDA APPROVES NEW AIDS DRUG

The Food and Drug Administration has approved the first in a new class of drugs. The drug, Nevirapine, will be sold under the name of Viramune. Nevirapine interferes with the same viral enzyme as older AIDS drugs like AZT and ddI. Used in combination with one of the older drugs, Nevirapine modestly lowers HIV in the bloodstream. Used in triple combination with a protease inhibitor and the results are more dramatic, according to recent studies.

INSIGHT INTO HIV'S PATH

After 10 years of intense research, five different scientific groups hit upon the same key molecule that allows the AIDS virus to infect human cells. It is hoped that this discovery will enable scientists to infect animals with HIV, which they haven't been able to do, and therefore do more testing of new drugs and vaccines.

Scientists have long known that HIV could attach itself to cells by latching onto a molecule called CD4, but CD4 itself didn't seem to let the virus fuse with a cell. The new molecule, called chemokine receptor-5 (CCR5), does allow HIV to fuse. According to scientists, CCR5 is absolutely required by HIV strains in the earliest stages of the disease.

Another molecular find, called fusin, was reported in May and appears to be important to HIV's work in the later stages of the disease.

Researchers suspect that a variety of chemokine receptors may play a role in the process. John Moore of the Aaron Diamond Center, one of the discoverers of the receptor, says, "I think we still have a lot to learn...but knowing more about how HIV gets into cells is a useful first step in finding ways to stop it from doing this."

1st U.S. CASE OF RARE HIV STRAIN

Scientists have identified a Los Angeles area woman as the first person in the United States to carry a rare strain of the AIDS virus. The finding could force changes in HIV screening tests to protect the nation's blood supply.

The rare form of HIV is called Group O and it escapes detection by current antibody tests in about one of every five cases, according to the CDC.

Antibody tests failed to detect the virus in the woman even though she had AIDS symptoms. Only when the CDC did more sophisticated tests was the virus found. The woman had immigrated to the U.S. from West Africa in 1994. The CDC says this is a very rare form of HIV and that it is the only known case in the United States. The strain does not appear to be any more deadly than the more common form of the virus.

Fewer than 100 Group O infections have been reported worldwide and is most common in West Africa. Improved tests will be available within the year and there is no added danger posed to the U.S. blood supply.

by the way

CAUSTIOUS OPTIMISM

by Mike Martin

Once again we are being bombarded with news from the International Conference on AIDS, this time it's the 11th annual affair in Vancouver, British Columbia, Canada. Every year the newspapers and TV are filled with the latest from these conferences. And every year, I steel myself for the onslaught. It's not that I don't want to believe everything I hear, it's just that the story of AIDS is a delicate imbalance between euphoria and disappointment. So as the 15,000 people from 125 countries meet in Vancouver to talk about the state of AIDS, I choose to remain cautiously optimistic and a shade bit skeptical of the hype. I have hope, to be sure. Still, I agree with Larry Kessler of Boston's AIDS Action Committee when he says, "We see a glow at the end of the tunnel, but we don't see the light."

Will I live long enough for a cure for HIV? Could be. Certainly I'm more optimistic now than even a year ago. Have we got a cure yet, or even treatments that promise long life? Not yet. With treatments of combination drug therapies and the new class of drugs called protease inhibitors, optimism in the medical world is high. New viral load testing is a better indicator of how much virus is in a person's blood giving doctors hope of more informed and quicker treatment decisions. But what does all this mean in the long term? The truth is only the long term holds the answer. And some of my friends may not have a long term in their future. It is hard to be totally optimistic when my friends are dying and nothing we know of so far will change that. I wish it were not so.

And there is the global picture to think about. While drugs to combat HIV are more numerous, they come with a pretty stiff price tag. In the places of the world where HIV is most prevalent, Africa and Asia, these drugs are simply out of reach financially for the vast majority of people with HIV. Even in the U.S., long term therapy on these drugs could force many people into poverty and onto Medicare and Medicaid. The cautiously optimistic experts also worry about the virus, which has been pretty adept so far, becoming resistant to the latest, greatest drugs. Add in those people who will suffer serious side effects and reactions to these new drugs and you now know why a cure is not yet a reality. We're getting closer, but we ain't there yet.

Not that I want to rain on anybody's parade, I would like nothing better than to sit down and write a column about how this terrible scourge is under control and about how the millions infected with HIV are out of danger. I am a fervent believer in the power of hope, as I wrote in this column last month. Still, it is hard to work myself up into a frenzy every year when the International Conference is held, when news is fast, furious and promising, and then reality checks in to the Hotel Life and Death and much of the good news is reworked to a lower pitch of excitement.

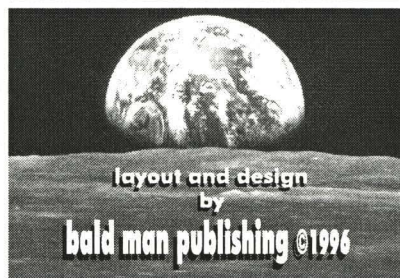
So, I say, to the medical world, thanks for all your good work and keep it up. I appreciate the work going on and the great numbers of people trying to solve this problem. I have hope for the future, but give it to me straight. In the meantime, I live with my own sense of cautious optimism over my own fate. I call it my five-year plan. In my own mind, I believe that I will live well for five more years, and every year on my birthday, I give myself the same optimistic promise of five more years. It's worked for eight years now and serves me well.

On the homefront, I am very optimistic about the hiring of Stephen Moskey as the new Executive Director for The AIDS Project. Add the recent hiring of Carol LeBlanc as Director of Support Services and things are looking up at the Project. With the rest of the staff and volunteers, The AIDS Project is well positioned to carry on its good work.

In The Affirmative, and me personally, is lucky to have the talents of two volunteer writers on board. Amanda Sewall is writing in these pages for the third month in a row and Bethany Roma premieres with her story on Peabody House and its new Executive Director. I feel very fortunate to have both of them contributing to this newsletter. We recently met over lunch for the first time and they both are intelligent, warm, and enthusiastic. And I really like working with them.

It came to my attention that some people thought the size of the type in the last issue was a little small. I can't argue with that. Still, In The Affirmative needs to fit into eight pages and I try to include as much information as possible each month. Given the choice of bigger type and less news or smaller type and more news, well, I've got to go with more news everytime. Also, to make the newsletter a little more pleasing, I try to include artwork and photos. I hope they add to the overall effect of the newsletter.

As reported last month, the Client Advisory Board at TAP is taking the summer off. If and when it returns will be up to TAP's clients and its new Executive Director. I would encourage any and all clients to contact me or the new Executive Director to indicate whether or not you feel that the Client Advisory Board should continue and what changes you would like to see happen. Attendance at these meetings was very low and it is hard to affect change and to justify taking up staff time when clients don't participate. Any organization, I feel, should have an organized forum for its clients to participate in the workings of that agency. But more importantly, clients need to be involved. Sometimes that means sitting through meetings, sometimes even boring meetings, to get the clients' point of view across to the people who provide the services. So I hope the Client Advisory Board does continue in some form or other for the sake of the agency and its clients.



In The Affirmative is a monthly newsletter published by the clients and staff of The AIDS Project for people living with and affected by HIV/AIDS. Letters, articles or other submissions should be sent to: In The Affirmative, c/o The AIDS Project, P.O. Box 5305, Portland, ME 04101 or call (207) 774-6877. Submissions can be printed anonymously as long as the person submitting the material includes his or her name and phone number for verification. News, information and features are as up-to-date as possible prior to publication. Any medical information included in this newsletter is submitted for the reader's information only, to be used as the reader so chooses.

Contributors to this edition of In The Affirmative include:

Douglas Eaton, Getty Payson, Bethany Roma, Amanda Sewall, Alan Stearns, Susan Tremblay and Jill Tacy. Mike Martin, Copy Writer and Editor.

VIRAL LOAD TESTS

by the Boston AIDS Writers Group

What is a viral load test?

A viral load test is a measurement of the number of viruses floating around in the bloodstream. After taking a blood sample, the doctor will send it to the lab where they will count how many copies of the virus there are per milliliter of blood.

There are two types of tests, PCR and bDNA. The first type uses PCR to make millions of copies of the virus's operating instructions known as RNA. This type of test is approved by the FDA. It can accurately measure viral loads above 400 per milliliter. There are variations of this test but they use essentially the same method.

The second type, bDNA, directly measures the amount of HIV RNA. Because it counts the number of pieces of RNA without copying it first, initially it was accurate for viral loads above 10,000 per milliliter. Scientists have developed better versions of this test accurate to 500 per milliliter and they will be available soon. In fact, many new tests will be available soon. It is important to know that they all measure the same thing.

What do the results mean?

There are two measurements of how severe HIV is. One is T-cell counts and the other is viral load. T-cell counts tell how much damage has been done to the immune system at any given time. If T-cells are low then some type of therapy is indicated to prevent the onset of opportunistic infections. The significance of viral load tests is that, unlike T-cell counts, they can predict how severe the infection will be in the future. In other words, if viral load is high, then HIV is doing damage to the immune system and will lead to AIDS sooner than if the load is low.

The analogy is to pretend you are riding in a car that is heading toward a wall. Your T-cell count tells you how far from the wall you are, so if you have lots of T-cells you are far away. Your viral load tells you how fast you are going, so if you have a high viral load it means you are going very fast. Naturally, you want to be far away and going slow. Before, with just T-cell counts, we only knew how far you were from the wall, but now, with viral loads, we can tell how fast you're moving. This is crucial because it enables a doctor to say "the infection is moving too quickly" and then make an effort to slow the HIV down, or "it is moving very slowly" and continue to monitor your status.

Here are some guidelines for judging how fast you're going: If viral load is under 2000 copies per milliliter (moving slowly) then HIV poses little threat to the immune system; under 10,000 (just rolling), HIV is causing minor damage to the immune system. A viral load greater than over 10,000 (coasting) is causing some damage, and over 30,000 (moving fast) can result in significant damage to your immune system. Note that people with full blown AIDS will have viral loads in the millions.

How to use the results?

Viral load tests, when considered along with T-cell counts, are a quicker and more accurate way of choosing when and what type of therapy is necessary. For people not on antivirals, the viral load test can suggest when to begin using them. People taking antivirals can use viral load tests to decide if they are working and when to switch them.

To manage HIV, it is best to have a series of test results to begin with -- two viral loads and T-cell counts taken two to four weeks apart is a good starting point. This series of tests will tell a person if they are stable or if HIV is damaging their immune system and intervention is necessary. If viral load has been rising or is over 30,000, or T-cell counts are below 600 and have been dropping faster than 100 per year, or T-cell counts are below 300, aggressive treatment is in order.

If aggressive treat is necessary, talk to a doctor about what antiviral combination would be best to start on. Use a combination because it has been proven that combination therapy extends health far above and beyond the use of one antiviral at a time.

Before starting a new drug therapy get a viral load first, then after a month of therapy get another. If the therapy is working you're second viral load should be significantly lower than the first. In this case you are on an effective therapy and should stick with it, monitoring viral load every three months. If the viral load doesn't go down, then the doctor should probably switch treatments.

Treatments which drop viral load are usually associated with better results, and it seems that the more powerful the reduction in viral load and the more sustained, the better for you.

What to watch for?

As HIV illness develops the levels of virus can go up and down. Sometimes after flu shots or when you are sick, the results of viral load tests can sometimes go up very high; so in such cases wait a full month and get the test redone. It is unclear what these short-term rises in viral load mean, but this is one reason why no treatment decision should be based on only one test. In the case where you have one high test that is not consistent with past results, wait one month before checking viral load again. You need more than one test over a period of time so that when it comes to using viral load tests as part of your treatment decisions your doctor has an accurate picture of how you are doing.

Other uses of viral load tests.

When it is established how well a viral load test can predict a person's long term health, it could be used to drastically shorten drug studies. This may mean more and better drugs available sooner to those HIV-positive's who need them. Viral load tests are being used to measure the drug effectiveness in all current protease inhibitor trials. Measurements of viral load were considered with T-cell counts at the FDA hearings when deciding to grant approval for d4T, saquinavir, and the AZT/3TC combination. There are additional possibilities for viral load tests in the future. A PCR test which measures viral load down to 20 is now in development. A variation on the viral load test could be used to screen blood products for HIV if the FDA approves it for that specific use, and might also be used to predict the risk of transmission of HIV from mother to fetus. And since every person responds differently to antiviral therapies, viral load tests will effectively individualize the treatment of HIV disease. Viral load tests make it possible to find the best drug combination for each person.

NEWSBRIEFS

AIDS CASES IN U.S. LEVELING

The number of people with HIV in the United States is leveling off at about one in every three hundred Americans age thirteen and over. New infections seem to be keeping pace with deaths each year.

Dr. John Karon of the CDC says, "We're running in place, but it's a deadly place to run."

The number of Americans infected with HIV in 1992, the latest available, ranged from 650,000 to 900,000. In 1986 the range was 550,000 to 650,000.

The study found that half of all HIV-infected people in 1992 were men who have sex with men, and that 25 percent were injection drug users. The fastest growing group was people infected through heterosexual contact, that group tripled in size from 1986-92 from 4.5 percent to 15 percent.

More men than women carry the virus. One of every 160 men was infected in 1992 compared to one of every 1000 women.

WORLD POPULATION RISING

The AIDS epidemic is raging in parts of Africa and will depress population growth on that continent much more severely than previously predicted. However, even AIDS will not make a significant dent in the world's population, which if birth rates in some developing countries continue at their present rates could reach 100 billion by the end of the next century.

Carl Haub, a demographer with the Population Reference Bureau, said that despite AIDS and some slowdown in population growth in parts of the world, birth rates in developing countries are still twice the level needed to stabilize world population.

Africa remains the continent with the fastest expanding population in the world. Without more effective measures, its population will shoot up by 300 million over the next 15 years. Sub-Saharan Africa will have 1.25 billion inhabitants by 2025, 100 million less than without the effects of AIDS.

Around 8,500 people become infected with HIV everyday worldwide and most have little hope of getting the costly new treatments now available. These drugs can cost upwards of \$16,000 a year and most African countries spend less than \$10 a year for one person's health care. Peter Piot of the United Nations AIDS program says, "Nine out of ten HIV infections occur in the developing world where people are desperate for a vaccine." But there is expected to be little progress toward a vaccine reported at the 11th International Conference on AIDS being held in Vancouver, British Columbia.

It is estimated that 1 million children have AIDS or HIV and that about 65 percent of those children live in Sub-Saharan Africa. Anywhere from 1.3 to 3 million children have already died from AIDS. One in three children orphaned by AIDS is younger than five years old.

NEWSBRIEFS

EARLY DELIVERY MAY REDUCE AIDS TRANSMISSION TO BABIES

Delivering an HIV-infected woman's baby promptly after her water breaks appears to reduce the risk of passing on the AIDS virus during childbirth.

About 7,000 HIV-infected women give birth each year in the United States. Without treatment, about one in four transmits the virus to her child. However, taking the drug AZT during pregnancy reduces that risk by two-thirds.

A study begun before AZT became routine therapy in pregnancy in 1994 shows that obstetrical practices also may play a role in HIV transmission. The study found that if the baby is born more than four hours after the mother's water breaks, the risk of passing on the infection nearly doubles. However, researchers say they have no evidence that this delay in delivery makes any difference if infected mothers are already taking AZT.

Dr. Sheldon Landesman, the study's author, says, "There is a possibility that in cases where AZT has not been used or cannot be used, the obstetrician may want to consider a Caesarean section in a woman who is going greater than four hours."

The study, conducted on 525 HIV-infected women, found that the share of infected babies rose from 14 percent to 25 percent when delivery occurred more than four hours after the fetal membrane ruptured.

The study was published in the New England Journal of Medicine in June.

FDA ASKED TO HALT NORPLANT

An advocacy group petitioned the FDA to halt sales of the contraceptive Norplant, saying it is too risky.

Some 1 million American women use Norplant, which is six matchstick-sized rods implanted under the skin of the upper arm. The rods release a synthetic hormone that prevents pregnancy for as long as five years.

Norplant's approval was hailed in 1990 as the first major new contraceptive since the birth control pill 30 years earlier.

But about 200 lawsuits have been filed over Norplant, including class actions representing some 50,000 women. Most claim they weren't adequately warned about side effects, such as headaches, weight gain, prolonged menstrual bleeding, ovarian cysts and depression.

The Population Research Institute, a non-profit organization that lobbies against Norplant, told the FDA that those health problems show Norplant is "seriously flawed."

The group played a 1995 BBC broadcast that accused some international studies of coercing women into testing Norplant. It also charged that Norplant may make women more vulnerable to the AIDS virus, citing a May study that found a hormone in Norplant thinned the vaginal wall of monkeys so that HIV could more easily penetrate.

people at TAP

A reader suggested that it would be interesting to learn a bit about the people on the staff and the board of directors of TAP. So, we asked the staff and board to fill in a little questionnaire that asks them to tell our readers a little something about themselves. Some of the questions are serious and some are just for fun, and each staff or board member was encouraged to skip any questions that didn't cause an answer to flow from brain to pencil easily. There are 20 board members and 20 staff persons at TAP and we'll publish four responses each month.

Douglas Eaton, Hotline/Counseling

Douglas is TAP's Hotline, Counseling and Testing Coordinator. He lives in Portland and has been with TAP about a year. He has a M.M. from the University of Colorado.

His goal is to expand the hotline service to targeted groups, such as teens, women, and men who sex with men. He hopes to expand TAP's counseling and testing to twice a week. His reason for being involved is the "impact AIDS has had and is having on close friends."

He enjoys reading, cooking and traveling. His favorites are: books, *Zorba the Greek* and *The Penitent*; movie, *Witness*; magazines, *Cooking Light* and *Yankee*; TV show, *Jeopardy*; play, *Painting Churches*; color, blue; actor and actress, Richard Dreyfuss and Katherine Hepburn. His fantasy vacation would be to travel to New Zealand on a steamship. His best trip was to the Mozart festival in Salzburg. He calls a salmon dinner at the Roma Cafe c. 1980 the best.

He most admires Frannie Peabody and Dennis McLaughlin. Douglas was a founder of the Boulder County AIDS Project (1985) in Colorado and its Board President for two years. He sighted the Serenity Prayer as a philosophy to live by.

Getty Payson, Case Manager

Getty is TAP's York County Case Manager, working out of TAP's office in Lafayette Place in Kennebunk. She's been with TAP about 6 months and lives in Portland. She has a Masters in Clinical Counseling. She lives with her partner, Kathleen Potts.

Her goals are "to provide compassionate support and advocacy for people living with HIV. Also to increase the availability of services in York County." She says, "I believe people with HIV/AIDS are still very stigmatized and I want to be a person who helps change this. I also feel I can learn a lot in doing this."

Her favorites: book, *A Winter's Tale*; movie, *Field of Dreams*; magazine, *Parabola*; TV show, *Friends*; play, *Miss Nowhen Dinner*; color, blue; singer, Joan Armatrading; actress and actor, Susan Sarandon and Nicholas Cage; fantasy vacation, Nepal. The best trip she's ever taken was to East Africa. Her favorite meal is artichoke dip with rosemary bread, spaghetti with hot pepper sauce, and a fine finish with Ben and Jerry's ice cream.

She most admires Martin Luther King and Sister Helen Prejean and her philosophy is to "live and love in the present as fully and deeply possible."

Alan Stearns, Board Member

Alan lives in Portland and has been on the Board since February. He has a B.A. from Brown University, an M.P.A. from the University of Maine, and a J.D. from the University of Maine. Asked about family or relationship, he dryly replied, "Indeed." Alan is an attorney.

His goal is to "allow TAP to retain its status as stable, yet growing, respected and yet cutting edge." He says, "The concept and reality of HIV makes inactivity not an option," as his reason for involvement in HIV/AIDS.

His favorites: book, *Cien Anos De Soledad*; movie, *Cinema Paradiso*; magazine, *Vanity Fair*; TV show, *Twin Peaks*; play, *Midsummer's Night Dream*; color, walnut; singer, Joe Jackson; actor and actress, Matthew Broderick and Bernadette Peters; fantasy vacation, Indonesia. His favorite meal is breakfast at a diner before a hike.

His quotes and philosophies to live by are: "Mediocrity sucks", "Money can wait", and "The world won't end if I say 'No'". He most admires Nelson Mandela and Mahatma Gandhi. Asked to pick three roommates (real or fictional), he chose Gromet, Babe's singing mice and Hobbes.

Asked if he liked to share anything else, he said, "Mom, I am a homosexual." Alan is on the Boards of Maine Won't Discriminate, Outright, and the Munjoy Hill Neighborhood Organization and is a staff attorney at the Maine Chamber and Business Alliance.

Susan Tremblay, Development

Susan is the Assistant Director of Development at TAP and has been with TAP for three and a half years. She lives in Portland with her significant other, Eric Lindstrom.

Her goal is "to raise lots of money to keep TAP a vital organization." She says of HIV/AIDS, "It is a challenging field that allows me to do good work for deserving people."

She enjoys musical theater, movies, reading, travel and food. Her favorites: book, *The Fountainhead*; movies, *Mary Poppins* and *Brazil*; magazine, *Gourmet*; TV show, *E R*; plays, (musical) *Cabaret*, (non-musical) anything by Tennessee Williams; actor and actress, Harvey Keitel and Judy Garland; fantasy vacation, a European tour. Her best trip was to Akumzli, Mexico. Her best meal is pizza at Pizzaria Regina's in Boston (where she used to live).

She most admires her mother and her sister. Her quote is "Eat, drink and be merry!"

Asked to pick three roommates, she chose: Her grandmother, who was the world's most fabulous cook and food authority; Luciano Pavarotti, who could sing me to sleep every night; And John Travolta, "for those occasions when I must absolutely, positively disco dance!"

Susan has previously done similar work for an AIDS service organization in Atlanta and did marketing for a computer software company in Boston.

ANNOUNCEMENTS OF INTEREST TO PEOPLE WITH HIV/AIDS

URGENT MESSAGE TO PERSONS RECEIVING SSI OR SSDI PAYMENTS

Due to legally mandated changes in Social Security, persons receiving SSI or SSDI payments due to alcoholism or drug addiction will no longer be eligible for these payments. Benefits will be terminated in January of 1997, as will the benefits of Medicare or Medicaid. If you are receiving these benefits because of alcoholism or drug addiction, or if you are unsure, contact your case manager immediately. The AIDS Project will work with its clients to do all that is possible to help.

CALL YOUR CASE MANAGER IMMEDIATELY AT 774-6877

Lunch

As always, people with HIV/AIDS are invited to share a free lunch and good company at The AIDS Project every Thursday at Noon. These are healthy, nutritious, and filling meals lovingly prepared by volunteers, led by the gracious Sylvia. So come and join the good time and fellowship.

A big "Thank You!!!" to the **Big Sky Bread Co.** for donating a wide and varied and delicious selection of breads on the 2nd Thursday of every month for the noon lunch at TAP.

Correction

In the last issue of In The Affirmative figures on Maine's cases of AIDS were incorrectly attributed by year. Rather than the figures being attributed to March 1996, I inadvertently put March 1995. My mistake.

Tickets to area events are often available at no cost for clients at The AIDS Project. Steve Zimmerman is now in charge of ticket coordination, so call Steve at TAP at 774-6877 for information. If he's not in, leave a message. And by the way, Steve did an outstanding job making sure clients got tickets to events during Pride Weekend in Portland.

Positively Social, a social group by and for people with HIV/AIDS in Maine, will hold a get-together in Bath on Sunday, August 11th in the afternoon. It's a barbeque and should be a great time. For more information call 774-7630 or 499-0166.

Volunteers are always needed at The AIDS Project. If you have the time and desire, call Jill Tacy, TAP's Volunteer Coordinator at 774-6877.

5 Important Facts You Need To Know To Stay Healthy

by Steve Frankel, A&U Magazine

Understanding Hypermetabolism.

Studies show that all people with HIV become hypermetabolic. This means your body uses 10% more calories and nutrients to maintain basic body functions like respiration, heartbeat, and rebuilding immune cells. A lot of symptoms associated with HIV progression may be due to nutritional deficiencies from hypermetabolism. Some studies suggest that T-cell count drops are largely due to deficiencies in nutrients like vitamin A, Zinc and Copper, which are needed to build T-cell counts.

Ridding Your Body of Free Radicals.

Free radicals are highly unstable by-products created naturally as your cells use oxygen. They can do damage to your cells if unchecked. Studies show that HIV creates an overabundance of free radicals and they play a major role in killing the immune system. Free radicals are neutralized by anti-oxidants like beta carotene, vitamins A, C, and E. Eating foods rich with anti-oxidants is recommended.

Making Sure That What You Eat Is Easily Digested.

HIV tends to cause an inflammation of the gastrointestinal tract preventing the absorption of nutrients and causing diarrhea, loss of appetite, fatigue, insomnia, and susceptibility to various infections and diseases. Avoid foods that further inflame your bowels. Some culprits are meat, dairy, citrus fruits, wheat, white bread, spicy foods, fried or greasy foods, fast foods, vegetable oils, black pepper, tobacco, alcohol and coffee. Foods that soothe the bowels include grains like millet, barley, and oatmeal, steamed or boiled vegetables like carrots, turnips, broccoli, cabbage, Brussel sprouts, kale, white fish and fresh garlic. Some supplements also help soothe your bowels, like non-dairy acidophilus, echinacea, golden seal root, rose hips and pau d'arco.

Supplementing Your Immune Boosting Diet.

It is important that you consult your doctor or nutritional consultant to set up a regimen of good quality vitamins, minerals and amino acids to boost your immune system.

Keeping A Positive Outlook.

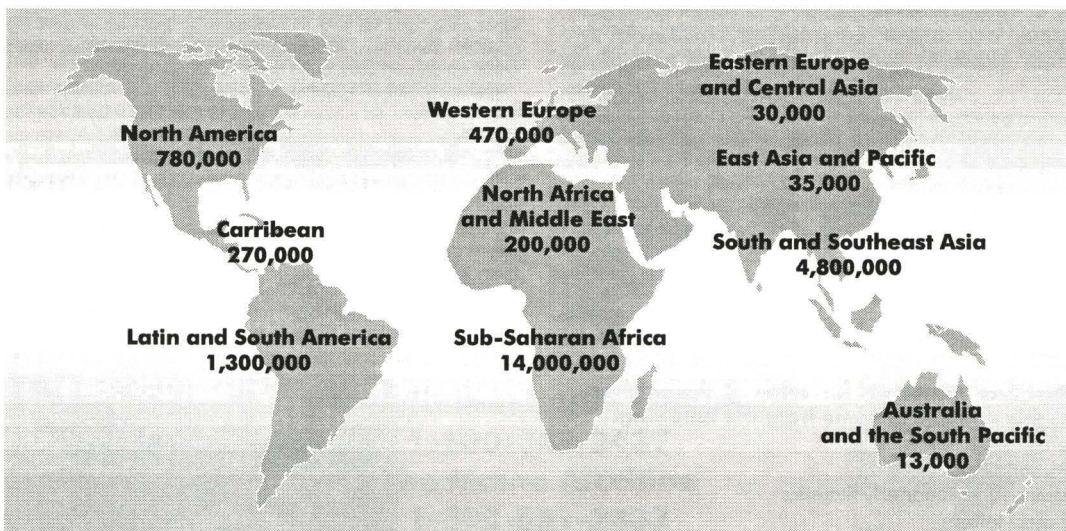
Keeping a positive attitude every day is absolutely essential to staying healthy, especially for a person living with HIV. Research has shown that a positive attitude can actually boost the number and aggressiveness of your fighting immune cells, as well as create endorphins that further boost your moods and health. In addition, findings of long-term survivor studies show the significant impact your mind has on your health. This means you should actively create support systems among friends, family and groups to nurture and support and inspire your path to good health.

HELP !!! HELP !!! HELP !!! HELP !!! HELP !!!

**An AIDS Project client needs dogwalker(s).
The dog needs to be walked
and the owner is unable to do it.
Here's a chance to really help out.
Dogwalker(s) needed for
Monday, Wednesday, Friday and Saturday.
Call Jill Tacy at 774-6877 ASAP, please.**



AIDS around the world



Estimated mid-1996 distribution of people living with HIV/AIDS according to UNAIDS

NEWSBRIEFS

AIDS RISK DECREASES IN BLOOD SUPPLY

The risk of catching the AIDS virus from a blood transfusion is calculated to be just two in 1 million.

"The safety of the blood supply has dramatically increased over the past decade. While there still is a risk, it is exceedingly small," said George Schreiber of Westat Inc., a company in Rockville, Md., that figured the latest odds.

Blood banks routinely find most tainted donations when they check blood for antibodies to the AIDS virus. However, infected pints occasionally slip through if the donors are newly infected and have not started producing antibodies.

Records of almost 600,000 repeat donors were used to estimate how many newly infected people give blood during the approximately 22-day "window period" before a person begins making detectable amounts of antibodies. Donations in that period can also allow infections of HTLV, a cancer virus, as well as hepatitis B and C to get past the screening process.

Researchers estimate the risk of AIDS-tainted donations during the window period at 2 in 1 million and anyone who receives a tainted donation has a 90 percent chance of getting infected. The risk of getting HTLV is 2 per million, hepatitis C is 10 per million and hepatitis B is 16 per million. Researchers found a surprisingly strong link between hepatitis C infection and snorting cocaine. Other factors included sexual promiscuity and needle drug use.

New tests to reduce the 22-day "window period" by almost half are likely to be instituted within a year.

AMA REVERSES STAND, SEEKS MANDATORY HIV TESTING OF PREGNANT WOMEN

In a surprising turn-around on an explosive issue, the American Medical Association endorsed mandatory testing of all pregnant women and newborns for HIV, the AIDS virus. The AMA had long favored voluntary testing because there was little doctors could do to treat a pregnant woman infected with HIV. That changed with the realization that AZT can dramatically reduce a woman's risk of passing the virus onto her baby.

AIDS activists, civil libertarians and some mothers warn that such testing invades a woman's privacy and could lead to job discrimination. The CDC and many medical groups favor counseling all pregnant women about HIV but making testing voluntary.

The AMA vote was a close one, 185 to 181, and it carries no legal weight, but may influence the thinking of physicians and policymakers. Those opposed worry that mandatory testing would discourage women most at risk from seeking prenatal care.

The position taken by the AMA was criticized by the American College of Obstetricians and Gynecologists. President Clinton signed a law in May that requires testing of newborns if too few pregnant women agree to testing.

our feature story

THE "AIDS LADY" AND EIGHTH-GRADERS

by Amanda Sewall

In recent months, I've found myself doing things I never thought I would do, then again, by the time I'm done with this life, I'm pretty sure that every entry on my "I'll never do that" list will be scratched off with permanent marker. What I've found myself doing is standing in front of groups of teenagers answering questions like "What is oral sex?" and "How do homosexuals get AIDS". This is part of my role as HIV educator for the American Red Cross. I've only been doing the whole AIDS thing for about six months, but during that short time I've found myself crashing through walls of sexuality defenses and discrimination opinions in order to reexamine my own grounding so that I can portray HIV and AIDS in a way that might germinate compassion and not concern. This is no small task and neither were the hours of introspection (a dreaded word) that I needed to subject myself to so that I felt that what I was telling these kids was a fair message for all. A theoretic concept which is a near impossibility (no individual over the age of one second has not been subjected to some outside bias or influence) if you ask me, but something I needed to try or at least lean toward. Thinking about my opinions and values, why I had them, where I got them, who gave them to me, and whether or not they were really true or just a compilation of other peoples' values stored in my sponge of a brain, has been part of a never-ending duty begun the day I realized that all those wonderful institutions, I trusted as purveyors of truth, weren't always telling the truth. I refused to walk into a room of students and spew off a bunch of opinions that were not my own, but merely the socially correct thing to say. Doing about fifteen HIV 101 presentations, followed by a day of skills building, for multiple groups of spring-fevered eighth-graders (Yikes!) helped solidify the ground I now stand on.

Eighth-graders in the spring, just like any of us in the spring, are full of new life, a promise of growth, the need for sun and warmth. And like so many of Mother Nature's creatures, inspired by the undeniable pull of mating season. They've got one foot in the doorway of high school; they're just on the brink of coolness, and puberty (for that matter), and only one summer left to grow chest hair and get breasts before having to share a locker room with the seniors. Actually, in dealing with eighth-graders this spring, I was amazed at how varied the group was. They ranged from open-eyed young woman holding tight to the "I'm not having sex until I'm married" ideal to the couple holding hands under the table and getting incredibly flustered when words like "semen" and "vaginal fluid" fell out of my mouth and hit the air. Some of these kids were born clinicians, asking me technical questions that I had no clue how to answer. Some of them were born theologians asking me questions about death and why. Some of them were born comedians asking me questions about s-e-x for the benefit of their friends and to see if I would answer, which I did without turning red, I might add. And all of them, and me, too, looking for quick formula answers to a question like "When will I know I'm ready for sex?". Well, I gave up waiting for that light bulb to go off over my head long ago, but I gave up waiting for marriage, too. I'm truly not the person qualified to answer that question. I'm not sure how I did answer it, but I am sure it was slightly more inspirational than "You probably won't."

The questions which sent me for the biggest loops were ones I generated through a creation of my own demise. It's called a "Question Bag" and it gets passed around the room at the end of day one (HIV 101) to be filled with anonymous, anything goes questions to be answered at the beginning of day two (assertive skills). As I'm passing around the scrap paper on which they can write questions, I explain that, besides personal

questions, anything goes can mean questions about heterosexuality, homosexuality, confidentiality, or any other "iffy" they can think of. What I find in the bottom of that bag is always interesting.

The first time I went through the whole Question Bag routine, I was surprised, and more than a little encouraged, to find that the majority of the questions lurking at the bottom of the bag were about homosexuality. I was also surprised that even though they asked the questions, the second I started answering them, I lost my entire audience to a combination of looking out the window, fingernails, and notebook doodles. They're so curious about a community of people, a culture of people, which exists within their own community, and has existed since well before the B.C. got changed to A.D., but who they have no contact with and little concept of. And whatever concept they do have is causing eyes to wonder and walls of defense to fall. Every session where the Question Bag gets passed around comes back the question, "How to Gay people get AIDS?". In training to become an HIV educator, we were taught to look for the question within the question, to read between the lines of black and white and get at the heart of what an individual is trying to ask. I see an almost endless line of curiosity and questions pouring out of the simple six-worded phrase, "How do Gay people get AIDS?". So I answered as best I could, even though the answers seemed directed at nothing more than air. But even if one of them was listening, it was worth it, and all of them were listening, voluntarily or not, on some level.

Out of all of the eighth-graders I presented to, out of all the curious upturned faces, there was only one who reeked of neglect. Neglect and possible Attention Deficit Syndrome, but I'm not a clinician. A permanent furrow lived between this kid's brow, his arms crossed over his chest, and eyes out the window every time I'd catch him paying attention. After the presentation, the teacher and I were chatting and she confessed that he was the only kid without a permission slip, but he was the kid who needed it most, so she let him stay. Yeah, he needed it most. Unfortunately, about two years ago! But how can a teacher know? How can one tell what's going on in a kid's home, in his or her mind, with their bodies until, boom, there's a problem? But drugs and sex are probably a reality for this kid already, not something to be careful of when "you decide the time is right to try it". That's what struck me most about all of them, how different they were on levels of growth and maturity. There will always be the puberty-proficient, socially-adept soccer captain who's ready to try anything and there will always be the too shy to talk to girls but a whiz on the computer kid who really has no interest in trying anything, just yet. We are all a mere creation of experience, and no two individuals ever experience anything quite the same way. Reaching them all with one standardized presentation ain't easy, but it hurts worse not to try.

The most difficult question I had to field was "Do you have HIV?". Not only did it open the gate to Confidentiality Street, on which one's comfort level is often the toll, but it also allowed me to feed that monster of mystery with all those drama lessons I took in high school and college. (I knew they'd come in handy some day.) I wouldn't answer, at first, and then I told them why. I told them about violence. I told them about losing jobs and insurance. I told them about losing friends and families. I told them about discrimination. I told them about Homophobia. And I was ecstatic when they asked "But why, just cause someone has a virus?". Yup, just cause someone has a virus. And they didn't get the concept, and I was glad. I hope they

Resource materials for some of the articles in this newsletter come from the following:

USA Today
Portland Press Herald
Maine AIDS Quarterly Statistics
Project Inform
Boston AIDS Writers Group
A & U Magazine
Maine Emergency Management Agency



feature story continued

never do.

Day two always gets a lot lighter, which I'm grateful for because I sometimes feel like the prophet of reality and depression. Day two consists of a chat on different levels of pressure, ways to resist pressure, and then ends with a "before" assertive training role play and an "after" assertive training role play. As I was writing the role plays, I found it difficult to create one about teen sexuality and choices made under pressure without doing the typical "John says yes, but Jane says no, but according to John, Jane's eyes say yes" routine. I wanted to steer away from the stereotypical norm, but I also wanted to provide a positive display of female empowerment (having been in a few "my lips and eyes both say no" situations myself). So I thought, wouldn't it be great if I could go with the typical "Hey, Jane, let's go upstairs and get away from the party (hint, hint)" scenario, but get a male to play the female role and vice versa. Then I thought, they're eighth-graders and I'm really pushing it. On the very first day when I asked for volunteers, the captain of the soccer team raised his hand and said "can I play the girl part?". Why, of course, you can my boy! This was also the day that there was a substitute teacher and the energy level in the room was a bit spastic, but, hey, if it works...

That same day we finished early and the students decided they wanted to write their own role play. "Sure, what a great idea," I said, still somewhat green to the ways of eighth-graders. "What should it be about?" I asked. Instantly it was about sex and instantly the female was the dominant force. Five minutes, and a lot of giggles later, the entire role play consisted of four lines. Veronica says, "Let's have sex", Tom says, "I'd rather go grocery shopping", Veronica says, "Good we can pick up some condoms", and Tom says, "I was thinking more along the lines of broccoli". I couldn't help myself, if you can't beat 'em, join 'em, and I thought it was hysterical. I then had to calm myself down, along with a room full of energized kids and remember my task as a facilitator and turn the situation around by having it pertain in some meaningful way to the topic at hand. So I reached into the farthest corners of my mind and found this: Veronica introduces a level of pressure, whereby Tom resists the pressure by proposing an alternative (a viable option discussed earlier in the presentation), Veronica then increases the level of pressure, and then Tom succeeds in diffusing the situation with humor (another viable option). Good job, Tom! Way to be assertive. Stretched, yes, but we had a good time.

There exists the cliché "out of the mouths of babes", a phrase I never really had much use for, nor did I ever think I'd be old enough to use. But I have to say, I've learned much, been inspired to think much, and experienced much all from those I'm expected to teach. If nothing else, and I won't believe nothing else, I know they remember my face. I can tell by the cries of "Hey, there's the AIDS Lady" which follow me down the hall whenever I'm asked back to a school for a repeat performance. "The AIDS Lady", a title earned by doing things I never thought I'd do.

Amanda Sewall is an HIV educator for the American Red Cross and her territory is the entire State of Maine. She works out of their Portland office. This is her third article for IN THE AFFIRMATIVE. Her contributions are voluntary and greatly appreciated. Note: in past issues I've misspelled her last name and am pleased to correct it in this issue.

PEABODY HOUSE REVISITED; THEY, TOO, HAVE A NEW EXECUTIVE DIRECTOR

by Bethany Roma

(continued from page one) to what he thought was his retirement. Tom's retirement plans included the usual travel plans, hobbies and volunteer activities. He spent two weeks in Guatemala on behalf of "Witness for Peace". Tom worked on the "Maine Won't Discriminate" campaign and was a speaker for "Maine Speak Out", a statewide program through the Augusta Unitarian Church that "puts a face on discrimination." His leisurely life of retirement ended when a friend told him of Peabody House's mission and search for an Executive Director. As he would say, he was "hooked."

As Executive Director, Tom sees his job as one of a support person. His job is to support the mission of Peabody House. In order to accomplish this, he plans on building on the in-place infrastructure to assure its strength. His priorities are to: 1.) assure the quality of care provided; 2.) raise funds to ensure the continuation of services; 3.) maximize sources of revenue and assistance; and 4.) tend to the daily administration in order to protect the mission of Peabody House. Priority number three is already progressing as they are now an approved Medicaid servicer. This means that Medicaid will reimburse Peabody House for some of the services provided to residents.

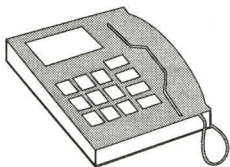
Peabody House is a remarkable place with an admirable mission. Hopefully the day will come when the services of Peabody House will no longer be necessary and AIDS will be a thing of the past. However, until that time, Tom Cathcart will ensure that Peabody House continues to serve people infected with AIDS, as it was originally envisioned to do.

Bethany Roma is a volunteer contributor to IN THE AFFIRMATIVE. This is her first article for the newsletter and I look forward to many more excellent stories from Bethany.

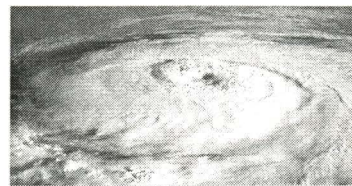
AIDS

AIDS in Maine* since the beginning.
Southern Maine: 382
Central Maine: 227
Northern Maine: 111

*as of 3/31/96



**The National AIDS Hotline
1-800-342-2437
The Maine AIDSline
1-800-851-2437
Teen AIDSline (Wednesdays 6-9 pm)
1-800-851-2437**



MAINE HURRICANE INFO

As the hurricane season is upon us, The Maine Emergency Management Agency and Central Maine Power issued the following information about Maine's hurricane season.

- Hurricane Season: June 1-November 30.
- Peak Months: August and September.
- Wind Speed: up to 110-120 mph.
- Typical Wind Speed: 74-90 mph.

► Hurricane Watch:

Hurricane effects will probably occur within 36 hours.

► Hurricane Warning:

Strong probability that hurricane effects will occur within 24 hours. Take protective action immediately.

► As a hurricane approaches, strikes and passes:

Traffic increases, stores have long lines, heavy winds begin, light objects blow around, small limbs fall, businesses close early, heavy rain begins, small streams flood, heavy seas strain boat moorings, downed tree limbs and flood waters block escape routes, power lines come down, people and animals are injured by flying objects, beaches erode, buildings near the shore are damaged, large trees are downed blocking streets and damaging buildings, moorings break and boats collide, a temporary calm occurs when the eye moves overhead, winds shift to the opposite direction and rapidly increase, possibly stronger than before as the eye passes, larger rivers flood, and finally the hurricane passes.

► When a Watch is issued:

Listen to weather reports regularly.
Fill car gas tank (pumps run on electricity).
Get extra cash (ATM's run on electricity).
Check flashlights, radio, batteries, first aid kit.
Obtain 2-week supply of prescription drugs.
Check supply of plastic/wood for repairs.
Move boats to safety.

► When a Warning is issued:

Board up large windows.
Bring movable items inside.
Tie down objects too big to bring inside.
Listen to TV/radio for official information.
Leave mobile homes for sturdier shelter.

► If ordered to evacuate:

Leave immediately.
Leave utilities on (unless told otherwise).
Turn off major electrical appliances.
Bring medications, disposable diapers, baby and diabetic foods.
Bring flashlight, radio, batteries, sleeping bags, snacks, books, games, toilet articles, sturdy shoes, and extra clothes.
Do not bring alcohol or firearms.

► Remember:

Most shelters do not allow pets.
Usually shelters provide minimal meals.

While the worst damage is usually near the coast, high winds and heavy rains can cause problems well inland, too.

Editor's note: I was born during Hurricane Carol on August 31, 1954. It's listed as a notable hurricane in the World Almanac. During my formative years, my parents always introduced me as "Mike, the hurricane baby." Except for excessive wind, I have nothing else in common with hurricanes.

support groups

Mondays

5:30-7:00 p.m. - HIV and Substance Abuse Recovery

A safe space for people living with HIV and in the process of recovery from alcohol and drug addiction. Small Group Room, TAP.

Tuesdays

10:30 a.m.-Noon - HIV Infected and Affected Drop-in Support Group

A place for both persons infected and affected to express feelings, share experiences and receive support. Large Group Room, TAP.

NEW !!!! 6:00 p.m.-7:30 p.m. - An Exploration of Spirituality (July 2 to August 6)

An eight week group (limited to 8-10 people) designed for people living with HIV to explore their sense of what spirituality means in a safe and non-judgmental atmosphere. Open to anyone interested, whether Buddhist, Atheist, Taoist, Christian, Nature Enthusiast, or whatever. Open to anyone! Kennebunk Office. Call Getty, TAP's York County Case Manager, for more information at 985-8199.

Thursdays

Noon - Open Client Lunch

Informal gathering of TAP staff and clients. Large Group Room, TAP.

HIV and IDU Recovery

Discovery House and The AIDS Project is cosponsoring a safe and supportive place for people living with HIV, who are also in recovery from intravenous drug abuse. It is not necessary to be a client of either agency. Contact Randy May at TAP 774-6877 or Willie Willette at Discovery House 774-7111 for more information about the group.

5:30-7:00 p.m. - People Living with HIV

Drop-in support group open to anyone with HIV/AIDS. Large Group Room, TAP.

Other Support Groups - Other Counties

Androscoggin/Oxford Counties

Tuesdays, 1:30-3:00 p.m. - People Living with HIV

Drop-in support group. 3rd Tuesdays of the month, also open to partners. Group Room at TAP Office at 1 Auburn Center, Auburn. For more information contact Diana Carrigan at 783-4301.

Groups Resuming in the Fall:

Mixed HIV Status Gay Male Couples

A closed, time-limited support group that provides a space for both positive and negative partners to explore issues specific to their relationships. This group is limited to five couples, so please contact Victor Rash at TAP 774-6877 to sign up. Because of the success of this group, if we have enough interested couples, we will run a second group. This group will begin the second week of September.

Heterosexual Couples Group

A closed, time-limited support group for couples with one or both partners living with HIV. This group is limited to five couples, so please contact Randy May at TAP 774-6877 to sign up. This group will also begin the second week of September.

Polarity Yoga

An open morning drop-in support group for anyone living with HIV. "Polarity yoga is based on the premise that the least amount of effort can produce the greatest results. Using movement, sound and breath, Polarity Yoga exercises the body, mind and spirit, allowing our vital energies to flow freely, bringing harmony, balance, and insight into our own truths."

Videos and Safer Sex for Men

An open discussion group for gay, bisexual and questioning men of all ages. This safe and confidential educational group will focus on safer sex today, barriers to safer activity, and skills development for healthier choices. Contact John Holverson at 774-6877 for more information.

New Groups Starting in the Fall:

Heterosexuals Living with HIV

A drop-in support group for straight men and women who are living with HIV.

HIV Negative Partners

A time-limited closed group for HIV-negative gay male partners, offering a time and place to share experiences, clarify feelings and needs, and gain strength and hope toward living and loving someone infected with the virus.

Any suggestions or questions about support groups, contact Randy May, LMSW, Case Manager at The AIDS Project - (207) 774-6877.

THE AIDS PROJECT

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(or 142 High Street)
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Portland, Maine 04101

Phone: 774-6877
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