



GIPPSLAND  
WOMEN'S  
HEALTH  
SERVICE INC.

REG. NO. A0024460W  
ABN 21 214 835 436

SPRING 2011

# NEWSLETTER

## Good Vibrations

### CONTENTS

### PAGE

Editorial	1
Captain Chlamydia	2
White Ribbon Day	2
Save the Date - AGM	2
Pridentity	3
Supporting Gender and Sexual Diversity in Schools	3
Birthing Options	4
The Power of Me	4
Good Vibrations	6
Think Pink Courtesy Car	7
World Association for Sexual Health, Biannual 20th World Congress of Sexual Health, Glasgow	8
Nurse's Snippets	12
Web Resources	14
Application for Membership	15



Spring 2011

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### Editorial

Sexual and reproductive health is an important issue for women, not only in regard to their physical and emotional health, but also within the context of developing and maintaining interpersonal relationships. We know that there are both sex and gender differences for women in regard to sexual and reproductive health, including the incidence and impact of sexually transmitted infections, social pressures and expectations, and choices associated with pregnancy and childbirth. More information on childbirth and birthing options is contained in the articles on pages 4 and 5, including a fascinating personal story.

*"No one should die as a result of sex, but millions do." Gill Greer, IPPF - Quote from World Association for Sexual Health, Biannual 20th World Congress of Sexual Health, Glasgow.*

Gippsland Women's Health Service is partnering with a number of other agencies and departments to develop and implement a Regional Sexual and Reproductive Health Strategy which particularly focuses on reducing the rates of sexually transmitted infections among young people and reducing the rate of teenage pregnancies. When two GWHS staff, Jodie Pullman and Alma Ries, recently attended the World Association for Sexual Health Conference in Glasgow, they undertook to utilise this experience to also highlight the importance of understanding the dangers of Chlamydia and how easily it can be spread, as you can see from the article on page 2 and the many pictures of "Captain Chlamydia" throughout this newsletter.

An overview of the Glasgow Conference and summaries of many of the presentations which provide information on a number of sexuality education programs are outlined on pages 8 to 11. These programs are of particular interest to us here at GWHS as one of the focus areas for implementation of the Gippsland S&RH strategy is within the education environment. Nurse's Snippets contains information on a range of sexual health and related issues which have significant impacts on women that were also presented at the Conference. We were also very pleased and proud to have a poster presentation on the delivery of the Life! Taking Action on Diabetes program to women with Polycystic Ovarian Syndrome (PCOS) from Alma Ries accepted for the Conference.

A number of GWHS staff also recently attended the launch of the resource, Pridentity Inclusive Sexuality Education, produced by Women's Health in the North. This great resource provides information and strategies to assist schools to deal with homophobia within the school environment and to provide inclusive education for all students. More information on this project and resource can be found in the article on page 3. Good quality information is key to making informed choices and decisions about all aspects of health and wellbeing. In addition to the articles in this newsletter, details of relevant websites for general health information, as well as some sites specifically related to this edition, are listed on page 14.

We hope you find these useful.

**Diane Wilkinson**

*Chief Executive Officer*



*Captain Chlamydia in Amsterdam.*



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The title for our Summer 2011 Edition Newsletter is "The Rights Issue" where we discuss Rights for women.

If you have something you would like to contribute, we would love to consider it. The closing date for submissions is 31st October 2011.

A DROP OFF SLOT for resources is in the front door of our building at 56B Cunninghame Street, Sale.

The statements or opinions expressed in this newsletter do not necessarily reflect the views of Gippsland Women's Health Service Inc.

# Captain Chlamydia

Our feature artist for this newsletter is a little different to those we have featured before!

Staff members Jodie Pullman and Alma Ries attended the World Congress for Sexual Health in Glasgow and decided to take a little travelling companion along with them to illustrate how easily Chlamydia can be spread.

They took some cheeky photos of the little bacteria in various places during their travels and the photos were uploaded to Facebook and Twitter to illustrate the importance of safe sex especially when travelling.

For those who follow us on Facebook and Twitter you would have already seen some of the adventures! We have decided to include some of Captain Chlamydia's travel photos for this special edition of our newsletter relating to matters of sexual health.



November 25 marks both the International Day for the Elimination of Violence Against Women and White Ribbon Day, the first day of the White Ribbon Campaign. Gippsland Women's Health Service will be selling ribbons and taking donations from our office in Sale.

## Save the Date!

Gippsland Women's Health is proud to present:

Let's have a talk with... *Nelly Thomas*

Nelly has recently released her first health promotion DVD - "The Talk", a sexual health and ethics DVD for teenagers and their parents/carers featuring celebrities, health ambassadors, experts and comedians all talking The Talk.

Nelly will be also be speaking about sexual and reproductive health for women of all ages.

You can check out Nelly's website at [nellythomas.com](http://nellythomas.com)

**GWHS Annual General Meeting** will be held prior to Nelly's presentation

**When: 5:30pm on Wednesday, 16th November, 2011**

Light supper will be provided.

**Where:** The Lakeside Club (Sale Bowls Club)  
Cnr Foster and Guthridge Parade, Sale

**RSVP:** 9th November, 2011 **Phone:** 03 5143 1600

**Email:** [admin@gwhealth.asn.au](mailto:admin@gwhealth.asn.au)

# Pridentity Launch

A number of Gippsland Women's Health Service staff attended the launch of Women's Health in the North's newest resource - Pridentity: Inclusive Sexuality Education Kit, in Melbourne recently.

This fabulous comprehensive resource kit has been several years in the making. It is ready to pick up and use within any sexuality education program. Activities have been developed to sit across three classroom sessions; however there is flexibility for the program to fit in with a range of school timetabling.

The resource kit has been developed to improve the experience of Same-Sex Attracted and Gender Questioning (SSAGQ) young people within the education system and improve their health and wellbeing outcomes. "Writing Themselves In 3" - a research report on SSAGQ young people, identified schools (which are supposed to be a safe place for all young people) as the most common site of homophobic behaviour including verbal, emotional and physical abuse.

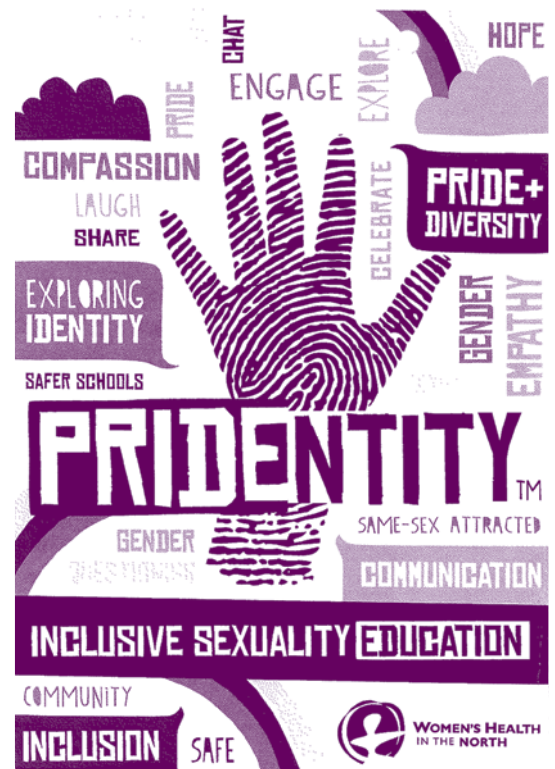
The study also showed alarming statistics that 31% of SSAGQ young people had harmed themselves and 16% had attempted suicide because of homophobia. In schools where there had been policies against homophobic behaviours, there were fewer incidences of attempted harm and suicide. Many of these young people said they wanted sexuality education within the school that included information on same sex attraction and gender questioning, normalising and celebrating diversity of their communities. This kit has the resources to assist schools with the curriculum content to do just that. It fits within the health and personal development domain across several topic areas.

For further information or to obtain a copy of the resource **contact: [info@whin.org.au](mailto:info@whin.org.au)**

nb. "Writing Themselves In 3" - The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people. Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

**Jan Tracey**

*Health Promotion Worker*



*"There are 3 necessities for sexual health and they need to work together. 1. Sexual rights, 2. Sexual health education and counselling, 3. Confidential high quality services". D Apter, Finland.*

*- Quote from World Association for Sexual Health, Biannual 20th World Congress of Sexual Health, Glasgow.*

## 'Supporting Gender and Sexual Diversity in Schools'

Free professional development for teachers, support staff and anyone who works in schools facilitated by the Safe Schools Coalition Victoria.

### What?

This introductory session will explore:

- What makes a safe school and what difference does it make?
- What is the impact of homophobia on young people?
- How can you challenge homophobia in your school and classroom?
- How can you develop more inclusive teaching and learning?
- What support do same sex attracted and gender diverse students need?
- How can you support student led activism to celebrate diversity?

Using the latest research on the impact of homophobia in schools, we draw on best practice from Australia to prepare participants with knowledge, skills, ideas and resources to challenge homophobia and create safe, inclusive schools.

### Where?

DEECD - Gippsland Regional Office, cnr Kirk and Haigh St, Moe Please register at [www.pd-online.com.au](http://www.pd-online.com.au)  
For queries relating to registration contact Anne Outhred, DEECD Regional Office on 5127 0400 or [Outhred.anne.l@edumail.vic.gov.au](mailto:Outhred.anne.l@edumail.vic.gov.au)

### When?

**Tuesday 8th November 2011,**  
**10am - 4pm**  
(registration at 9.30am)

# Birthing Options

Women have an expectation that pregnancy and birth will be safe and successful, with the anticipated outcome being a healthy baby and mother along with a positive birthing experience. In Australia in 2008, 20 women died due to pregnancy, giving a maternal mortality ratio (MMR) of 8 deaths per 100,000 live births. (The infant mortality rate per 1000 births was 4.1 that year). However like the tip of the iceberg, the rest of the story is that for every death due to pregnancy there are around 80 instances of women surviving (sometimes with permanent ill effects) life-threatening complications. In comparing the worst and best outcomes in the world, in Afganistan there were an horrific 18,000 deaths with an MMR of 1400 contrasting with Denmark's 3 maternal deaths with an MMR of 5. In Australia, the Indigenous MMR is 2 to 5 times that of non-Aboriginal women depending on the year in question.

Sometimes there can be tension in Australia between doctors, midwives and women with regard to pregnancy and birth. Everyone wants the best outcomes but have different beliefs on how to attain them. Probably the two extremes of the ideologies would be those women who don't have antenatal care and have an unassisted home birth (known as freebirthing) against those women requesting (or doctors performing) elective caesarean section when there is no apparent medical need.

According to World Health Organisation figures for 2010 there were 6.2 million unnecessary caesarean sections (CS) performed around the world. A figure of 15% of all births is accepted as an acceptable CS rate for best maternal and infant outcomes. Low income countries tend to have too few (with poor outcomes for mothers and babies) and middle and high income countries too many.

In 2008 in Australia the CS rate was 30.3% which equates to 40,851 women. This means potentially there were over 20,000 unnecessary CS. While there has been speculation that larger babies, and older mothers may make a higher CS rate more necessary, the 15% acceptable rate established in 1985 remains current. Two recent reviews involving 700,000 women have found repeat C/S may be partly to blame for the high rates. Australia has a low VBAC (vaginal birth after C/S) rate.

The importance of regular ante-natal care during pregnancy cannot be overstated, and has not really been questioned. But for many years there has continued to be a push (no pun intended) by women and some health professionals for women to reclaim their bodies, with more options for 'natural birthing' including home births, birthing suites in hospital, water births, midwife only care in hospitals etc.. For women working towards a normal delivery there are many different 'styles' or techniques taught for managing labour and the following account is one woman's story of what worked for her.

## Alma Ries

*Community Health Nurse*

References available on request.

## The Power of Me

When I found out on Easter Sunday 2010 that we were expecting our fourth child, my thoughts quickly turned to how we would bring this baby into the world. In the first 20 weeks of my pregnancy I did a lot of soul searching trying to work out what I wanted for the birth of our last child, and how I could achieve this. While our first 3 children were delivered vaginally, and safely, my memory of their births is dominated by fear, panic, pain and feelings of being out of control. They were all intervention ridden, and I couldn't shake the feeling that there had to be a better way.

Around this time, I started researching HypnoBirthing, which claimed to be a unique method of relaxed, natural childbirth, enhanced by self-hypnosis techniques. It was said to provide a method that allows women to use their natural instincts to bring about a safer, easier, more comfortable birthing. The more I read about HypnoBirthing, the more it became clear that this was the method that we would use to introduce our precious baby to the world.



In the 10 weeks leading up to our birth, we had been practicing daily using a HypnoBirthing Rainbow Relaxation track, birthing affirmations, visualizations, and partner lead relaxation. We were dedicated to our practice, and had become proficient at achieving deep states of relaxation. After 2 days of stop start labour, by Tuesday evening, at 4pm, I rang the hospital and told them to expect us sometime tonight. I was fairly confident that this was it, and that contractions would not stop again. At 6pm I got into bed and started the rainbow relaxation track, and Contractions stopped again. I must admit that at this stage, after 2 long days, I was exhausted and deflated. It seemed like every time we put this track on, it slowed things down. In hindsight, I think I was so efficient at getting myself into a deeply relaxed state, that I was inadvertently slowing labour down!



Then, at 8pm the contractions started up again. They were 30 minutes apart, but much more intense than they had been so far. I was bending over the couch, using visualisation and breathing to get through the contractions. While they were certainly intense, they were not painful. My husband was rubbing my back and we were coping easily, which is not hard when you have a 25 minute break between contractions. At 10pm we decided to go to bed and get some sleep. As I was getting up from the couch, I had another contraction and during that contraction, I felt my water break. What a fantastic feeling! I had never experienced spontaneous rupture of membranes, and I was so happy! I knew then that it was really happening, and that we were going to meet our baby soon.

We had a shower and by the time we got out at 10.30pm, contractions were coming every 2 to 3 minutes. We called the hospital again and messaged our student midwife, to let them know that we were coming in. Breathing and visualization were still working really well for me. We got to the hospital at 11pm, put our music on, dimmed the lights, and hooked up our baby's heart rate monitor. At 11.20pm I was examined by our midwife. Four to five cms dilated, and almost fully effaced. I must admit, I was a little disappointed. I thought that I would have been further along. Our midwife was very assuring and encouraging though. At this stage, she read through our birth plan. During this time, I was still contracting every 2 to 3 minutes, staying upright and having my husband rub my back. While I was aware that the contractions were intense, the word painful never really crossed my mind. By about 11.45pm I was exhausted. I told my husband that I needed a break and to put the 'Rainbow Relaxation' track on (I was half joking, I never really thought that it would make a difference at this stage). From here, the next 1/2 hour felt to me like about 5 minutes. I lay down on the bed and my husband said that I looked like I was sleeping. I remember having 2 contractions, and shivering a lot. I had trained my brain so well during the lead up to this day that I was able to get myself into a state of total relaxation, and apparently I stayed totally still for the entire 25 minute track. After hearing this from my husband in the days after, I realised the power of the mind and the body to work together to achieve almost anything. After the track finished, I jumped up and asked to have our music put back on. In hindsight, I think that I was in transition (or close to it) during this time. For me, transition had always been the worst part of my previous labors, so it was fantastic to be so relaxed and in control.

Contractions were coming thick and fast by this stage, and it was around this time I panicked for the first time. I told my husband that I thought that the baby was coming, and that I was not ready. At this stage I was trying to hold the baby in as I could feel her moving down all on her own. I remember the feeling of tension and felt like this moment lasted for a really long time (actually it only lasted a few minutes).

Seven minutes after my initial feeling that the baby was coming, our daughter slid effortlessly from my body needing only my breath to help her into the world. I reached down and pulled our baby to my chest. This was such a special moment, as it had been a particular goal of mine. I picked her up, opened my eyes, and my husband said looked like I had just returned from a walk in the park. The room was dark, there were no sounds apart from the soft tones of the midwives and my husband, and my breath. There was no pushing, no panic and no feeling of helplessness. Our student midwife passed me some towels and I held our precious baby to my chest as we all stood quietly in awe of what we had all just experienced.

At this stage my obstetrician arrived and I looked up and said "I just had a baby!" It was 12.37am, 1.5 hours after arriving at the hospital. The umbilical cord was short, so I sat down and we waited for the cord to stop pulsating. My husband cut the cord while I was holding our baby in my lap. She was aware, and looking around, but at this stage had not made a sound. I lay back and cuddled her to my skin. After about 1.5 hours together on my chest, she was checked, weighed and measured 3.462kg, 51cm long 34.5 head.

My experience with the birth of our daughter has made me appreciate and understand the power of the mind and body to work together to achieve anything. I hope that reading our birth story will inspire someone. I never thought that I could achieve such a perfect birth, but with dedication and commitment I was able to. Such is the power of me.

### **Renee Robinson**

*Community Contribution*

Thanks to the two special midwives at Central Gippsland Health Service who helped us to achieve our birth plan and to Kym at Kym Donaldson Hypnotics, [hypnotics.net.au](http://hypnotics.net.au)

# Good Vibrations

Did you know that the vibrator had its beginnings as a treatment for an ancient condition known as female hysteria? That it was an academic researching needlepoint who rediscovered the secret history of a device created for “a job know one else wanted”?

Welcome to the world of higher education, where a sharp mind, insatiable curiosity and a doctorate in History can lead you into some surprising insights.

That's right - sex aids and academic research that serves to both titillate and enlighten. After all, who said research had to be dull and boring in order to be significant - and profitable? It can be provocative, savage and offbeat as it illuminates.

Take Rachel P. Maines. Her research has spawned a veritable industry into the history of the vibrator. Maines, who earned her doctorate in history at Carnegie Mellon University in 1983, published *The Technology of Orgasm: Hysteria, the Vibrator and Women's Sexual Satisfaction* in 1999. It has since been translated into French, Spanish, Italian and Japanese.

A documentary on her research is now available on DVD. *Passion & Power: The Technology of Orgasm* recently screened in the US as part of a celebration of Women's History Month.

Never heard of it? Well, then you might have seen the publicity for the Pulitzer and Tony shortlisted play *In the Next Room - or the Vibrator Play* (MTC April 7 - May 14). The Broadway comedy focuses on a neglected doctor's wife and the “scientific experiment” he is conducting with two patients in the room next door. The play is based on Maines's book and research.

A Hollywood movie starring Maggie Gyllenhaal, also based on Maines's book, is now in production. Its title is *Hysteria* - after the common and chronic ailment in women that use of a vibrator was said to have cured.

Maines says she is often asked when she presents papers at workshops how she managed “to find this esoteric topic”. Doctorate students will nod in recognition when she admits “I didn't – it found me”. It often seems with research that we chance upon something while looking for something else. That's the exciting part – when all avenues broaden out in possibility.

While researching women's textile history in America and flipping through piles of needlework magazines from the 1880s, Maines noted with surprise numerous advertisements for a device that looked startlingly similar to a modern vibrator. But they weren't called vibrators – they were marketed as a “health and relaxation aid”. Still – the ambiguous phrase “all the pleasures of youth...will throb within you” alerted Maine to the possibility of an alternative to cross stitch.

Maines research investigated “hysteria” as a disease paradigm in order to track down the reason for the evolution of the vibrator. Hysteria was diagnosed by Hippocrates in the first century A.D. In the second century, Galen described it as a disease caused by sexual deprivation. Maines said his remedy of genital massage therapy is found in medical texts until the end of the 19th century.

She also discovered that while physicians knew massaging a woman to orgasm would “cure” hysteria, they felt it was time consuming, temporary, and a tough skill to master. Husbands didn't want the task either. In short, it was “the job no one wanted”.

Enter the vibrator. Maines writes that “massage to orgasm of female patients was a staple of medical practice among some (but certainly not all) Western physicians from the time of Hippocrates until the 1920s and mechanizing this task significantly increased the number of patients a doctor could treat in a working day.”

Many bold attempts at mechanical intervention, such as vibrating chairs, were trialed before physician Joseph Mortimer Granville designed a battery powered vibrator on the early 1880s.

Advances were swift - by 1900 a wide range of vibratory apparatus was available to physicians, from low-priced foot-powered models to the Cadillac of vibrators, the Chattanooga.

Amazingly the “social camouflage” of this - well, sex industry of sorts - remained undercover and in the advertisements of textile magazines until the 1920s.



*Captain Chlamydia checking out the vibrators in Amsterdam.*

Then the pornography industry discovered the vibrator and put it centre stage in porn movies. Once the spotlight was on the real reason the machines were so popular with women, the vibrator disappeared from women's magazines - and history, until Maines's research.

By the time the vibrator re-emerged in the 1960s and 1970s, with Women's Liberation, it was openly marketed as a sex aid for women. Maines points out in her book, wide knowledge of and availability of the vibrator finally "put into the hands of women themselves the job that nobody else wanted."

Not only is the "cure" within women's grasp, they have also seized the method of production. What does a woman want from her sex aid? According to two savvy mothers from Wollongong, who have launched their own vibrator, The Be Be, women want a vibrator that looks great, feels great, and isn't gimmicky or embarrassing to buy.

Their website proclaims "because every woman wants a bit of pleasure". To prove their point, every purchase comes with free batteries, to get you started straight away. The glossy women's magazines have declared the glam vibrator hits the spot.

The Be Be follows on the high heels of the Goldfrau, a ceramic dildo designed by Judith Glover, a lecturer in industrial design and product engineering at Swinburne University, Melbourne. Glover specialises in sex toys, and promises her product "will last longer than any relationship". Glover says she put a lot of effort into the design, with an emphasis on ergonomic and functional considerations.

For men who fear a woman's ownership of a vibrator implies criticism or will usher in an age of women not needing men, Maines has the last word "If orgasm is the only issue, men don't need women either."

#### Evelyn Tsitas

Writer Journalist Communications

[www.evelyntsitass.com](http://www.evelyntsitass.com)

Evelyn Tsitas is a PhD student in Creative Writing at RMIT University. The co-author (with RMIT Public Relations lecturer Caroline van de Pol) of the parenting book *Handle With Care*, Evelyn has an extensive background in journalism and communications. Evelyn writes crime fiction (she is the winner of a Scarlet Stiletto Crime Writing Award) and Gothic horror; excerpts of many of these short stories can be found on the Clan Destine website. [www.clandestine-books.com.au](http://www.clandestine-books.com.au)

*"There is lots of data around STI's, pregnancy, abortion etc., but not much about happiness and positive sexual experiences." D Apter, Finland - Quote from World Association for Sexual Health, Biannual 20th World Congress of Sexual Health, Glasgow.*



*Goldfrau vibrator which was designed by a female industrial design lecturer at Swinburne University.*

## TLC Courtesy Car Service

...A Wonderful New & Innovative Service provided by The Think Pink Foundation Living Centre (TLC)

Breast cancer patients and their carers are often waiting around metropolitan Melbourne hospitals for several hours in between appointments or investigations (particularly regional and rural patients who have travelled long distances to Melbourne).

There are no free transport services currently in existence that would enable patients and their carers to travel to The Living Centre (TLC), free of charge, if they are 'day patients' at hospital. The TLC Courtesy Car is a 'Pink VW Bug' proudly donated by Pink Hygiene Services and driven by trained TLC Volunteer Drivers.

TLC will collect patients and their carers from Melbourne hospitals in 'Rosa - The Lady Bug' and chauffeur them to The Living Centre where they can relax in our beautifully appointed lounge, be served light refreshments, speak with our Breast Care Nurse and Peer Support Volunteers, access the internet, and/or have a relaxation massage or one of our TLC Salon Services. They will then be safely driven back to their treating hospital in time for their next appointment.

**This service is FREE OF CHARGE.**

The service operates Monday to Friday 10.30am-3pm. For bookings or more information please contact The Living Centre on **Phone: 03 9820 2888 or Email: [thelivingcentre@thinkpink.org.au](mailto:thelivingcentre@thinkpink.org.au)**



# World Association for Sexual Health Biannual 20th World Congress of Sexual Health, Glasgow.

The World Health Organisation says that ‘Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled’.

To further illuminate the meaning of sexual health and the breadth of conference presentations, The World Association for Sexual Health (WAS) statement in the Journal of Sexual Health states that:

**“Sexual health....goes much beyond the domain of disease and dysfunction and their treatment... Sexual health is a complex field of activities and practices including education, psychological and psychosocial approaches, therapy, medicine, public health, sexological research, basic life sciences, behavioral sciences, social and anthropological sciences and ethics. It is even more complex since the WAS establishes a central link between sexual health and sexual rights, which opens the way to a whole range of activities related to advocacy, promotion and defense of human rights when these are threatened”.**

Sexual Health Rights were a constant theme throughout the 6 days of the program. These rights are expressed in the World Health Organisation’s Millennium Development Goals (MDG’s) especially MDG 5 and the recent MDG 5B. “Target 5.B: achieve, by 2015, universal access to reproductive health”. The United Nations will monitor compliance with this target. More about this important issue in GWHS summer newsletter “The Right Issue”.

GWHS has a real and deep commitment to improving the sexual health of Gippsland women of all ages. This is demonstrated not only in the work we undertake but also in supporting two staff members to attend the 20th World Congress for Sexual Health in Glasgow. Jodie Pullman (Health Promotion Officer) and Alma Ries (Community Health Nurse) both attended the conference from 12th-17th June. Those of you who follow us on Facebook and Twitter, would have seen the Chlamydia tour! There were 7 stated conference themes.

They were:

- Bio-medical research (basic, physiological, pharmacological).
- Clinical approaches (medical, psychological and sexological).
- Sexuality Education.
- Social, Behavioural & Historical research (non clinical).
- Public Health / Epidemiology / Public Policies.
- Sexual Health & Sexual Rights actions and advocacy.
- Ethics, principles, practices and issues.

GWHS Community Health Nurse Alma Ries presented a poster at the conference on the Life! For Women with PCOS (Polycystic Ovarian Syndrome) Program, which was held in Sale during 2010. The abstract for the poster was featured in the June 2011 edition of The Journal Of Sexual Medicine , Volume 8, supplement 3; on p297. The exciting news is that we will be able to continue to offer this course for women around Gippsland in the future.

The following notes are from sessions that were attended:

## EFFECTIVE SEX-ED: CONFESSIONS BY A BELIEVER

I. Vanwesenbeeck, Rutgers WPF, 2Utrecht University, Utrecht, The Netherlands

Effectiveness of sex education has been shown around the world. It shows positive benefits even at primary school levels. Evaluations showed that students having age appropriate knowledge around puberty, relationships and sexuality, meant they understood what constitutes harassment and abuse, had increased acceptance of homosexuality and improved communication skills even with their parents.



*Alcohol can loosen inhibitions and lead to unsafe sexual practices. Look out! Captain Chlamydia is indulging again!*

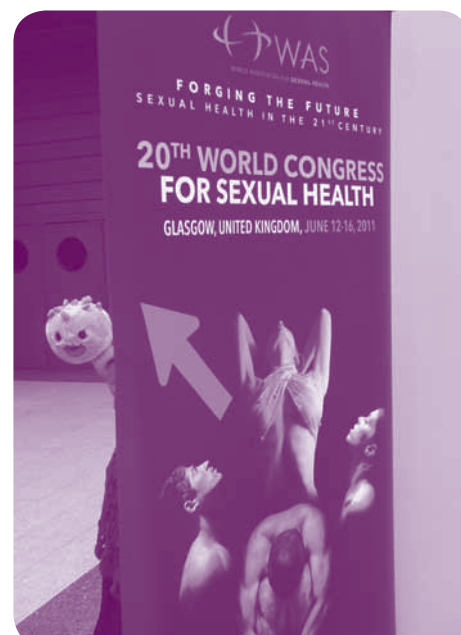
***“Sexual health education programs constantly have to be evaluated as to costs and benefits, other areas of the school curriculum like history or geography or maths do not. Why the difference?”***

*M. Henderson - Quote from World Association for Sexual Health, Biannual 20th World Congress of Sexual Health, Glasgow.*

Evidence of cost effectiveness were shown when sex education was integrated into the curriculum by regular class teachers, thus reaching many students. 10-40% of students may have negative health events averted because of this education.

There were only modest effects of sex education on vaginal sex, condom use and attitudes. No long term effects shown on attitudes and behaviours and pregnancy rates. No effect has been demonstrated on incidence of HIV/AIDS, or STI's. The reasons for this related to:

- Provision and teacher reasons: including short programs and teacher quality. Not all teachers are able to teach sex education. Their ability to do so is not often measured.
- Program content: Abstinence only education is futile and overly optimistic, assuming all problems solvable. It carries an assumption of individual decision making as key, ignoring lack of services, gender and power issues. It also has a narrow focus on fear and risk.
- Student and Learning related reasons: content needs to be tailored to link with experiences and realities of the students. There are competing scripts of safe versus fun sex. It helps if students feel they need the knowledge. Strong moral frameworks make sex education more difficult.
- Environment reasons: within the school context there may be gender and status differentials, exploitation and abuse. Out of school context, there may be conflicting messages between home and school, a lack of youth friendly services, legal context or limited education. With the internet and its virtual world, sex education is only a drop in the ocean.
- Methodological problems: Research requires a long follow up with high numbers of students to gauge impact of sex education. There is difficulty with randomised control trials in the field and the reliability of self-reports by young people. Sex education needs to be flexible and this is the opposite to research which must be very structured. It is a miracle that any effects of sex education are ever shown at all given the preoccupation with evidence on individual behaviour change. There is an urgent need for an adequate response to HIV/AIDS epidemic. There is competition with biomedical interventions plus persistent controversy over sex education with a gradual narrowing down of rationale – sex education is more than just safe sex!



*Captain Chlamydia sneaking into the World Congress for Sexual Health in Glasgow.*

## SEXUAL RIGHTS, PARENTS AND YOUNG PEOPLE

G. Greer IPPF, London, UK

"No one should die as a result of sex but millions do. Too young to know but too young to die!"

Notes for this session were mainly statistics which were fairly sobering:

- Fear, stigma and cost stop young people accessing sexual health services, even where they exist.
- One third of adult ill health results from adolescent ill health including sexual ill health.
- There are 1.75 billion young people in the world, 80-90% of these in the undeveloped world.
- Adolescent girls give birth to 10% of all babies with morbidity of 23% (causes negative health outcomes).
- Half of all deaths from illegal abortions occur in 15-19 year old girls. 60% of girls aged 19-24 are married before they are 18 = 600 million girls.
- 75% of the world's poverty occurs in middle income countries.
- There are an estimated 100 million STI's annually around the world.
- 60 million girls are assaulted annually in Sub-Saharan Africa. In Pakistan Swara girls are used to settle disputes, in Nepal menstruating girls are not allowed to go to school. On the positive side, Ethiopia is working to stop child marriage and in Nicaragua numbers of pregnant 13 year olds are dropping due to sex education.



*"It is easier to persuade a male partner to use condoms to avoid pregnancy than to avoid STI's."*

*B. Sazdanovska - Quote from World Association for Sexual Health, Biannual 20th World Congress of Sexual Health, Glasgow.*

## GOOD CATHOLIC SEX

J. O'Brien Catholics for Choice, Washington, DC, USA

This was a fascinating and challenging session by a very engaging speaker. He said that the Roman Catholic Church (RCC) hierarchy's view on sex/sexuality differed from the churchgoers, and reflects the ideology of white celibate men. There is control by a few over many. USA surveys of Catholics have shown that: 60% oppose abstinence only sex education, 97% oppose refusal to allow the oral contraceptive pill and abortion. Catholics around the world support condom use as a means to preserve life i.e. HIV/AIDS prevention. Surprisingly Dr John Rock, a Roman Catholic, invented the pill!

O'Brien said the Roman Catholic Church came from Judaism, which was full of healthy sexuality, advocating sex on the Sabbath. While Plato and Socrates separated the body from the soul, Judaism didn't. In 300AD the Council of Elvira, with a fixation on celibacy, ruled on adultery and abortion.

Sex only for procreation led to bans on contraception and masturbation. Rules forbade sex on all but 61 days of the year! O'Brien talked about history with Pope John 23 and Vatican 2 trying to bring the RCC into modernity, finding they should not be involved in laws and policies. That pope's unexpected death stopped this process.

Apparently in RCC you must (his emphasis) follow your own conscience – it is the final arbiter. Some vital questions he recommended considering: 1. who do you/they represent? 2. Is what you/they are saying factually correct? E.g. when life starts. 3. How does what you are saying affect other people? E.g. opinions about abortion. 4. Can you be a Roman Catholic and disagree with church hierarchy?

## NEW APPROACHES IN SEXUALITY EDUCATION in Finland

D. Apter, Väestöliitto, Helsinki, Finland

The experience from Finland reflects the interconnectedness of school-based sexuality education and the availability of sexual health services in response to the needs of the population.

This presentation was very interesting and focused on the way in which sexuality education had been delivered in Finland. The key message that came from this talk was the huge impact that health policy can have on the sexual health of a population. Finland had its lowest rates of teenage pregnancy and abortion during the 1990s when free contraception and health care was available. When services were cut due to economic decline, these figures rose again.

In promoting positive sexual health at a population level there are three essentials:

- Recognising sexual rights.
- Provision of sexuality education and counselling.
- Sexual health services.

The level of political commitment and resources provided will reflect in the results obtained.

In Finland, having a clearly stated national curriculum with appropriate teacher training, comprehensive sexual health services and good political will were needed to improve sexual health indicators.

## COST AND COST-EFFECTIVENESS ANALYSIS OF SCHOOL-BASED SEXUALITY EDUCATION IN SIX COUNTRIES, E. KETTING

Nijmegen International Center for Health Systems Research and Education (NICHE), The Netherlands.

"Sexuality education needs to start at age 5."  
"Sexuality education is a human right."

This symposium focused on the results of a ground-breaking study into the cost and cost-effectiveness of sexuality education (SE) in six countries (four developing, one in transition and one developed country), commissioned by UNESCO in 2010.

Why an economic analysis? Policy-makers all over the world involved in decisions on school-based sexuality education programs, are facing three important economic questions: what are the costs of developing the program, what are the costs of implementing and scaling up the program, and do the programs provide value for money?

Cost effectiveness involves looking at the effectiveness of sexuality education in terms of health outcomes, that is, cost per unintended pregnancy, STI, and HIV infection averted.

The sexuality education programs studied varied widely in terms of their scope (abstinence-only vs. comprehensive), position in the school curriculum (mandatory vs. optional, and integrated vs. stand-alone), duration (from a few months to several years), their age (from just starting to 20 years old), and several other characteristics.

Cost per student highly depends on the programme duration, class size, and teacher salary level. Other important cost components are operational, teaching materials and advocacy, which may be costly in a context of low acceptance of sexuality education. Through scaling up and increased coverage, the cost per student can be reduced significantly.

The following sexuality education characteristics should be prioritised:

- Full uptake in schools.
- National scaled up projects.
- It is CRUCIAL that sexuality education is delivered in conjunction with access to youth friendly sexual and reproductive health services.
- Intra curriculum programs recommended.
- At least 12-20 lessons (minimum 45 minutes each) delivered over several years.

## STANDARDS FOR SEXUALITY EDUCATION IN EUROPE: Symposium

The "Standards for Sexuality Education in Europe" were developed by a group of 20 experts from nine European countries under the guidance of the Federal Centre for Health Education (BZgA) in Cologne, Germany and the WHO Regional Office for Europe. The Standards are an important instrument to overcome huge differences in quality and scope of sexuality education in the European region.

I found this symposium to be extremely beneficial and relevant to the work we are doing at GWHS with the Gippsland Sexual and Reproductive Health Strategy. It reinforced the need for policy around comprehensive (or holistic as was the preferred term) sexuality education in schools.

### IT'S ALL ONE CURRICULUM: GUIDELINES AND ACTIVITIES FOR A UNIFIED APPROACH TO SEXUALITY, GENDER, HIV, AND HUMAN RIGHTS EDUCATION

D. Braeken, Youth Operational Division, International Planned Parenthood Federation, London, UK

This part of the symposium introduced us to a new curriculum resource that can be used to develop or revise sexuality education curricula. The resource was developed by an international working group and responds to the Millennium Development Goals and conforms with guidelines and priorities established by UNESCO, WHO and UNAIDS. The resource contributed to the development of the 'Standards for Sexuality Education for Europe'.

The resource works from a human/sexual rights perspective which is crucial in sexuality education and says that there needs to be youth participation in research, program development, planning and evaluation.

A rights based approach leads to a learning environment based on equality, respect and human rights. Sexuality education can support young people to address violations of rights and builds critical thinking and advocacy skills.

It is important to focus on gender and power in sexuality education as it creates more equitable gender norms, decreases rates on intimate partner violence, females have more control over the terms of sex and there is less sexual coercion.

Copies of the "It's all one curriculum" resources can be downloaded at the IPPF website at [www.ippf.org/en](http://www.ippf.org/en)

C Winkelmann, WHO Collaboration Centre for Sexual and Reproductive Health, Federal Centre for Health Education, Cologne, Germany

Informal sex education is inadequate for modern society. Without standards some young people may receive very little or no sexuality education and thus suffer from sexual ill health.

The aim of the standards for sexuality education is to:

- Ensure the quality of sexuality education
- Support age appropriate development.
- Assure a positive approach to sexuality.
- Assure the rights of children and youth to access to comprehensive information.

The Standards are based on a positive interpretation of sexuality, which they consider to be a part of physical and mental health, and on the acknowledgement of sexual rights.

The 'Standards' are based on the assumption that holistic sexuality education needs to start at birth, continue through childhood and adolescence into adulthood. The new guidelines not only indicate what information should be given but also which specific skills children and young people should acquire, and which attitudes should be promoted at specific age periods. For a copy of the Standards go to: [www.bzga-whocc.de](http://www.bzga-whocc.de)

## THE MEDIA: SEXUAL HEALTH SAINT OR SINNER: Symposium

The public media - radio, television, print, the internet as well as social networking such as Twitter and Facebook - has been blamed for many of the problems in our sexualised society. Banner headlines, celebrity shock stories, pornography of all kinds - none of these are helpful to the cause of sexual health, sex education and a mature view of sexuality.

This symposium gave an interesting perspective on how the media is portrayed as being both a saint and a sinner when it comes to sexual health.

Whether involuntarily or voluntarily, young people are exposed to sexual images. Speakers at the symposium stressed the importance of involving young people in the creation of sexuality media. When creating resources including websites, re-sources etc., it is imperative to include young people in the planning so that the language is relevant to them.

Y. Ohlrichs from Rutgers WPF in the Netherlands gave a very interesting presentation with the message that all media messages in sexuality, whether good or bad, can be used in sexuality education. He suggested that sexuality educators should use the media to help young people understand sexuality. Even though the public media is often gender biased, we can use this to the benefit of young people by using the media to stimulate discussion and gain awareness and skills for using and understanding (non) verbal, gender specific communication. It can also be used to teach media skills, discuss values and teach about sexual diversity.

Educators can use the media to start communication about sexuality but need to be sure it is used age appropriately.

# NURSE'S SNIPPETS

## *Nurse's Snippets*

### from the International Sexual Health Conference

#### SEXUALITY, OBESITY & GENDER

N. Bajos, France.

While this study relates to French people I found the issues for overweight and obese women to be very thought provoking. This is especially so considering the well-researched negative attitudes of some of our own health professionals, including some doctors and dieticians, to overweight patients.

The French 3rd National Telephone Survey on Sexual Behaviour surveyed over 12,000 people aged 18-69 in 2006. In 1939 there was a 4 year gap between men and women's age at sexual debut; this gap is now only 4 months. Women are catching up. Only women have had an increase in numbers of sexual partners, and increase in homosexual practices. As well women reported increased rates of masturbation and oral sex, with partnered women over 50 years of age more sexually active than previously reported. Across all age groups respondents thought that men had more sexual needs than women!



**The Difference Between Women & Men**

Outcomes were different for men and women with high BMI's (overweight and obese). Overweight/obese women experienced more social stigma than their male counterparts. Overweight women are more likely than overweight men to perceive themselves as too fat. Obese women are 30% less likely to have a sexual relationship and 5 times more likely to find partners on the internet. Those aged 30 years or less have a four-fold increased rate of unplanned pregnancy and abortion compared with normal weight women. They are also less likely to be prescribed the oral contraceptive pill and less likely to visit doctors or gynaecologists. No reasons were given for this. Low rates of combined oral contraceptive pill prescriptions was not compensated for by increased rates of progesterone only contraceptive prescriptions for these women. A new paper by L. Bacon and L Aphramor 'Weight Science: Evaluating the Evidence for a Paradigm Shift' (Nutrition Journal 2011, 10:9) echoes this finding; "weight stigmatization and discrimination impact on health, health-seeking behaviors, and quality of health care". Cartoon from [www.funnyhub.com](http://www.funnyhub.com)

#### SEXUAL ASPECTS OF THE PHYSICALLY IMPAIRED FEMALE BODY

W. Gianotten, Rehabilitation Sexology, The Netherlands.

The four R's are **1. Rehabilitation 2. Rights 3. Responsibilities and 4. Rewards.**

This talk was about the effects of visible and invisible impairment on sexuality. Visible impairments include stroke, spinal cord injury, multiple sclerosis and Parkinson's disease. Invisible impairment includes things such as incontinence, heart and kidney disease. Both can lead to disturbed sexual function, identity and relationships. Physical impairment at a young age is a risk factor for sexual abuse and can also lead to exclusion from relationships and reproduction. Because sexuality is such an important part of life, rehabilitation and care staff must have an awareness of the increased risk of disturbance, and also that sexual expression can play a positive role in the healing process. Sex education needs to be impairment specific. Disturbed sexuality deserves attention as part of rehabilitation with experienced rehabilitation sexologists who have extensive toolkits to help clients/patients. Rehabilitations centres without such staff are cannot be regarded as gold standard.

While impairment can lead to diminished sexuality with diminished function, for some people sexuality improves. Some women (the speaker spoke specifically about women in Netherlands) who are left out of the sexual script, may have less inhibitions or moral restrictions. She also made the point that the best oral sex lovers are those paralysed with a spinal cord injury. General, romantic and erotic/porn literature needs to be inclusive of disability. Sexuality is not only for the healthy.

## THE CONSEQUENCES ON QUALITY OF LIFE AND SEXUALITY IN CHRONIC FEMALE SCHIZOPHRENIC PATIENTS

I. Miclutia, Romania

Anti-psychotic drugs used to treat schizophrenia can produce sexual side effects including lowered libido, orgasmic dysfunction and dyspareunia (pain at intercourse) due to vaginal dryness.

These side effects can result in women not taking their medications as they find these side effects more distressing than other side effects like weight gain or sedation. Patients under-report sexual dysfunction and psychiatrists underestimate the importance of sexual dysfunction to patients. It is important for patients and their treating practitioners to talk about these issues and to closely manage drug therapies to improve quality of life.

## SEXUAL PERVERSION? CULTURAL AND MEDICAL VIEWS THROUGHOUT HISTORY

J. Peakman -Birkbeck, University of London, London, UK

This talk was about sexual health from the view of what constitutes sexual perversions, looking into the past and today including the dynamics of sex and power. Who decides what a perversion (a moral judgement) is? The DSM V (a diagnostic manual) classified homosexuality as a psychiatric illness and didn't remove it fully until 1983. A perversion suggests it is abnormal, and even today heterosexuality is "the definitive line of normality".

An acceptance of sexual differences is a must for good sexual health.

In the past onanism (meaning masturbation of self or others as well as coitus interruptus) was decreed a sin and regarded as self-pollution. It was criminalised in the 16th century and clitirodectomies were performed on women to stop masturbation!

In recent times, new fetishes have included 'Plushies' and 'Furries', with people dressing up as animals or their favourite cartoon characters. Animal sex farms in America were discussed in the frame of -if it doesn't hurt anyone or anything and gives pleasure to both parties, is it a perversion? Should it be illegal? (Surprisingly this issue was discussed on ABC's Q & A one night!). An interesting web link the speaker recommended is: [www.humansexmap.com](http://www.humansexmap.com)

## INTIMATE PARTNER VIOLENCE (IPV) AND SEXUAL HEALTH

Prof Charlotte Watts, London School of Tropical Medicine.

Internationally, Intimate Partner Violence (IPV) includes the use of actual or threatened use of physical, emotional, sexual, psychological violence as well as controlling behaviour. The World Health Organisation (WHO) has undertaken a multi-country study on Women's Health and Domestic Violence which has included surveys of over 10,000 women in 10 countries. Australia is not part of this study.

What are the impacts of IPV on sexual health? Women living with IPV have less control, so experience more unplanned pregnancies and abortion, more STI's and HIV. Forced sex at first sex was often by a husband-to-be with rates as high as 30% for women in Bangladesh, down to 1% of women in Japan. The younger age at first sex, the more likely it was to be forced. In South Africa women who experience IPV (highest rates in world) are 50% more likely to be infected with HIV (Jewkes 2003). Married women who experience IPV had a threefold increase in STI's. Physical IPV is strongly correlated with sexual ill health. The higher the levels of IPV the higher the levels of sexual ill health. IPV may be the underlying cause of many presenting sexual health problems.

Globally, women experiencing IPV are most likely to tell no-one, then most likely to tell friends/neighbours, after that family, and are least likely to tell service providers.

**Men who abuse are more likely to have concurrent sexual partners, have an STI, have alcohol problems and refuse to use condoms.**

**Alma Ries**

*Community Health Nurse*





# Web Resources

## A Guide to General Health Websites...

*The internet is an amazing place for all things relating to health. It is always very important to ensure the website you are using is reliable, accurate and written by a reputable source, as there can be misleading and incorrect information available. The following websites are excellent resources and recommended by Gippsland Women's Health.*

### HealthOntheNet.org

The Health On the Net Foundation (HON) is an international nonprofit group promoting and guiding the deployment of useful and reliable online health information, and its appropriate and efficient use. It is accredited with a special NGO status to the Economic and Social Council of the United Nations. Their mission is to guide the growing community of healthcare consumers and providers on the World Wide Web to sound, reliable medical information and expertise. In this way, HON seeks to contribute to better, more accessible and cost-effective health care.

### health.gov.au

The Federal Department of Health and Aging website has links to other websites, latest health news and links to government departments relating to all health matters. The department's role is to achieve the Australian Government's priorities (outcomes) for health and ageing.

### healthinsite.gov.au

Reliable, up-to-date information is crucial today - particularly when it comes to health matters. Australians are increasingly turning to the Internet as a source of health information. While the Net provides a massive amount of useful information, it also leads users to information of questionable quality. In line with the Australian Government's strategy of delivering services via the Internet by 2001, HealthInsite was conceived to bridge the gap between the increasing potential for consumers to access health information via the Internet, and the absence of quality control of web information.

### betterhealth.vic.gov.au

The Better Health Channel provides health and medical information to help individuals and their communities improve their health and wellbeing. It is a very easy website to navigate around and the information provided is quality assured, reliable, up to date and easy to understand.

### jeanhailes.org.au

The Jean Hailes Foundation for Women's Health provides a unique response to the needs of women through excellence in research, community and professional education and clinical care.

### nbocc.org.au

National Breast and Ovarian Cancer Centre (NBOCC) is Australia's national authority and source of evidence-based information on breast and ovarian cancer. The website has many excellent resources including personal stories and tools to assess your risk of cancer.

### thewomens.org

The Royal Women's Hospital is Australia's largest specialist hospital dedicated to improving the health of all women and newborn babies. This website is has an excellent A-Z fact sheet section for many health conditions as well as an unplanned pregnancy guide.

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## Health Websites Relating to "Good Vibrations"

World Association for Sexual Health  
[worldsexology.org](http://worldsexology.org)

White Ribbon Day 2011  
[whiteribbonday.org.au](http://whiteribbonday.org.au)

Pridentity - Information  
 Available from Women's Health in the North  
[whin.org.au](http://whin.org.au)

Think Pink Foundation  
[Thinkpink.org.au](http://Thinkpink.org.au)



REG. NO. AOO24460W

## Application for Membership

### Gippsland Women's Health Service Inc.

Any woman who resides, works or studies in the Gippsland region and supports the Statement of Purpose of Gippsland Women's Health Service Inc is eligible to be a member of the Association.

Name \_\_\_\_\_

Address \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone \_\_\_\_\_ (AH) \_\_\_\_\_ (BH) Email \_\_\_\_\_

New Membership  Membership Renewal Have you changed your address in the past 12 months?  Yes  No

If Yes, what was your previous address? \_\_\_\_\_

Individual Membership enables you to vote at the AGM and general meetings, stand for election as a member of the Council, access to library service, invitations to special functions, inclusion on our mailing list for programs, workshops and forums.

Do you wish to receive a newsletter?  Yes  NoIf Yes, do you wish to receive the newsletter via email  or Australia Post Do you wish to receive periodic email updates?  Yes  No

Membership is for one year only and must be renewed annually at the time of the AGM. There is no entrance fee or annual membership subscription.

I agree with the Statement of Purposes and wish to become a member/renew my membership of Gippsland Women's Health Service Inc. for one year, ending after the Annual General Meeting 20\_\_\_\_. (please complete relevant year)

I accept that GWHS Constitution requires a register of Members be retained by GWHS and that a list of member names will be available for viewing by other GWHS members at the GWHS registered address in accordance with the Constitution and Privacy Legislation.

In the advent of my admission as a member of the Association, I shall at all times comply with the rules of Gippsland Women's Health Service Inc.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Please complete and return to:  
**Gippsland Women's Health Service Inc.**  
 Repty Paid 664, Sale Vic 3850

**Office Location:** 56B Cunninghame Street, Sale Vic 3850  
 Telephone: 03 5143 1600 or 1800 805 448 Fax: 03 5143 1224  
 Email: admin@gwhealth.asn.au Website: [www.gwhealth.asn.au](http://www.gwhealth.asn.au)

#### For Office Use Only:

Date Received: \_\_\_\_\_ Date Entered into Database: \_\_\_\_\_

Staff Member: \_\_\_\_\_

**GIPPSLAND WOMEN'S HEALTH SERVICE NEWSLETTER**

SURFACE  
MAIL

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AUSTRALIA

Print Post Approved  
Publication No. PP 0435 13 / 00019

**IF NOT DELIVERED RETURN TO:**

Gippsland Women's Health Service  
PO Box 664 SALE 3850



**GIPPSLAND  
WOMEN'S  
HEALTH  
SERVICE INC.**

REG. NO. A0024460W  
ABN 21 214 835 436

Gippsland Women's Health Service is an independent, regional health service run by women for women. The Association develops and implements health promotion programs based on the social model of health, which work at a number of levels to empower women to increase control over, and improve their health.

**The Service Offers:**

- Information resources
- Free Health Information Line - 1800 805 448 to speak to our Community Health Nurse
- Free, confidential pregnancy testing, options counselling and telephone options counselling
- Information, referral and support to all women of Gippsland, their partners and health professionals

**Why a Women's Health Service?**

- Women and men have different health needs
- Women use health care not only for ill health, but for health maintenance, such as pregnancy, contraceptive management and menopause
- Women in their role as carers use health care services more frequently than men
- Women are more likely to be socially and economically disadvantaged than men

**24 HOUR CRISIS LINES**

- |  |              |
|--|--------------|
| ■ Triage (Mental Health Emergency Service)                                       | 1300 363 322 |
| ■ Women's Domestic Violence Crisis Service                                       | 1800 015 188 |
| ■ Gambler's Help   | 1800 156 789 |
| ■ Lifeline   | 13 11 14     |
| ■ Kids Help Line   | 1800 551 800 |
| ■ Latrobe Community Health Service<br>24 Hour Aged, Disability and Carer Support | 1800 242 696 |
| ■ Gippsland Centre Against Sexual Assault  | 1800 806 292 |
| ■ Pregnancy, Birth and Baby Helpline   | 1800 882 436 |

**As an information service/health advice line for all women's health queries, you may call  
Gippsland Women's Health Service on 1800 805 448 or  
5143 1600 from Monday - Thursday: 9.00am to 4.00pm, Fridays: 9.00am to 3.00pm  
You can also leave a message after hours and we will get back to you.  
However, please note that we are not a crisis service.**