



GIPPSLAND
WOMEN'S
HEALTH
SERVICE INC.

REG. NO. AOO24460W

NEWSLETTER

Busting Myths

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Autumn 2007

Gippsland Women's Health Service

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EDITORIAL

Myths, misconceptions and mistaken beliefs all have something in common - they are generally based on misinformation or a lack of understanding about things. Whereas myths can sometimes have a basis in history, often the original story or situation has been embellished or modified over time. At other times, myths can be a "convenient explanation" to give credence to a particular way of thinking or standpoint.

Myths may have little consequence in our lives and can often be a source of humour as in the case of some of the myths about menstruation on page 11. However, they can also significantly influence our decision making processes and our attitudes to issues and situations, both in our own lives and in the world around us.

In this issue, we have highlighted myths that are often associated with a range of issues that impact on the lives of women, including violence, abortion and gender-based persecution. If we are going to have genuine discussion and make informed decisions about these very important issues, it is important to have as much information as possible.



In addition, we have looked at a number of common questions about cannabis (or marijuana) and health risks associated with its use.

I was also very interested to read the article provided by one of our members, Mari, on the use of the menstrual cup as an alternative to tampons and pads.

As always, Nurse's Snippets provides us with information on a range of topical issues and the results of our body image survey conducted last year are set out on page 13. We greatly appreciate the time taken by all those who completed and returned this survey and we will continue to look at the issues raised by you in future editions of the newsletter.

And, or course, Stephanie has provided us with a great list of resources available from the GWHS library, including a number of DVDs from the Move It or Lose It series from Arthritis Victoria on exercising and

strength building.

I trust you will find this edition of our newsletter both informative and enjoyable.

Diane Wilkinson
Executive Officer

Gippsland Women's Health Service in partnership with The Jean Hailes Foundation for Women's Health is delighted to provide this opportunity for women to hear about a range of issues on healthy ageing.

Presenters from The Jean Hailes Foundation for Women's Health and Gippsland Women's Health will provide a wealth of relevant information on ageing well including a naturopath's approach.

Presenters:

Dr. Valerie Arnold, GP, JHF will provide an overview of healthy ageing
Ms. Sandra Vilella, Naturopath, JHF will provide a naturopath's approach to ageing well
Gippsland Women's Health Service - overview of services

PARTNERS WELCOME & BRING A FRIEND *** Bookings are essential ***
Limited seats so book early to avoid disappointment
This event is proudly sponsored by The Department of Veterans' Affairs

When: Thursday May 3rd 2007

Time: 7.00pm – 9.30pm (doors open 6.30 for refreshments)

Where: Morwell RSL Cost: Gold coin (pay at the door)

RSVP: Monday April 30th 2007 (for catering purposes) **Bookings:** Phone: 51431600



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The title for our Winter 2007
edition Newsletter is
"Opening Doors"
Around Social Connectedness

If you have something you would like to
contribute, we would love to consider it.

The closing date for submissions
is Friday 27th April.

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

Dispelling the Myths Surrounding Violence against Women

"Convincing numbers of Victorians hold attitudes which serve to condone or trivialise violence against women or undermine efforts to address it"¹, and whilst there has been a move away from violence supportive attitudes over the last ten years, strong myths surrounding this issue still remain in our community.

Late last year VicHealth released a report titled, 'Two Steps Forward One Step Back' which outlined these findings and also highlighted some of the myths relating to violence against women still present in our community. Based on this report and Amnesty International's 'Stop Violence against Women Myth Busting Fact Sheet', the following article aims to list and address common family violence related myths.

MYTH 1: Violence against Women isn't that Widespread or Serious

REALITY: The statistics speak for themselves. Violence against women is alarmingly prevalent. Domestic violence contributes to more ill health and premature death for women aged 15-44 than any other single factor. In Australia, one in three women who have been in a relationship have experienced violence by a partner².

ATTITUDE: Some members of the community do not realise that family violence comes in many forms. It can be physical, emotional, sexual, financial, or spiritual. In fact, "one in three Victorian's did not agree that trying to control one's partner by denying them money is a form of violence"³. In addition to financial violence, emotional and social violence are generally less likely to be seen as serious by the Victorian community despite research evidence demonstrating their negative health and social consequences for women.⁴

These attitudes highlight a lack of understanding about the nature of partner abuse. Family Violence is in fact any attempt by one partner to have power or gain control over the other. All types of violence have serious health consequences for the victim.

MYTH 2: Things can't be that Bad if She Hasn't Walked Out.

REALITY: There are many reasons why women stay with someone who has been violent towards them. The most compelling reason is that it can be safer to stay. Research has shown that violence often escalates and becomes unpredictable when women leave. Leaving can be dangerous. Other reasons why a woman might stay include:

- Dependence on her partners money or earnings
- Fear, shame, guilt
- Family pressure to keep the marriage intact
- Children
- Fear of being socially isolated
- Hope that the partner really will change

The fact the woman is unwilling or unable to leave does not excuse the violence committed against her.⁵

1. VicHealth, *Two Steps Forward One Step Back*, 2006:22

2. Amnesty International Australia, *Stop Violence Against Women, Fact Sheet 2, Myth Busting*, http://www.amnesty.org.au/_data/assets/pdf_file/11679/fact_mythbusting.pdf Accessed 15/01/07.

3. VicHealth, *Two Steps Forward One Step Back*, 2006:22

4. Ibid

5. Amnesty International Australia, *Stop Violence Against Women, Fact Sheet 2, Myth Busting*, http://www.amnesty.org.au/_data/assets/pdf_file/11679/fact_mythbusting.pdf Accessed 15/01/07.



Continued from Page 2

ATTITUDE: VicHealth's report highlighted that this myth is perhaps one of the most prevailing in our community with the majority of respondents agreeing that it is hard to understand why women remain in violent relationships. Over the last 10 years the number of people supporting this myth has increased by around 4%. According to VicHealth the lack of positive change in community attitudes relating to this myth is of concern given evidence that barriers to women separating from violent partners persist.

MYTH 3: Women Abuse Men Just as Much as Men Abuse Women.

REALITY: Research in Scotland has found that female partner assault constitutes the largest proportion of family violence, with assaults against male partners constituting just 1.1% of all family violence. This research is echoed by the Australasian Centre for Policy Research who states that 'Family violence is primarily perpetrated by men against women and children. Indeed, it appears that violence against women is largely perpetrated by partners rather than strangers.'⁷

ATTITUDE: A considerable proportion of Victorians surveyed by Vic Health (20%) believed that violence is perpetrated equally by both men and women. This percentage has increased by 11% in the last 10 years indicating that there is a poor understanding in the community that domestic violence is committed mainly by men against women and is frequently characterised by a persistent pattern of controlling and abusive behaviours.⁸

MYTH 4: She Asked for it. She Provoked it. She Deserved it.

REALITY: Perpetrators often blame women for provoking them, and women often blame themselves because they have been consistently told that violence is their fault, however no behaviour justifies a violent response. Violence is a tool used by one partner to control or overpower the other partner. When a man is inclined to be violent there is no behaviour or response a woman can use to prevent or stop his abuse. There is only one person who is responsible for violence - the abuser.

ATTITUDE: While very few Victorians were prepared to justify partner violence, Vic Health's Report brought forth evidence of support for beliefs excusing it. Nearly one in four respondents believed that domestic violence can be excused if the partner genuinely regrets what they have done afterwards.



'Cartoon copyright Judy Horacek, reprinted with permission, www.horacek.com.au'

MYTH 5: Violence is in Men's Nature.

REALITY: Violence is not built into men's genes – using violence is a choice men make to exercise power and control. Even children, who have learnt to be violent because this is the behavioural model they have grown up with, are very open to learning otherwise. For example in a refuge shelter for women, 1 in 4 children believed it is OK for a man to hit a woman if the house was messy. After group counselling, none of the children believed this.⁹

Most men who are violent toward their partners are not violent towards friends or colleagues, even if frustrated, thus highlighting the fact that violence is about a desire for power and control.

ATTITUDE: Nearly one in four respondents to the Vic Health survey believed that domestic violence can be excused if the violence results from a temporary loss of control. Surprisingly, the report also found that the antiquated myth that, 'rape results from men not being able to control their sexual urges'¹⁰ was still present in the community with nearly two people in every five supporting this potentially dangerous myth.

As this article illustrates, there are many myths still present in our community relating to Violence against Women. These myths can be damaging in that they result in victim blaming and a lack of empathy and understanding for victims of partner violence. If you would like to speak out against Violence Against Women you can do so by joining Amnesty International Australia's Campaign at www.amnesty.org.au/svaw or by calling 1300 300 920.

If you would like more information about the rights, entitlements and supports available to those affected by partner violence please call GWHS. We are also available to provide information on services and support to family members of those who might be experiencing violence and provide information about ways in which family members and friends can best support and assist women affected by violence.

Stephanie Walters

Health Promotion Project Worker

6. Women Abuse Prevention, *Woman Abuse: Dispelling the Myths*, www.womanabuseprevention.com, Accessed 16/01/2007.

7. Nicholas, R., 1995, Australasian Centre for Policy Research, *the Role of Alcohol in Family Violence*, Commissioners Drugs Committee, May 2005:1.

8. VicHealth, *Two Steps Forward One Step Back*, 2006:22

9. Jaffe, P., 1987, *Promoting Changes in Attitudes and Understanding of Conflict Resolution Among Child Witnesses of Family Violence*:7, Family Violence Prevention Division, National Clearinghouse on Family Violence, Canada.

10. Ibid

CANNABIS UNCUT

Everybody knows that heroin is extremely bad for you. Many people would say that cocaine, ecstasy and LSD are too. But what about Cannabis? It's a fair question, because cannabis, or marijuana, is the most commonly used illicit drug by pregnant women and women of reproductive age.

According to the Australian Institute of Health and Welfare report "Statistics on drug use in Australia 2004", marijuana/cannabis was the most common illicit drug used, with one in three persons having used it at least once in their lifetime and 11% of the population having used it in the previous 12 months. Studies have shown that many people perceive that when cannabis is taken in moderation it is alright, with the perceived risks of marijuana use increasing with increased frequency of use.

So let's look at the facts:

1. What are other names for Cannabis?

Cannabis is the short name for the hemp plant Cannabis Sativa however Cannabis is know by many other names including; marijuana, pot, grass, dope, mull, yundi, ganja, hooch, dagga or hash.¹

2. What is in Cannabis?

Cannabis consists of some 60 chemicals which are technically termed, 'cannabinoids'. These chemicals can have a multitude of effects on your health. When Cannabis is smoked it is absorbed through the lungs into the blood stream and can be detected within 1-2 minutes of smoking. It is then distributed through the body and brain and concentrated in the body's fat stores. When Cannabis is taken orally via food or liquid the absorption into the bloodstream is slower, taking one to three hours, however the effects of the drug may last longer. The effect that using Cannabis will have on a person varies widely depending on the part of the plant used, the experience of the user, their physiological makeup and the amount of the drug used.

3. Who uses Cannabis and why?

Cannabis is the most commonly used illicit drug in Australia. When people start using Cannabis they are usually in their mid to late teens, with one in 5 teenagers having smoked Cannabis in the last 12 months. Australian teenagers are beginning to use Cannabis at an earlier age than they did in the past. The average age for first use was 18.5 in 2001.

Cannabis causes changes in the user's mood, and how they think and perceive their environment. Some users experience a mild 'high' which results from an altered sense of time and heightened senses. However for others the experience can be unpleasant. Some users have reported experiencing confusion and problems with thinking and memory whilst research also shows that some users will experience anxiety, depression, paranoia and panic. Some users even report hallucinations or delusions

While there is little research examining the reasons why people use cannabis it has been suggested that users believe the risks of use are low and they perceive Cannabis use as socially acceptable.

4. What are the physical health effects of Cannabis use?

Short Term:

- While there have been no reports of fatal overdose due to cannabis poisoning, persons who have existing medical conditions, such as asthma, bronchitis, high blood pressure or heart disease, place themselves at risk of aggravating these conditions if they choose to use Cannabis.

Long Term: Dependence

- Respiratory (breathing) problems, such as wheezing, episodes of bronchitis, aggravation of asthma and chronic obstructive airway disease.
- Cannabis may increase the risk of heart attack in people who have other risk factors for heart disease such as obesity or cigarette smoking.
- Cannabis increases the risk of cancer, especially of the throat, mouth and lungs, due to the agents contained in the Cannabis smoke.
- Cannabis has been found to reduce the sperm count and testosterone levels in male animals whilst evidence also suggests that heavy use can affect female fertility.
- Cannabis has been reported to help relieve the symptoms of some medical disorders including glaucoma, multiple sclerosis, HIV-related wasting disorders and pain. Recently Sativex® (a commercial preparation of herbal cannabis), has been registered for medical use in Canada for the treatment of pain.

5. Is Cannabis use linked to mental health disorders?

Cannabis and Psychosis:

Although it is rare, after a session of heavy Cannabis use people may experience a short term psychotic episode. This can last from several hours up to 3 days. If this is the case, there is loss of contact with reality, disordered thoughts, paranoia about other people and objects and sometimes hallucinations. Cannabis use is also reported to cause a psychosis that lingers for weeks or months however this is very rare.

Continued from Page 4

Most people who experience psychosis after cannabis use have a vulnerability to developing a mental health disorder or actually have a disorder. Cannabis use by these vulnerable individuals may trigger an episode of their illness. People who have a family history of mental illness (and this may not be known by many people) may experience negative mental effects including psychosis if cannabis is used regularly.

There is a lot of debate as to whether cannabis causes schizophrenia, a mental health disorder which in most cases causes serious mental health problems over many years. People who smoke cannabis in their teens may have an increased risk of developing schizophrenia however it is not known if Cannabis is the trigger or the cause. Cannabis use results in any mental health disorder becoming more severe and difficult to manage.

Cannabis, Depression and Suicide:

People who use Cannabis are more likely than others to experience depression and of these users depression is more likely to occur in young women users. A link has been established between the high rate of suicide in Australian males and the common use of Cannabis among this group.

Cannabis, Anxiety and Violence:

Cannabis is a sedating drug and is less likely to trigger violence than other substances such as alcohol or cocaine. Cannabis users who commit violence typically have a history of violent acts prior to drug use.

6. What risks are associated with Cannabis use during pregnancy?

Using any drug while pregnant may have a range of effects on the unborn child. Similar to most other drugs Cannabis taken during pregnancy will pass from the mother to the foetus. Cannabis is often used with other drugs like alcohol and/or smoked with tobacco so carries additional risks.

Potential health risks listed on the www.druglibrary.org site include - lower birth weights, length and head circumference; possible impairment of foetal brain development; relative prematurity; malformations due to toxic effects; higher rate of miscarriage and perinatal death. THC also accumulates in breast milk.²

7. Can Cannabis use impair or delay intellectual, social and emotional development?

While there are serious concerns about potential effects of cannabis use on memory and learning, it is still unclear whether Cannabis causes lasting problems in these areas. Adolescent Cannabis use has been linked to a range of social problems while lack of motivation is a very commonly reported effect of Cannabis use. Some users report loss of interest, being less productive, having difficulty in carrying out long-range plans, tiredness, depression and difficulties with concentration and attention.

Current heavy cannabis use may decrease your IQ test scores however this effect seems to disappear after Cannabis use has stopped. Interestingly, adolescent Cannabis use is associated with poorer school performance, more absent days, leaving school early, leaving the family home, early sexual activity and teenage pregnancy and divorce however whether these outcomes are confounded by other risk factors is unclear.

8. Is Cannabis stronger now than it was in the 70's?

Available information indicates that the average chemical content of cannabis has increased a little over the last 20 years however the main difference in strength comes from the fact that the head of the plant is now more commonly used. Additionally the method of consumption has changed over time with today's users being more likely to inhale cannabis via a water pipe known as a 'bong'. It is thought this method of use may result in greater exposure to inherent chemicals.

There has been no systematic investigation of whether hydroponically grown cannabis is stronger than naturally grown cannabis however concern has been expressed over the use of additives such as fertilizers, pesticides, and hormones in hydroponic cultivation to try and increase yield.

9. Is Cannabis a gateway drug?

Cannabis use, particularly at a young age, increases the risk of other drug use. The link between Cannabis use and the use of other illicit drugs is usually due to personal traits that make it more likely for the person to take part in risky behaviour.

Stephanie Walters

Health Promotion Project Worker

Information for this article was sourced from the Australian National Council on Drugs 2006 Cannabis Answers to Your Questions Booklet, March 2006, unless otherwise referenced.

References: 1. *Family Drug Support, A Guide to Coping, version 3, November 2002 (1)*
2. <http://www.druglibrary.org>

Gender-based persecution: the facts

Refugee women are among the most vulnerable people in the world. Whilst most refugees experience traumatic and life-threatening situations, often women must also contend with extreme levels of physical, sexual and gender-based violence. For many of these women, resettlement will remain an impossible dream.

What is gender-based persecution?

Gender-based persecution is defined as oppressive, harmful or abusive treatment meted out on the basis of one's gender that amounts to severe discrimination and is likely to result in physical, sexual or psychological harm or suffering. Women can suffer from gender-based persecution that is unique to their gender, such as female genital mutilation or forced abortion, or types of persecution that are more likely to be inflicted upon women than on men, including rape, domestic violence, honour killings or being trafficked into sexual servitude.

Gender-based persecution can occur in a women's public or private life. The persecution can arise from government social policy or discriminatory cultural practices and attitudes to women. It affects women across the globe, in all cultures and social classes. It can be carried out by public officials, men in positions of power and private individuals, family members, neighbours or partners.

Seeking asylum

Refugee women and women displaced in their own country are especially vulnerable to persecution on the basis of gender. They may be persecuted and abused by governments, insurgent groups and other refugees as a result of surrounding social tensions, the breakdown of normal legal and government codes and the loss of traditional protection mechanisms, such as male family members, through fighting and a breakdown in contact. The collapse of social order that often accompanies conflict means refugee women rarely have access to adequate legal avenues when they face gender-based persecution.

Women may also flee violence at the hands of family members or members of their community. They may also fear the local police or judicial authorities as these people can often be the ones to carry out the persecution.

Generally, even though refugee status has been granted to people fleeing persecution by governments, women's refugee claims of gender-based persecution have often been dismissed as private incidents that are specific to a particular culture, religion or political regime.

"A refugee is someone with a well-founded fear of persecution on the basis of his or her race, religion, nationality, political opinion or membership of a particular social group, who is outside his or her country of origin and is unable or unwilling to return." The Refugee Convention.

After continued pressure from refugee advocates and human rights bodies, gender-based persecution has begun to be recognised by international law, governments and protection bodies as a serious abuse of women's human rights and a legitimate basis for refugee protection.

In the late 1980s the United Nations High Commission for Refugees (UNHCR) developed a specific humanitarian visa class entitled 'Women at risk'. This visa class aims to benefit refugee women in desperate circumstances who lack the protective social supports of friends or family, or who are vulnerable to or have experienced, rape, gross discrimination or sexual violence.

Protection in Australia

Australia is one of only three countries to host a Woman At Risk resettlement program, which began in 1989. Since that time, the Government has resettled approximately 6000 refugees under the program. Each year, 10.5% of all refugee places are allocated specifically to Women at Risk.

While significant, Australia's Women At Risk program is not yet adequate. Refugee advocates have argued strongly that the quota is too low. There are also concerns about the adequacy of care and support systems for the women.

Additionally, under the Australian program, 'woman at risk' are identified as those who are without the protection of a male relative. This narrow definition is contrary to the UNHCR policy, and fails to take into account the personal circumstances of refugee women. It fails to take into account whether or not it is appropriate to assume the male relative can or will protect a particular woman.

The existence of gender-based persecution needs to be acknowledged and understood by decision-makers, immigration officials and the general public as a human rights abuse that is never acceptable, and as something that can occur in all facets of a woman's life – work, home or in the company of friends, government officials, strangers, employees or family members.

Resettlement countries, including Australia, have a responsibility to ensure that refugees and asylum seekers who are victims of gender-based persecution are supported and encouraged to state their claims. Governments must acknowledge, value and respect these claims and provide victims with adequate and appropriate protection and support.

Jodie Pullman

Health Promotion Officer

Information in this article has been obtained from the following sources:

Amnesty International Australia. 'Women fleeing violence, seeking asylum' Fact Sheet

www.amnesty.org.au



amnesty international australia
promoting and defending human rights

Uniting Justice Australia, 'Refugee Women at Risk' Fact Sheet

http://nat.uca.org.au/unitingjustice/resourcearchive/infoandaction/factsheets/FS_WomenAtRisk.pdf

Debunking the Myths about Asylum Seekers

Women have migrated to Australia from diverse countries and cultures. Most are voluntary migrants but some are refugees or asylum seekers. Under Australian law introduced in 1992, all asylum seekers who arrive without valid entry papers (including women and children) are held in mandatory detention until their refugee status is proven. In some cases this can take years.

This article looks at some of the common myths surrounding asylum seekers in Australia.

Myth 1 - Asylum Seekers are Illegal

Fact: This is untrue. Under Australian Law and International Law a person is entitled to make an application for refugee asylum in another country when they allege they are escaping persecution. Many asylum seekers are forced to leave their countries in haste and are unable to access appropriate documentation. In many cases oppressive authorities actively prevent normal migration processes from occurring.

Myth 2 - We're being swamped by hords of boat people

Fact: 300,000 refugees arrived in Europe to seek asylum in 2000. In contrast, 4174 reached Australia by boat or plane. In 2000, Iran and Pakistan each housed over a million Afghan refugees. The real burden of assisting refugees is borne in the main by the world's poorest nations.

Myth 3 - Australia already takes too many refugees

Fact: Australia receives relatively few refugees by world standards. In 2005-06 a total of 14 144 visas were granted under the humanitarian program (Dept of Immigration and Multicultural Affairs). This number has remained relatively static in recent years despite the ever-increasing numbers of refugees' worldwide.

Refugees re-settle all over the world. However, the distribution of refugees across the world is very unequal.

Tanzania hosts one refugee for every 76 Tanzanian people (1:76)

Britain hosts one refugee for every 530 British people. (1:530)

Australia hosts one refugee for every 1583 Australian people. (1:1583)

Myth 4 - It is not safe to let them out

The news coverage of asylum seekers 'escaping' from detention centres often depicts these people as criminals. People are warned not to approach them and to notify police.

Many fear that if asylum seekers were allowed to stay in the community they would commit crimes, spread disease and would disappear into the community without being cleared by the authorities.

Fact: These same concerns are expressed around the world, however Australia is the only Western country that mandatorily detains these people whilst their claims are being heard. Other countries that do not have mandatory detention have not seen crime waves, the spread of disease or other social problems, indeed in some countries the rules are becoming more humane.

Myth 5 - There is no alternative to Mandatory Detention

Fact: Asylum seekers claims need to be assessed for legitimacy. Australia is the only Western country that mandatorily detains asylum seekers whilst their claims are being heard. At a cost of \$104 a day per head the policy of detention is very expensive. Community based alternatives to mandatory detention can be found internationally and within the current Australian parole system. Sweden receives similar numbers of asylum seekers as Australia, despite having less than half the population. Detention is only used to establish a person's identity and to conduct criminal screening. Most detainees are released within a very short time, particularly if they have relatives or friends living in Sweden. Children are only detained for the minimum possible time (a maximum of 6 days).

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Jodie Pullman
Health Promotion Officer

Abortion Myths Answered...

Abortion is the term most non-medical people associate with a termination of pregnancy. In the medical world this is called medical or surgical abortion which is "the early ending of a pregnancy, prior to full term, by medical intervention. This procedure occurs early in a pregnancy, usually before 12 weeks, when the foetus is not capable of surviving as it is not fully developed" (Women's Health Victoria, 2007). However abortion is the term also used in the medical world for a miscarriage, which is termed a spontaneous abortion.

There are no accurate figures in Australia for surgical abortions, as only a couple of states including South Australia have mandatory reporting and record numbers accurately. Around 20% (a conservative estimate) of all pregnancies end in a spontaneous abortion or miscarriage, sometimes before a woman even knows she is pregnant when it may be experienced as a late, heavy period. In the following article, the word abortion will apply to medical abortions.

The Australian view:

Abortion is generally available in Australia and regarded as legal. However in all states excepting Western Australia and Canberra, this is not so. Abortion law in Australia varies across state and territory jurisdictions but the procedure is generally not considered illegal if undertaken to protect the mother's physical and mental health. However, apart from the states mentioned, abortion remains in the Criminal Act in Victoria and the rest of Australia.

Laws that regulate the practice of medicine apply to the provision of abortion. Three additional categories of criminal law also relate to abortion. In Victoria, the Menhennitt ruling (1969) represents the legal position of the crime of 'unlawful abortion'. The ruling determined that abortion was lawful if it was considered necessary to safeguard the physical and mental health of the pregnant woman. However after successful prosecution in Tasmania, the presence of this ruling has made it difficult for doctors who may believe in a woman's right to choice, but are reluctant to expose themselves to possible court action. In fact when this occurred in Western Australia a few years ago, their Parliament hurriedly acted to move Abortions onto the Health Act and off the Criminal Code.

Studies in recent years have shown that Australians who are fundamentally opposed to abortion under any circumstances represent the smallest minority (Australian Reproductive Health Alliance). The Australian Survey of Social Attitudes 2003 showed that 81.2% of respondents were pro-choice, agreeing that a 'woman should have the right to choose whether or not she has an abortion'. Similar beliefs were held by respondents with religious views, with 77% supporting the right of a woman to choose whether or not she had an abortion.

Global myth busting:

There are many myths surrounding abortion, which are often in stark contrast to the real picture. The Women's Global Network for Reproductive Rights has produced

the following information that debunks the anti-choice myths surrounding abortion:

Myth:

Criminalisation of abortion is a sure way to eliminate abortion.

Reality:

Criminalisation of abortion simply drives abortion underground. It does not stop women from having abortions; rather it forces women to have abortions in dangerous conditions, which threaten their health and lives. A clear example is Romania under Ceaulescu where abortion was forbidden for any women younger than 45 with less than five children. Notwithstanding a special arm of the Secret Police Force to monitor pregnant women and to keep an eye on married women who did not conceive, the abortion rate and the maternal mortality rate related to abortion was higher in Romania than in almost any other European country. (GWHS Nurse's note: in fact illegal/unsafe abortions are still a leading cause of maternal deaths in the world today.)

Myth:

Legalisation of abortion prevents clandestine abortions.

Reality:

Legalisation in itself is insufficient to prevent clandestine abortions. While information is lacking and where services are inaccessible for many women, clandestine and unsafe abortions continue to take place. India, Russia and Zambia are examples of countries where abortion is legal but where there are still high numbers of clandestine abortions. This is due to several factors; women are unaware of their rights, women are still being stigmatised when they are known to have had an abortion, and services are absolutely inadequate to help all women who need an abortion.

Myth:

When abortion is legalised, the abortion rate will increase.

Reality:

Comparative research in Europe on the developments regarding abortion has shown that the legalisation or liberalisation of abortion has not caused an increase in the incidence of abortion. The abortion rate is not dependent on legalisation per se but on other conditions like the availability of adequate contraceptive services and sexual education.

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In many Central, Eastern and Southern European countries the abortion figures remained high after legalisation, because contraceptives and sexual education were hardly available. In several Western European countries where legalisation was accompanied by a strong impetus in sexual education and contraceptive services, the abortion figures started to decrease after legalisation.

Myth:

It is mostly young, unmarried women who are having abortions.

Reality:

Women of all ages, married and unmarried, have abortions. In Latin America, abortion rates among women over 35 are twice those of women aged 20-34. A study from India showed that a large majority of women seeking abortions were between 20 and 29 years of age and most had several children already. In Africa, data points to a growing reliance on abortion by older women with several children. In Tunisia rates are highest among women aged 25-39. Nevertheless, teenagers and young women remain a vulnerable group regarding unwanted pregnancies. In the United States abortion rates tend to be highest among teenagers and women between 20 and 24 years of ages.

Myth:

Women will always be traumatised by having an abortion.

Reality:

Whether women are traumatised by abortion depends on the circumstances in which the abortion took place. Abortions performed in illegal and unsafe conditions and forced abortions are traumatic. Where abortion is illegal, women are criminalised and are forced to have abortions in secret. In those circumstances, women dare not talk about their thoughts, their fears and their experiences, which is traumatic in itself and causes unnecessary feelings of guilt. Often, abortionists or their helpers abuse them. In countries where abortion is legal, where information about abortion is readily available, and where there are good quality abortion services, including the provision of counselling services before and after the abortion, abortion may be a difficult decision for women but is hardly ever a traumatic experience. *(GWHS Nurse's note: studies in Australia show that it is women who are forced to have a termination by their partner or parents who may suffer mental health problems afterwards.)*

Myth:

Induced abortion is always a dangerous and complicated procedure.

Reality:

Abortion, in legal circumstances and in countries with a good health care system, performed by well-trained and skilled people, is an easy and very safe procedure. After the thirteenth week of pregnancy the procedure is more complicated and there is more risk involved, but again when performed by competent people, still the risk is relatively low. Abortion is far safer than childbirth.

Myth:

Where contraceptives and sexual education are available, abortion services will no longer be necessary.

Reality:

Even in countries like Denmark, Sweden and the Netherlands where contraceptive services and sexual education are widely available, abortion services remain necessary. However the Netherlands have the lowest teenage pregnancy rate in the world and this is thought to be due to their excellent sexual health education in schools and the ready availability of condoms. There are and always will be girls and women with unwanted/unplanned pregnancies. Contraception can and does occasionally fail. Women in menopause, who have not menstruated for a long time and think they could no longer get pregnant, suddenly find themselves pregnant. Pregnant women who lose their partner may not feel able to raise a child alone. Women are raped and subjected to incest when not protected by contraception. These are just some examples to show why abortion services will always be necessary, not as a necessary evil but as a social reality and a basic right of women.

Jodie Pullman,

Health Promotion Officer

References:

- ACSPRI Centre for social Research (2003) Australian Survey of Social Attitudes 2003, Australian National University, Australia.
 Jacobson, J.L (1990) The Global Politics of Abortion. Women's Global Network for Reproductive Rights, Netherlands.
 Women's Health Victoria (2007) Abortion, www.whv.org.au/health_issues/abortion.htm

My Cup of Relief

Us women always have a lot on our minds to worry about; what's for dinner, kids, family, household, money, contraception etc. Periods also used to be in my list of things to worry about. But about nine months ago I found a way to make them much more bearable.

When my son was born, I was very interested in using cotton nappies, as they were much more environmentally friendly and healthier for my baby than disposable nappies. If you actually add up how many disposables a baby goes through in a year, the figure is quite shocking. This got me thinking of how much waste my monthly use of period pads was creating.

I had read of alternatives like cotton pads, and other methods which cut back on waste, but one particular article caught my eye: "experience the freedom that period pad and tampon providers only promise". Quite a statement most would think. But after looking into the menstrual cup it sounded like it deserved a shot.

The menstrual cup is and acts literally as it sounds - as a cup. During your period you place the cup in the vagina, but not as deep as you would a tampon. When the cup is placed correctly, you cannot feel it inside you as it catches the menstrual flow. When full, it is taken out, and is emptied into the toilet and washed manually before being reinserted. It has a small stem at the bottom to help get it out.



Every woman has different kinds of periods. Mine are quite heavy and I empty my cup usually twice a day. It's made from clear silicon (rubber is also available) and with proper care can last for 10 years. The cup comes with a really good users guide and the internet offers even more information.

I ordered my cup from the internet. In the beginning it wasn't easy to use. Inserting it was difficult, and getting it out without making a mess was difficult. But after about 3 periods I knew how to work with it. And it really did work! No more itchy and sweaty pads. No more bad smell of dry blood. I could wear anything and do any activity and still feel comfortable. Between periods I keep my cup in a cotton bag that came with it, and during my periods it is always with me.

As it turns out 'experience the freedom' was more truthful than I thought it could be! Though the menstrual cup goes in the vagina, it doesn't dry or scratch the vaginal walls or leave fibres behind as tampons can. The cup doesn't interfere with the vagina's self-cleaning ability as tampons can and so has never been linked with toxic shock syndrome.

I got really excited about this cup; I wanted to tell everyone about it, including my poor husband! I found out that two of my friends had actually been using it for a while and they were also keen to share their discovery.

I have just moved to Australia from Finland, (English is my second language in case you haven't noticed) and no one here seems to know about this cup. So here I am sharing my experiences and some official facts about it.

- The menstrual cup can last for up to 10 years with proper care. In that time a woman uses about 1700 pads or tampons.
- In the market there are many different cups with a choice of 2 sizes: one for women under 30 who haven't been pregnant and one for women after pregnancy or women over 30 even if they haven't had a baby.
- The cup has never been linked to any health risks; it won't cause irritation and is suitable for women with sensitive skin, thrush, eczema or allergies.



The biggest problem with the cup is that it is very easy to forget, though you can keep it in for a maximum of 12 hours. Another setback is of course, like with tampons, you have to take it out before having sex. But these are things I can live with.

I'm very annoyed that I hadn't heard of this cup earlier. I am only 23 however and take comfort in the fact that I won't have to use pads and tampons ever again. But why doesn't anyone hear about it? "Most of us have grown up in an era, which offered no alternative to disposable feminine hygiene products and this fact has contributed to the way in which we think about our periods and menstruation".

We women have gotten so used to pads and tampons that we don't even question whether there is a better way. Most women have periods every month. And most of us find them quite annoying. But we deal with it because we all have them, and we all deal with them in the same way, its part of the routine. This is exactly where the problem for the success of the menstrual cup lies.

Continued from Page 10

"A number of different companies have attempted to promote the use of menstrual cups during the 20th century many of these products were withdrawn when they failed to gain enough market share".

It is the same with disposable nappies. The convenience of single use nappies, pads and tampons which fit with our routines, is simply too much of a strong selling point for menstrual cups and reusable cotton nappies to compete with. But this doesn't change the effectiveness of the cup, and the comfort it provides, as all those who use it know very well. It is my belief that the menstrual cup will slowly be accepted into wider use through word of mouth.

Using this cup has made me more open to new things, alternative ways to care for myself and my surroundings, and it has also taught me a lot about my own body. I would never go back to using pads, already just because of the greatly improved level of personal comfort they provide. It feels good thinking about how much better it is for me, and how much less waste I am putting out into the environment.

Think about the freedom and try it. You can always stop using it, if it doesn't suit you. But remember it will take a few cycles to get used to it. If it works for you like it has worked for me, you will feel the urge to tell every woman you meet about it, and appreciate the true comedy of pad and tampon advertisements offering the very same freedoms.

Quotes and more information:

www.mooncup.co.uk?menstrual_cup_not_convinced
www.kuukuppi.fi

Mari Nelson (*with a little help from her husband*)

Many thanks to Mari for writing this interesting article about a little known alternative for menstruation, and sharing her experience with us.



Fruit Tarts

July 2012

Myths About Menstruation

Do you remember hearing these when you were younger?

What you cannot do when having a period:

Wash your hair

Have a perm

Go swimming

Eat pickles

Go to the dentist!

and Start early – finish late

Virgins shouldn't wear tampons - MYTH

Tampons can't take away your virginity. If you feel comfortable using tampons during your period then go ahead. The only way to lose your virginity is by having sex.

You can't get pregnant during your period - MYTH

It's not likely, but there's always a chance - particularly at the end of the menstrual cycle. What's more, unprotected sex increases the risk of exposure to sexually transmitted infections.

Periods are unclean - MYTH

Quite the opposite! Periods are a sign that the female body is functioning healthily.

You shouldn't bathe or wash your hair during a period - MYTH

Rubbish! Some women perspire more during their periods, or find their skin and hair becomes greasier, so it's important to keep clean and fresh.

You should always rest during your period - MYTH

Do whatever makes you feel comfortable, but don't be afraid to exercise. If anything, it's a good way of controlling PMS and cramps because it increases the supply of oxygen to the muscles.

You can tell who is having their period - MYTH

At any one time, a quarter of all women between the ages of about 10 and 50 will be having their periods, but you can't tell just by looking.

NURSE'S SNIPPETS

20% of Women Lung Cancer Patients are Non-smokers: Study

"A US study has found up to 20 per cent of women who develop lung cancer have never smoked... They have attributed the high level of cancer among non-smokers to passive smoking."

This was the headline on A.B.C. online, and on the surface is shocking, but we know that workers exposed to passive smoking get lung cancer - hence new laws around this. It is also known that girls under 12 exposed to passive smoking have higher rates of breast cancer than those growing up in a non-smoking household. Smoking also increases the health risks associated with the oral contraceptive pill such as blood clots / strokes and also affects unborn children. It has also been found that smoking under 5 a day is no less risky than smoking more than 10 a day. There is no safe level of smoking. If you need help to stop, remember QUIT can help you, and our Library has some excellent books for women wanting to quit.

Pregnant Women Continue to Drink Alcohol

A new Australian study has found that 47% of pregnant women continue to drink alcohol during pregnancy and breast feeding, despite the fact that babies can be harmed by this. And it's no good pointing the finger at teenage mums because the finding was that "Tertiary-educated, older, English-speaking women on higher incomes were the most likely to drink". This may be because some Australian guidelines still say that drinking within the safe drinking guidelines is okay. The World Health Organisation statement is that there is no safe level of drinking during pregnancy, as alcohol crosses the placenta and can cause foetal alcohol syndrome. Some women have alcohol affected babies on minimal alcohol intake hence there is no safe known level of drinking during pregnancy. Australian guidelines are under review.

Are Women Cleaner than Men?

ABC news on the web (13.2.07) reports a study from the University of Arizona that found women's offices have 3.5 times more germs than men's. Reasons included the fact that we use hand lotion and makeup which both attract bacteria and get spread by hands and makeup paraphernalia. Our desk drawers are apparently another source of bugs because (according to the study) we store food in them, and another factor was that we are around children more, and of course they are germ ridden little things! Apparently 1/3 of handbags tested had faecal (poo) bacteria on them but "men's wallets and Palm Pilot cases were actually dirtier". Yuk! The study says bacterial wipes are good for cleaning surfaces, especially phones.

Nurse's comment: This highlights the need for good hand washing technique before eating and after the toilet-at least 10 seconds with soap and water making sure to include both thumbs and between the fingers. If you have your periods you need to wash your hands before changing pads or tampons as well as after. Hand washing is protective against gastro and a host of other viral and bacterial illnesses.

Sleep Apnoea

One of our valued readers thought that one of the articles from our last Newsletter ('Sleep and the Problem of Not Enough') should have mentioned more about sleep apnoea [sa] and its dangers. So here it is! Apnoea means not breathing. "Sleep apnoea is a disorder which can stop breathing up to 300 times a night. The main symptom is snoring, and the disease has been linked with car accidents, heart disease, stroke and hypertension. The frequent interruptions to sleep often cause early morning headaches and excessive daytime sleepiness".¹ It is now recognized as a women's health issue and a study done by The Australasian Menopause Society found that "Postmenopausal women are at high risk for undiagnosed sleep apnea"² "with the ratio of men to women affected is 2:1... Other important factors are thought to include age, race, genetics...obesity"³. Children with enlarged tonsils and adenoids can also suffer from sa. Getting drunk and snoring has the same effect and can be dangerous! So if you wake up tired and/or headachy and don't know why, you should discuss this with your doctor. She/he can refer you to a sleep lab where you'll be wired up while you sleep and via oxygen levels and other measurements a diagnosis can be made. Once diagnosed there are various treatments depending on the cause, and treatment can be life changing as well as life saving.

1. www.abc.net.au/science/news/stories/s109945.htm

2. www.menopause.org.au/education/sleepapnoea.asp

3. <http://thorax.bmj.com/cgi/content/full/54/4/284>

Over 1/4 New Cervical Cancers Affect Women in Their 60's

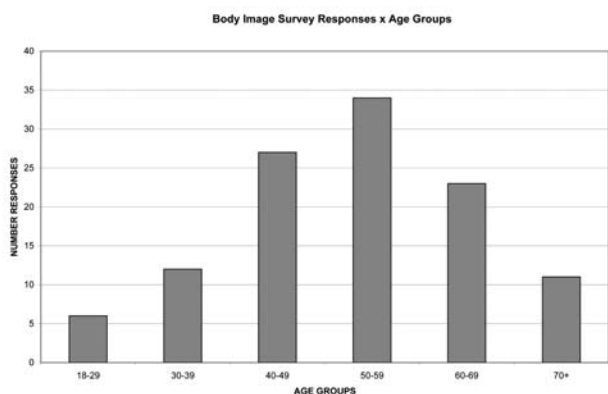
Australia has very low rates of cervical cancer because of papsmears. They detect pre-cancerous changes of the cervix in women who have ever had sex- which means genital to genital contact for both straight and gay women. Sadly a new study by the Australian Institute of Health and Welfare has found that only half of 65-69 year old women are being screened and one quarter of all new cervical cancers are in this age group. Is this because women in this group think that if they are no longer sexually active there is no need for a papsmear? Or are there other reasons like embarrassment or pain? Did you know that if a dry vagina is an issue, oestrogen cream applied vaginally for a short while can alleviate this problem? Whatever the reason it is important to discuss your concerns with your health provider, rather than avoiding this important life saving screening.

Papsmears are recommended every 2 years for sexually active women over 18 years (you start 2 years after first having sex or after turning 18 whichever comes last) and are a preventative measure, unlike breastcreeen where mammagrams try to find existing cancers. Of course your GP's can do them but nurses are also trained to do papsmears and generally give long appointments of about 45 minutes at the cost of about \$10 - \$15.00. Other women's health issues can often be discussed at these sessions. Local providers can be found on the web at <http://www.papscreen.org.au> or you can call GWHS to find your closest papsmear provider.

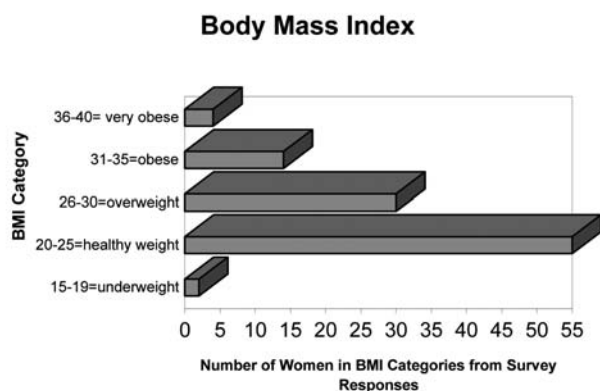
Alma Ries,
Community Health Nurse

RESULTS OF THE BODY IMAGE SURVEY

In the Autumn 2006 issue of GWHS Newsletter a Body Image Survey was distributed to our readers. 113 of you sent back surveys which was a fantastic result, thank you all. At last, we are pleased to be able to report the preliminary results to you, with following Newsletters looking at different areas of the survey in depth.



The survey asked Gippsland women how they feel about their bodies, their dieting behaviour, their level of self-esteem and things that have impacted on it, their height and weight, so we could determine Body Mass Index, activity levels, things that interfere with this, past dieting behaviour, doctor's and other professionals' impact on these issues to list but a few. We are not looking at BMI's to check weights but to look at how women feel about themselves in relation to that very arbitrary measure.



Women who've responded have given us a great insight into how they view themselves and their comments have really added to the picture for us. You'll see from the two graphs included in this article the ages and numbers of women who replied, and also their Body Mass Index across all age groups.

In looking at whether women see themselves as over, under or a healthy weight, it is clear this doesn't correlate with their actual weight, with many of the women within the healthy weight range, seeing themselves as overweight, and the majority of women engaging in various levels of dieting behaviour. This ranged from only 2 of all the women not dieting at all and 10 engaging in severe dieting behaviour. The majority of women across all ages engaged in moderate to high levels of dieting as calculated by the Key Dieting Questions.

Most do some physical activity of various sorts and barriers to being active included things like pain and time. Very few across all ages smoke and self-esteem as measured by the Rosenberg's 10 Question Scale showed most had medium self-esteem, a few high and none low, which is great. However this needs further breaking down to make it meaningful.

Things that impacted on how women in Gippsland feel about themselves included predominantly clothes shopping, but also family, magazines, TV, workplaces, friends and mirrors (not a category) but not newspapers.

Before the next Newsletter all these issues will be looked at and teased out, and then your answers will help us work better to help you! Thank you again for all your responses.

Alma Ries,
Community Health Nurse

It looked so much better
in the shop...



NEW RESOURCES AVAILABLE FROM THE LIBRARY

To borrow resources please call in to the service or phone us and we can send them to you using our FREE REPLY PAID Post System

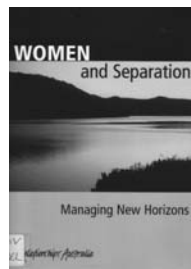
FREE CALL 1800 805 448

BOOKS *****

WOMEN AND SEPARATION - Managing New Horizons

Rogers, Margot et al

Relationships Australia booklet for women going through a separation or divorce with advice on looking after yourself, relationship with children, and the future.



AUSTRALIAN SECONDARY SCHOOL STUDENTS' USE OF ALCOHOL IN 2005

WHITE, Victoria; Jane Hayman

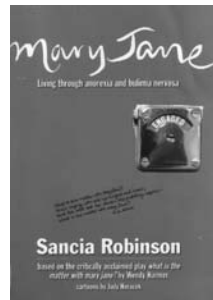
Evidence and statistics on research of 12-17 year olds.

20% of all 16-17 years consumed an amount of alcohol that exceeded Australian Alcohol Guidelines on at least one occasion prior to study. And when students do drink it is at levels that increase their risk of experiencing short term harms. 47% of females drank premixed spirits.

MARY JANE - Living Through Anorexia and Bulimia Nervosa

Robinson, Sancia

Mary Jane is the inspiring story of Sancia Robinson who has battled with anorexia and bulimia for over 15 years. In the world of waif-like catwalk models and a late twentieth century obsession with being skinny, this book is a timely guide to helping women of all ages deal with a negative body image. Packed with information, how to get help and make sense of the media madness, Mary Jane is a vital read for all women, their friends and families. It also has the advantage of being illustrated by Judy Horacek's wonderful cartoons.



BETTER PATHWAYS - An Integrated Response to Women's Offending and Re-offending

A four year strategy to address the increase in women's imprisonment in Victoria 2005- 2009 including better housing and access to legal support

WHEN THE CHILDREN ARRIVE - A Resource Book for Carers

Mirabel Foundation

Booklet for the carers of children orphaned or abandoned due to parental illicit drug use. Covers legal and Centrelink options, what to tell the children, whether to take children to a funeral or prison, behavioural difficulties, and looking after the Carer.



PARTNERS - A Guide to Successful Relationships

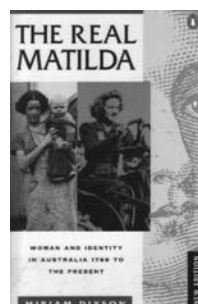
Relationships Australia

Booklet on starting a new relationship, the expectations, communicating with a partner, and warning signs

THE REAL MATILDA - Women and Identity in Australia 1788 to the Present

DIXSON, Miriam

Highlights the colonial influences and the role that women played as well as a review of modern times (1990s) relationships between Australian women and men

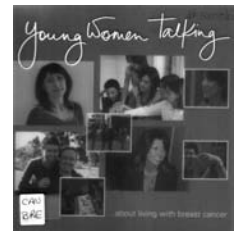


DVD *****

YOUNG WOMEN TALKING - About Living with Breast Cancer

BreaCan

Young women in an upbeat/cafe scenario, talking about diagnosis and afterwards. They talk about fertility, relationship issues, hairloss and kids.



MOVEMENT TO MUSIC - Easy Level: Move It or Lose It DVD Series No 1

Arthritis Victoria

DVD is designed for anyone new to exercise or who is looking for a new way to exercise without leaving the support of their chair. These are gentle movements set to music and designed to keep joints mobile and healthy.

CHAIR BASED EXERCISE - Easy Level: Move It or Lose It DVD Series No 2

Arthritis Victoria

DVD is designed for anyone looking for a new way to exercise without leaving the support of their chair. Exercises are for the whole body to improve joint and muscle movement as well as posture and strength.

CHAIR BASED AND MORE - Easy Intermediate Level: Move It or Lose It DVD Series No 3

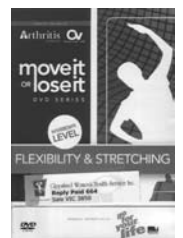
Arthritis Victoria

DVD is designed for anyone who can stand with the support of a chair and is looking for more of a challenge than purely chair-based exercise. It focuses on exercises either sitting or standing with a chair for support involving a series of muscles stretches and mobility exercises for the whole body.

FLEXIBILITY & STRENGTHENING - Intermediate Level: Move It or Lose It DVD Series No 4

Arthritis Victoria

This DVD is aimed at mobile older adults with good balance who want to improve their flexibility and are comfortable with exercise whilst standing. It focuses on the principles of yoga such as relaxation and breathing combined with exercises.



LOW IMPACT AEROBICS - Advanced Level: Move It or Lose It DVD Series No 5

Arthritis Victoria

DVD is designed for those who are comfortable with faster movements and changes in direction when walking. It focuses on improving fitness and strength which can resist the risk of falls.

CUTTING

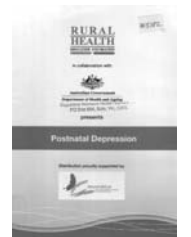
Jane PSA

Actress Demi Moore narrates a short 30 second animation on the effects of cutting and self harming and encourages young women to seek advice and help.

POSTNATAL DEPRESSION

Rural Health Education Foundation

Medical program on PND, that covers pregnancy as well as early motherhood and is suitable for both workers and clients. Issues affecting Koori and non-indigenous women are addressed. Assessment and treatment considers a number of factors eg: breastfeeding, the foetus and the infant, as well as the possibility of domestic violence. Program covers the trauma that PND can inflict upon all the family as well as women who have lost a baby. It also gives strategies for women affected by PND. Also available in video.





Application for Membership

Gippsland Women's Health Service Inc.

REG. NO. AOO24460W

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 _____ Post Code _____

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 NoDo you wish to receive periodic email updates? Yes No

> Membership is for one year only and must be renewed annually.

> 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 Woman's Health Service Inc.

Signature of Applicant _____ Date _____

Please complete and return to:

Gippsland Women's Health Service Inc

Reply Paid 664, Sale Vic 3850

Office Location: 56B Cunninghame Street, Sale Vic 3850

Telephone: 03 5143 1600 or 1800 805 448 Fax: 5143 1224

Email: admin@gwhealth.asn.au Website: www.gwhealth.asn.au

For Office Use Only:

Date Received: _____ Date Letter Sent: _____

Date Entered into database: _____ By: _____

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PO Box 664 SALE 3850



GIPPSLAND
WOMEN'S
HEALTH
SERVICE INC.

REG. NO. AOO24460W

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 from our free postage library service in the form of books, videos, articles, pamphlets and audio tapes
- 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 |
| ■ Co-Care 24 Hour Aged, Disability and Carer Support | 1800 242 696 |
| ■ Gippsland Centre Against Sexual Assault | 1800 806 292 |

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 9 am to 5 pm weekdays.

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.