

# Health Journey

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In this edition

Indigenous women's  
health

Sexualisation of girls

Improve your chances  
of pregnancy



## Editor's view

On 8 March this year we celebrate 100 years of International Women's Day.

The first International Women's Day in 1911 saw women demanding the right to vote, to hold public office, to work, to access vocational training and to not be discriminated against while at work.

In Queensland, most women have held the right to vote since 1905. However, it was not until 60 years later that Indigenous women held this right. In 1915 Queensland women were able to stand for election but it was not until 1928 that Irene Longman was elected. The Queensland State Parliament still has not had an Indigenous woman member to this day.

In 2011 women are leading active public and private lives but our work is still not valued as much as that of men – women working full time in Australia are paid on average 18% less than their male counterparts – still!

As mothers of dependent children have increased their workforce participation they have continued to act as primary caregivers as well as retaining the majority of domestic responsibilities. A recent report comments that "[mothers] have greatly increased their participation in the labour market, but fathers haven't matched that with an increase in unpaid household work."

A woman's income and burden of work impact directly on her health outcomes.

On 29 December the *National Women's Health Policy 2010* was released by the federal government. It notes overall improvements have been gained in the health of Australian women over the past two decades. However, these improvements have not been experienced equally. Aboriginal and Torres Strait Islander women in particular have not benefited as much from these improvements.

Aboriginal and Torres Strait Islander women live for, on average, almost a decade less than other Australian women. In our article on page 3 Kirsten Braun looks at five areas that we need to continue to work towards better outcomes for Indigenous women.

This International Women's Day we should celebrate the achievements of the past century but keep in mind that there is still much work to be done to ensure all women are equal.

If you would like to receive *Health Journey* via email each month you can subscribe online at our website [www.womhealth.org.au](http://www.womhealth.org.au).

Lorraine Pacey  
Editor



### About us

Women's Health Queensland Wide Inc (Women's Health) is a not for profit, health promotion, information and education service for women and health professionals throughout Queensland. Services include:

- **Health Information Line**  
A free information and referral service for Queensland women
- **Health information** and free lending library via [www.womhealth.org.au](http://www.womhealth.org.au)
- **Health education** for community and health professionals

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# Indigenous women's health and wellbeing

• In the centenary year of International Women's Day we look at the health and wellbeing of Indigenous women in Australia.

International Women's Day, held on 8th March, recognises the economic, political and social achievements of women in the past, present and future. While it is a day of celebration it is also a day to reflect on areas where improvement is still needed, such as Indigenous health.

The life expectancy for Indigenous women is 72.9 years, almost 10 years less than non-Indigenous women at 82.6 years. This figure is actually higher than previous estimates, although this sadly does not reflect an improvement in life expectancy, but a change in the way the statistic is calculated. Unfortunately, many Indigenous deaths are undercounted (i.e., the deceased person is not identified as Indigenous) which makes gaining an accurate picture of life expectancy difficult.

Here are five areas of Indigenous women's health and wellbeing where we need to 'close the gap'.

## **Pregnancy/birthing**

The Australian teenage pregnancy rate has dropped dramatically in the last few decades. However, a similar decline has not occurred in the Indigenous population with the indigenous teenage pregnancy rate more than four times higher than that of all teenage girls. Having a baby at a young age reduces the chances of continuing education and, in turn, employment prospects. Babies born to Indigenous women of all ages weigh on average almost 200g less than babies born to non-Indigenous women. Factors that contribute to this lower birth weight include nutrition, premature birth and alcohol and tobacco use during pregnancy. Indigenous women were three times more likely to smoke during pregnancy than non-Indigenous women (52% compared to 15%).

## **Cardiovascular disease (CVD)**

CVD is the leading cause of death amongst Indigenous women. This death rate is 2.6 times higher than that for non-Indigenous women. CVD is occurring at a much younger age in Indigenous people. For example, the death rates associated with CVD for Indigenous people in the 35-44 and 45-54 age groups are 7 and 12 times higher than for non-Indigenous people. Risk factors such as smoking, obesity, lack of physical exercise and poor diet all contribute to the higher rate of cardiovascular disease in Indigenous women.

## **Cervical cancer**

The incidence of cervical cancer in Indigenous women is more than double that of non-Indigenous women. Most significantly, the number of deaths from cervical cancer is between five and nine times higher for Indigenous women (depending on different years and which State statistics are included). One of the reasons



Indigenous women are dying from cervical cancer is that they are less likely to have regular Pap smears. There are many barriers to participation in cervical cancer screening including physical access to a Pap smear provider (and in particular a female provider), poor transport, lack of child care, embarrassment and lack of understanding about the actual procedure.

## **Diabetes**

Diabetes is a growing health problem for all Australians, but particularly for Indigenous Australians. The incidence of diabetes/high blood sugar for Indigenous women is over four times that of non-Indigenous women. More alarmingly, the death rate from diabetes was almost 12 times higher for Indigenous women than non-Indigenous women. Indigenous women develop diabetes earlier in life and, therefore, suffer from the complications (e.g., renal disease, retinopathy, heart disease, foot problems) from a younger age. While it appears there may be some genetic factors which contribute to the higher rate of diabetes in the Indigenous population, obesity due to poor diet and a sedentary lifestyle, is a key factor.

## **Family violence**

Many Indigenous women live with the constant threat of family violence. The term 'family violence' is preferred when discussing violence in Indigenous communities as the violence occurs in both intimate and family relationships. Indigenous women are more likely to be victims of family violence than non-Indigenous women and the injuries they receive are more serious. For example, hospitalisation rates for assault related injuries in Indigenous women are 35 times higher than for non-Indigenous women. There are many factors which contribute to family violence including the loss of land and traditional culture, poverty, inadequate housing, substance abuse, racism and a family history of violence.

## **What is being done?**

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes aims to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. Initiatives include reducing risk factors for chronic disease (smoking, poor diet, lack of exercise), improving the health and wellbeing of Indigenous mothers and their children and addressing substance use and family violence problems, among others. It is hoped that this targeted approach along with increased funding will see improvements in the area of Indigenous women's health in the future.

**Kirsten Braun**

# The sexualisation of girls

- Twelve year olds requesting Brazilian waxing and children's pencil cases
- emblazoned with an adult entertainment brand. What is happening to girls in
- today's society?

International Women's Day focuses on both the current status of women and also challenges. An area of developing interest worldwide is the sexualisation of girls and its impact on the next generation of women. Numerous reports in the United States, the United Kingdom and Australia all concur that the sexualisation of girls is a real concern with very real consequences.

Previously, concerns about sexualisation were predominantly related to children being exposed to sexual imagery that was actually intended for adults (e.g., children viewing adult movies). In more recent times, however, there has been a disturbing shift with young girls now becoming the direct targets of sexualisation. Young girls are no longer just inadvertently viewing a sexy billboard on their way to school, but are instead becoming the very subjects of sexy portrayals.

## What is sexualisation?

Sexualisation occurs in a number of ways

- 1 Valuing sexual appeal above other achievements/attributes.** An example is how many female characters in television shows and movies are distinguished for their beauty rather than any other characteristic. Similarly, some of the current breed of young female celebrities are famous for simply being famous, rather than for a specific talent.
- 2 Portrayal of girls as sexual objects.** The portrayal of young girls in provocative poses in advertisements is an example. This can also occur through the styling of adult women to look like girls (i.e., pigtails, wearing little girl dresses, sucking on lollipops). All of these images create a worrying blur between adult women and young girls.
- 3 Sexuality imposed on girls.** This form of sexualisation is a particularly disturbing development and involves imbuing children with adult sexuality. An example is the recent trend of clothing for young girls bearing slogans of a sexual nature; a t-shirt which reads "So Many Boys So Little Time".

When looked at in isolation, the use of pre-pubescent looking models and inappropriate clothing for young girls may seem innocent enough. However, it is the cumulative effect of all these images/items that is of concern. Girls are bombarded by what is sexy in the magazines they read, the television shows they watch, the internet sites they visit, the music they listen to and the video games they play.

In addition to an increase in the prevalence of sexual images, the sexual images themselves are becoming more extreme. In our media saturated society, marketers are having to increasingly push the boundaries to get noticed. This can be seen in the music industry with female popstars previously considered conservative now releasing raunchier music videos.

In recent times we have also seen the 'mainstreaming' of the adult entertainment industry. Reality television shows featuring industry stars, pole-dancing fitness classes and the expansion of adult entertainment brands into non-traditional products such as doona covers, make-up and pencil cases are all examples of how the adult entertainment industry has become normalised. Similarly, the internet has brought with it easier access to pornography and this pornography is increasingly hard-core.

## What are the consequences of sexualisation?

There is a growing body of research which demonstrates that the premature sexualisation of young girls has many negative effects. The Report of the American Psychological Association (APA) Task Force on the Sexualization of Girls, reveals that sexualisation undermines girls' confidence in their own bodies. This lack of self confidence can result in a negative body image and feelings of shame, anxiety and low self esteem.

Sexualisation has also been linked to mental health problems like depression and eating disorders. In addition, when girls are preoccupied by what they look like it affects their ability to concentrate and focus on mental tasks. A particularly alarming consequence is self-sexualisation, where girls begin to treat themselves as a sexual object. The recent phenomenon of girls posting semi-nude and nude pictures of themselves on the internet is an extreme example of self-sexualisation.

Sexualisation can also have a detrimental effect on the development of healthy sexuality. If girls are ashamed or embarrassed about their bodies this can impact on their ability to have healthy sex lives later on in life. They are, for example, less likely to be assertive when it comes to sexual matters. This could mean they are less able to successfully negotiate safe sex or are pressured into sex before they feel ready.

## What is being done?

In 2008 an Australian Senate Report on the *Sexualisation of Children in the Contemporary Media* made a number of recommendations. These included long term studies into the effects of premature sexualisation in children; a review of the classification of music videos with regard to sexualising imagery; dedicated children's television channels; classifications for magazines; and the introduction of comprehensive sexual health and relationship education into all Australian schools. There were also a number of recommendations involving the Advertising Standards Bureau including that they produce a half-yearly list of complaints concerning children and utilise community consultation to ensure they are in touch with community standards. However, to date very few of the Senate Report's recommendations have been realised.

## What about boys?

Sexualisation is of course not just confined to young girls. In the same way that young girls are being depicted as being sexy, young boys are being depicted as lotharios. A baby jumpsuit with the words "I'm A Tits Man" is an example of how boys are sexualised in our society. They too have to conform to a narrow set of ideals, in their case, of what constitutes masculinity.

In addition, greater exposure to pornography via mediums like the internet has resulted in boys having distorted views of women's bodies and sexual desires. There have been, for example, anecdotal reports of adolescent boys insisting their girlfriends have Brazilian waxes (as worn by many of the women appearing in pornography). Boys are being taught that girls/women are there for their sexual pleasure and are always sexually available. If boys only see girls/women as sexual objects, however, they may be unable to relate to them in other ways. Sexualisation may prevent boys forming meaningful relationships when they are older.

### What can parents/carers do?

There are a number of strategies that parents and those involved in the care of young girls (e.g., teachers) can adopt in order to combat the effects of sexualisation.

**Education** – A better understanding of sexualisation and the different forms it takes is an important step. Increased awareness of the issue can, therefore, bring about change. See the 'Further reading' section.

**Keep in touch** – Knowing what children are watching, reading and browsing is important as it is only by keeping in touch with the actual content that parents/carers can judge what is appropriate or not.

**Self-monitoring** – Be aware of what you say in front of girls, particularly regarding appearance (e.g., diets, weight, looks) or the appearance of others as these opinions are very influential.

**Extra-curricular activities** – Encourage participation in activities that focus on achievements (e.g., sporting ability) rather than appearance.

**Role models** – Emphasise those that are valued more for their achievements than just their appearance (e.g., solo sailor Jessica Watson). If a girl's idol is valued for their appearance emphasise their other attributes as well (e.g., charity work).

**Wise purchases** – Parents still fund the majority of purchases and so have the final say on what clothing, magazines, DVDs or video games are purchased and brought into the home.

**Sex education** – Find out what is provided at school and determine if there are any gaps (e.g., discussion of what constitutes healthy relationships).

**Media literacy** – Encourage schools to run media literacy program. These programs have been shown to have a positive effect on body image and self-esteem. Women's Health runs body image workshops for year 7-9 students which incorporate media literacy. See the Education page on our website.

**Speak up** – If you find an advertisement, television show or product unacceptable make your opinion known. It is only through consumer complaints that advertisers, publishers, producers and retailers are made aware of community standards. Alternatively, join an established lobby group such as Kids Free 2B Kids ([www.kf2bk.com](http://www.kf2bk.com))

**Cyber safety** – make use of filtering devices to reduce exposure to unwanted material such as pornography.

**Kirsten Braun**

## Further reading

**Report on the APA Task Force on the Sexualization of Girls**  
[www.apa.org/pi/women/programs/girls/report.aspx](http://www.apa.org/pi/women/programs/girls/report.aspx)

**Sexualisation of Children in the Contemporary Media Report**  
[www.aph.gov.au/senate/committee/eca\\_ctte/sexualisation\\_of\\_children/report/report.pdf](http://www.aph.gov.au/senate/committee/eca_ctte/sexualisation_of_children/report/report.pdf)

**Sexualisation of Young People Review**  
[www.homeoffice.gov.uk/documents/Sexualisation-young-people](http://www.homeoffice.gov.uk/documents/Sexualisation-young-people)

**The Lolita Effect: The Media Sexualization of Young Girls and What We Can do About it** M. Gigi Durham

**What's Happening to Our Boys?** Maggie Hamilton

**What's Happening to Our Girls?** Maggie Hamilton

**So Sexy So Soon: The New Sexualized Childhood (and What Parents Can do to Protect Their Kids)** Diane Levin and Jean Kilbourne

**Getting Real: Challenging the Sexualisation of Girls** Melinda Tankard Reist





# Five ways to improve your chance of pregnancy

There are a number of simple steps one can take to increase the likelihood of conceiving.

## 1 Don't leave it too late

Age is one of the most crucial factors in a woman's fertility. Women are born with all their eggs and therefore the quality of these eggs declines with age. For example, it is estimated that by age 35 women experience a 40% drop in fertility. Women are at their most fertile between the ages of 17 and 25. Unfortunately, many women of this age are still completing their education and/or establishing a career and are, therefore, not contemplating motherhood. Age also impacts on male fertility with sperm quantity and motility (how well the sperm swim) decreasing with age.

## 2 Maintain a healthy weight

Being overweight or obese can impact on a woman's fertility, primarily affecting her ability to ovulate. Similarly, when women are underweight their fat levels become too low, resulting in an irregular menstrual cycle and even amenorrhoea (loss of menstruation). In both cases, even a relatively small change in weight (loss or gain) can improve the chance of pregnancy. Women can maintain a healthy weight by participating in regular exercise and following a balanced diet.

## 3 Eat a well balanced diet

Busier lifestyles often result in our diets being neglected. Women may be relying too heavily on processed foods, many of which are high in salt, fat, sugar and artificial preservatives, colours and flavours. Women should instead aim to increase their intake of whole grains and breads, fruit and vegetables and choose low fat dairy products and lean meat. Women can also ensure that their diet is rich in zinc, a mineral that is thought to affect both female and male fertility. Foods high in zinc include shellfish, liver, wheat bran/germ, pumpkin seeds and almonds. Women who are planning on becoming pregnant also need to take a 400 microgram (mcg) supplement of folic acid at least one month prior to becoming pregnant and for the first three months of pregnancy. Folic acid helps prevent neural tube birth defects such as spina bifida.

## 4 Know your cycle

Many women believe that ovulation occurs in the middle of the menstrual cycle. In fact it occurs 12-16 days before the next menstrual period. While this will be mid-cycle for those with a 28 day cycle, it will differ for women with shorter or longer cycles. Women with regular cycles can get an idea of the time of ovulation

by subtracting 16 from the number of days in the cycle and then adding 4 (to give the span of days). For example, a woman with a 24 day cycle will ovulate between days 8 and 12 ( $24-16=8$  ( $+4=12$ )). After ovulation the egg will survive up to 24 hours whereas the sperm can live for up to five days (although the average is three). Pregnancy is therefore possible 3 to 5 days before ovulation and in the 24 hours following ovulation. A common mistake that couples make is having sex too late in the cycle.

In addition to charting their menstrual cycle, women can use a home ovulation test. Prior to ovulation a woman experiences a surge in luteinising hormone (LH). Ovulation tests are designed to detect this LH surge, predicting when ovulation is about to occur and, therefore, the optimal time to have sex.

## 5 Avoid cigarette smoke

While quitting smoking seems like an obvious decision before getting pregnant, it is surprising how many women still continue to smoke. Cigarette smoke reduces fertility by accelerating the loss of eggs. It is known, for example, that women who smoke experience menopause around two years earlier than non-smokers. Smoking also increases the risk of miscarriage and ectopic pregnancy. A woman's partner should also give up smoking as it reduces sperm quality. Second hand smoke also appears to be damaging so women should avoid environments where they may be exposed to cigarette smoke. Women can find support in quitting smoking by phoning Quitline on 137 848.

**Kirsten Braun**

## Still not pregnant?

It is estimated that in Australia one in six couples are infertile. Women under the age of 35 who have not conceived after 12 months of regular unprotected sex should consult their doctor. This time is reduced to 6 months for women who are aged 35 and over. There are a number of initial tests that can be performed to check for underlying causes of difficulty in conceiving. These may include blood tests, pelvic ultrasound and, for men, a semen analysis.

# Sex during pregnancy OK

- A recent journal article has found
- no evidence that having sex during
- pregnancy increases the risk of
- premature birth or other complications
- for women with a low risk pregnancy.

Published in the *Canadian Medical Association Journal*, the primer reviewed research on the topic and found that there was no difference in premature delivery/birth complications in women who had sex during their pregnancy and women who abstained from sex.

For women with a history of premature labour (i.e., pregnant with multiples, a previous preterm baby or cervical incompetence) there is limited evidence. Co-author Dr Clair Jones explains, "In populations at increased risk for preterm labour, there is no evidence to suggest a clear benefit from restricted sexual activity; however, this is a simple intervention that causes no harm and may be a reasonable recommendation until better evidence emerges". There is evidence to suggest that women with placenta previa are at risk of complications (albeit very rarely) and so should abstain from sex.



The article also dispelled a common myth that having sex and/or orgasm close to the due date can bring on labour. There is actually no evidence to suggest that this is the case. However, as there are no real downsides women can feel free to try this method.

## What it means for women

Women can feel reassured that sex during a low risk pregnancy is perfectly fine, but should make a decision based on what they are comfortable with. For some women sex during the later stages of pregnancy can be physically uncomfortable. Similarly, some partners feel uneasy about having sex during pregnancy and may prefer to abstain. If women are unsure of whether they are in the low risk pregnancy group they should check with their health care provider.

## Age of first period

Parents are often concerned about what age their daughter should get her first period (known as menarche). There is in fact quite a deal of variation, with the average being between the ages of 11 and 14. Menstruation is actually one of the last pubertal changes, with breast development and pubic and underarm hair growth occurring a year or two before the first period.

Research suggests that the average age of puberty has fallen over the last century. One reason for this is a rise in obesity amongst children. Menarche is related to body mass index (BMI), with girls with a higher BMI getting their periods earlier than those with lower BMI scores. Environmental toxins are also thought to play a role. Certain chemicals (e.g. those found in some plastics) can mimic the effect of the female hormone oestrogen. Contrary to popular belief, early puberty is not a result of growth hormones used in chicken meat production. This practice was banned in Australia in the early 1960s.

After menarche it is very common for a girl's periods to be irregular. It can actually take a number of years for regular periods to become established. However, if regular periods have become established and then stop, this may be due to other factors such as weight loss or stress.

If a young woman has not had her period by the time she is 16 she should consult a doctor to ensure that she does not have an underlying medical condition.

For more information read the *Understanding your menstrual cycle* factsheet at [www.womhealth.org.au/factsheets/menstruation.htm](http://www.womhealth.org.au/factsheets/menstruation.htm) or call Women's Health Queensland Wide's Health Information Line on 3839 9988 or 1800 017 676 (toll free outside Brisbane).



## From the web

### Raising Children Network

[www.raisingchildren.net.au](http://www.raisingchildren.net.au)

The Raising Children Network's website has now expanded to also include pre-teens and teens. The website has information on a number of key areas including behaviour, communicating and relationships, development, entertainment and technology, health and wellbeing and education. Parents can use the website resource to find advice on everything from puberty to cyberbullying.

### ParentLink

[www.parentlink.act.gov.au](http://www.parentlink.act.gov.au)

This ACT government website provides information, advice and contacts for parents and those caring for children. The young people section has information on a range of issues from parties, eating disorders, talking about sex, running away and depression.



# Ask a Health Question

Our Health Information Line receives calls and emails from women on a broad range of health issues. This regular column features answers to some of the most commonly asked questions.

**Q: I would like to get a Mirena IUD inserted. What's involved with this contraception?**

A: Mirena is a plastic intrauterine device (IUD) that slowly releases a small amount of levonogestrel (a progestogen hormone) directly into the uterus. It prevents pregnancy in a number of ways: by thickening the cervical mucus inhibiting sperm movement; inhibiting movement of the egg down the fallopian tube; and thinning the lining of the uterus, making it unfavourable for a fertilised egg to implant. Mirena provides contraception for five years.

Having a Mirena IUD inserted requires two appointments with a doctor trained in the insertion procedure, and ideally performing this procedure regularly. The first appointment includes your medical, sexual and reproductive history; an assessment of the device's suitability for you; usually a pelvic examination (to assess the size, shape, position and mobility of the uterus); and possibly a Pap smear. A screen for infections such as chlamydia and/or bacterial vaginosis also needs to be performed. After the initial assessment, the doctor will provide a prescription for the device which women can have filled at a pharmacy.

The second doctor's appointment is for the insertion itself, and should take place once screening results are back and any required treatments for an abnormal Pap smear or infections have been completed. Insertion is usually timed to occur within the first half of the menstrual cycle (to ensure that there is no possibility of pregnancy).

The Mirena IUD is quite easy and quick to insert, although some women do experience brief discomfort. Women may like to discuss pain relief options for insertion at their first appointment. The Mirena IUD is inserted into the uterus through the vagina using a long thin removable tube or applicator. It is recommended the clinic observe you for 20 minutes following insertion for dizziness or fainting. Cramping similar to period pain may occur for a few hours following insertion. Women may experience initial spotting or light bleeding (in addition to their period) for up to 6 months. After this most women find their bleeding declines in amount and frequency. Some women stop ovulating and menstruating altogether while using this contraceptive method.

A follow up appointment is recommended for between 3 and 6 weeks after insertion to exclude infection or uterine perforation (both very uncommon). Expulsion of the device also occurs occasionally, usually within the first year and mostly in women who have never been pregnant. The Mirena IUD has fine threads a few centimetres in length that pass through the cervix into the vagina. Women can periodically check the presence of the device by feeling for these threads. If a woman's partner finds the threads uncomfortable during sex the doctor can adjust them. The Mirena IUD is easily removed (by a doctor) and does not delay the return of usual fertility.

*For more information on the Mirena IUD and help locating a doctor who performs insertions, speak to one of the nurses on the Health Information Line (details below).*

call our **Health Information Line**

A free information and referral service for Queensland women

**3839 9988**

**1800 017 676**

(toll free outside Brisbane)

Staffed by nurse/midwives