JOURNAL 3: FACILITATOR’S HANDBOOK

COLOUR CODE: YELLOW

1. INTRODUCTION TO WISE UP

3. PROGRAM OVERVIEW

5. REPRODUCTIVE SYSTEM

6. PELVIC FLOOR MUSCLE EXERCISES
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  7.1: MENSTRUATION
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  11.1: GOOD FOOD DURING PREGNANCY
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12.1: WHY WOULD I WANT TO USE CONDOMS?
  12.2: THE BASIC FACTS ABOUT CONTRACEPTION
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19.1: HEPATITIS C: TEN QUESTIONS AND ANSWERS
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45.2: BALANCE
45.2: BALANCE (CONTINUED)
Information for the exercise and nutrition sessions are available from your local gym and Community Health Centres.

**Community Educators**

Wherever possible it is suggested that community educators are brought in to co-facilitate the program. These people can provide up to date information and are the experts in their field. They can also expose the participants to another view of the world as well as promoting the availability of their services in the community.

**The facilitator**

Clearly the facilitator should be a woman with some experience in working with women in custody. The program emphasises the importance of women sharing and learning from their experiences, therefore it is essential that the facilitator values the women's contributions. Wherever possible, the facilitator should use these experiences as examples with which to work through the topics.

This program is not designed to be delivered in a didactic fashion. Adult learning principles underpin the program and include group discussion, sharing of experiences and the promotion of critical thinking. The facilitator is part of the group and therefore does not become the *teacher*. It is preferable that the facilitator have experience in group facilitation of learning.
Module One. Sexual and Reproductive Health

Session: Introduction

Topic: Team building
      Introduction to women's health
      Communication exercise

Goals: To establish a group contract
       To introduce women to the WISE UP program
       To establish group cohesion and commitment
       To practice a communication exercise
       To explore what is involved in being healthy
Group Contract

Suggested Strategies
Groups work best when some ground rules are laid down. This way everybody has the opportunity to be treated with respect. Ask for suggestions from the group. Write them up on butchers paper when they are agreed upon. Negotiate if there are any disagreements and discuss any issues as necessary. Display group contract each session and refer to it as necessary.

Key points
- Punctuality,
- Breaks,
- Confidentiality,
- Respect each other, Listening,
- One person to speak at a time,
- No put downs, etc

Resources
Butchers paper  Pens  Sticky tape

Listening Exercise

Suggested strategies
Ask participants to form pairs. One person is to talk and the other to listen only. The talker may talk about herself, family, children, hopes and dreams for the future, etc. When both women have talked, return to the large group. Ask each woman to introduce her partner using only the information she has heard. A listening exercise will encourage active listening and help develop listening skills. Discussion can elicit why it is important to listen.

Key points
- Listening attentively and without judgement is hard to do
- Listening with empathy
- Taking the time to listen
- Being accepting and understanding
- Try not to rescue
- Not taking sides
- Reflecting back
- To get the correct message
- To not get confused
- Good to have someone really listen
- Difficult to listen attentively
Program Overview

Suggested strategies
Introduce the program. Discuss the topics being covered.
Ask for feedback to elicit information that this group requires and which is not
being covered.
Be prepared to answer questions.

Key points
- Describe the strategies which will be used during the program:
- Large group discussion
- Small group discussion
- Brainstorming
- Small research projects during the session
- Guest speakers (if appropriate)
- Homework
- Evaluations

Resources
Participant workbooks       Program overview

Staying Healthy

Suggested strategies
Explore what is involved in staying healthy and feeling good
Brainstorm in large group and write up responses on whiteboard, or
Use smaller groups and ask participants to write responses on butchers
paper and report back to large group
Large group discussion

Key Points
- Good health is dependent on a number of things.
- It is not just the absence of illness.
- To maintain good health, we have to work at it.
- Health is about:
  - physical things       - food, exercise
  - social things         - housing, community, friends
  - spiritual things      - freedom to practice, feeling good about oneself

Resources
Whiteboard       Markers       Butchers paper       pens
Why Women's Health?

Suggested strategies
Discuss issues relating to why women need a health education program
Brainstorm in large group and write up responses on whiteboard, or
Use smaller groups and ask participants to write responses on butchers
paper and report back to large group
Large group discussion

Key Points
- women have special health needs because of menstruation, pregnancy, menopause.
- women tend to use health services more because they often care for others and/or have babies
- women are more likely to be disadvantaged than men because they earn less money, have dependents
- disadvantaged people tend to be sick more often

Resources
Whiteboard    Markers    Butchers paper    pens

Homework

Suggested strategies
If a reflective journal is being used, hand out the exercise books.

Key points
Ask the women to write a few notes on how they feel about today's session and the course.
Ask them to think about the program during the week and write down any questions or concerns they have.

Resources
Exercise books
Module One. Sexual and Reproductive Health

Session: 1.1

Topic: Reproductive system

Goals: To discuss issues relating to sexual health
To identify women's sexual and reproductive system
To explore common beliefs, attitudes and feelings
To discuss the process of menstruation and interrelated feelings
To explore the use of visualisation as a strategy for relaxation
Sexual Health

Suggested Strategies
Large group discussion and brainstorm
- Invoke discussion to elicit what sexual health is about and what parts of the body are involved.
- Explore why we need to know about our sexual/reproductive system.
- Ask the group to think about where they got their information about their bodies, menstruation, sex, childbirth, etc.
- Women and girls are often not given the correct information about their bodies and sometimes, it is difficult to access this information. This can affect the way we feel about our bodies and whether we feel comfortable to seek health care and advice.

Key points
- Body parts involved:
  Reproductive organs, External genitalia, Breasts

- Keeping healthy involves knowing about:
- what is normal so the abnormal can be detected (mucus, discharge, lumps, etc)
- the changes which our bodies go through during the menstrual cycle, during pregnancy and during menopause
- check ups which we can do ourselves or get done somewhere else
- how to look after our bodies better

- Information comes from:
- mum, school, friends, TV, magazines, etc
- it is not always accurate
- a little knowledge may be a dangerous thing

Resources
Whiteboard and markers
Reproductive System

Suggested Strategies
Participants to work in pairs and label the diagrams of female reproductive system.
In large group, using labelled OHTs, go through naming the parts and describing the function
Be prepared to answer any questions.

Key Points
- Ovary: There are two ovaries each about the size of an olive. The ovaries contain the ova (eggs) of which there are up to 400,000. The ova are released at ovulation and travel down the Fallopian tube to the uterus. An ovum can live for up to 48 hours. The ovary produces oestrogen and progesterone until menopause when ovulation ceases and oestrogen is no longer produced.

- Fallopian tube: Two narrow tubes join the ovaries to the uterus. Fertilisation occurs in the Fallopian Tube.

- Uterus: (Womb) A strong, muscular organ about the size of a fist. The lining of the uterus is called the endometrium. If fertilisation occurs, the ovum embeds in the endometrium and the uterus expands as the baby grows. If there is no fertilisation, the endometrium is shed during menstruation.

- Cervix: The neck of the uterus. It protrudes into the vagina and feels like the tip of a nose. There is a small opening in the cervix called the os. Blood escapes through the os during menstruation. Sperm have to swim through the os to reach the ovum. The cervix makes mucus which changes during the menstrual cycle. Around the time of ovulation, the fertile mucus is sticky and stretchy and allows easy passage of sperm. A pap test is taken from the cervix.

- Vagina: A tunnel of muscle with the walls lying close together but which can easily be stretched open. The vagina is moist and the amount of moisture varies throughout the cycle and when a woman is sexually excited. This moisture keeps the vagina clean and healthy. After menopause, the vagina produces less moisture and the walls become thinner and less elastic.

- Vaginal opening: The entrance to the vagina.

- Clitoris: A small, sensitive lump which is the centre of sexual pleasure.

- Bladder: Where urine is stored before passing out of the urethra.
• Anus: The opening to the bowel through which faeces is passed

• Vulva: The term for the external genital area.

• Labia: There are two sets of labia or lips - the inner minora and the outer majora. The labia cover the clitoris, urethra and vaginal openings.

• Perineum: A thick band of muscle between the vaginal opening and the anus. This stretches during childbirth to allow the baby to be born.

Resources
Overhead projector OHT 1.1.1, 1.1.2, 1.1.3.
Poster size diagrams of female internal and external reproductive system
Body Talk Flip Chart
Pelvic model
The pelvic floor muscles are one of the most important sets of muscles for a woman to keep strong at all times in her life. If women were trained to tune up their pelvic floor muscles from childhood many would never suffer problems resulting from weakness of these muscles — problems which many women accept as a normal part of being a woman or mother.

**SELF MANAGEMENT**

- Exercise programme for pelvic floor strengthening.

1. Tighten the muscles around the entrance of the back passage (anus). Imagine that you are tightening the anus as if to prevent passing wind.

2. Tighten the muscles around the entrance of the vagina — imagine you have a tampon in the vagina and it is slipping out — you are tightening the muscles in the vagina to pull it up. To test the strength place your clean fingers (1 or 2) in the vagina and tighten the pelvic floor muscles squeezing the fingers. Feel the tightening and lifting effect.

3. Tighten and pull up the muscles around your front passage (urethra). Imagine that you are tightening the muscles as if to stop yourself urinating. A test of pelvic floor muscle efficiency is to stop the flow of urine midstream when urinating. This should only be done occasionally as a test — if done regularly it may cause urine to be retained.

4. Tighten and draw in strongly the muscles around the anus, vagina and urethra all at once. Hold for 5 seconds, relax for 15. Repeat this 3 times. Do this regularly throughout each day for the rest of your life.
The exercises will not help overnight — it takes time to restore muscle strength.

- If you have problems with these exercises check with a physiotherapist to make sure you are doing them properly.
- If symptoms persist, see your general practitioner.

**IMPORTANT**

Women who should pay extra attention to their pelvic floor exercises include:

- Pregnant women — before and after childbirth — especially after episiotomy.
- Women employed lifting heavy objects.
- Women after menopause.
- Women who have gained weight.

**NEW HABITS**

- Do your pelvic floor exercises daily — you can do them anywhere without anyone noticing — when driving, doing the dishes, while watching TV, or waiting for a bus.
- Eat a nutritious diet.
- Take regular exercise e.g. walking, swimming.
- Ask your general practitioner to check the strength of your pelvic floor muscles when you have your pap smear.

- Prepare your pelvic floor muscles for childbirth (relaxation and contraction exercises) and recondition them as soon as possible afterwards. If you have an episiotomy exercising the pelvic floor muscles will speed the healing process.

**RESIST**

- Ignoring your pelvic floor muscles — you are never too busy to exercise them.
- Becoming overweight.
- Constipation or straining to pass a motion.
- Accepting incontinence (even if it’s only a few drops) as part of motherhood or womanhood.
- Being embarrassed about the “lower parts”.

**ENJOY**

- Sport without the embarrassment of wet pants.
- Sex after childbirth and after menopause.
- Firmer vagina.
- Stronger orgasm.
- Quicker healing of episiotomy.
- Freedom from pelvic heaviness and dragging.

**PHYSIOTHERAPY**

Contact your local physiotherapist or a branch of the Australian Physiotherapy Association for information about physiotherapists who can provide further assistance.

**HEALTH REBATES**

A doctor’s referral is not required to see a physiotherapist. Appointments may be made direct. Treatment costs are rebatable under all higher table health insurance schemes.

(Published by the Australian Physiotherapy Association)

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PELVIC FLOOR MUSCLE EXERCISES

After you have had your baby, you need to strengthen your pelvic floor muscles.

Where are the pelvic floor muscles?

They are between your tailbone and your pubic bone. The tubes from your front and back passages (urethra, vagina and anus) all pass through your pelvic floor muscles.

What do the pelvic floor muscles do?

1. They support all the organs within your abdomen, especially when you are standing.
2. They give an extra squeeze when you cough or sneeze.
3. They help you control urine flow and wind (front and back passages).
4. They give you a better sexual response vaginally.

How can you help your pelvic floor muscles work efficiently?

This leaflet teaches you how to contract these muscles in order to strengthen them.

You need to identify the muscles you are trying to strengthen. When you try to interrupt your flow of urine, you are contracting your pelvic floor muscles. Imagine yourself stopping the urine flow, and concentrate on the muscles you are using to do this.
Menstruation

Suggested Activities
Large groups or small groups can be used to elicit information from the women.
The exercise of the questionnaire can be conducted in pairs
Discuss what happens and how you may feel.
Discuss myths and misconceptions associated with periods

Key Points
- Is the monthly discharge of blood from the lining of the uterus in women of childbearing age who are not pregnant.
- It occurs under the influence of hormones. The lining of the uterus is shed about every 26 to 30 days.
- It starts about 14 days after ovulation and lasts from 3 to 7 days.
- Oestrogen is a hormone produced during the first half of the cycle which causes the lining of the uterus to get thicker in readiness for a fertilised egg.
- Progesterone is another hormone produced after the ovum has been released.
- Ovulation is usually mid-cycle. It is the release of the egg from the ovary.
- Period pain is caused through the uterus cramping to expel blood through the cervix.
- Average blood loss is about 50ml.
- It can be eased by exercise, warm baths, stretching and pain killers like Naprogesic.
- Drugs, stress and big life changes can affect your periods.
- Feelings related to menstruation - what happens emotionally for women - irritability, mild depression, tiredness, tension.
- Body changes - include breast enlargement and tenderness, fluid retention, back ache, aching legs.

Resources
Body Chart Flip Chart
Myths, Beliefs and Misconceptions Question Sheet
Menstruation handout
1. Menstruation or bleeding starts. The lining of the uterus (or endometrium) comes away. This lining of blood and tissue flows out of the vagina.

2. Some women have PERIOD PAIN.

3. When hormone levels are low, the BRAIN sends a message to the OVARIES.

4. The OVARIES make the hormone OESTROGEN. A good way to think of hormones is as messages that get sent so that certain things can happen.

5. OESTROGEN makes the lining of the UTERUS, the ENDOMETRIUM, thicken and build up again. As oestrogen increases, the mucus from the cervix becomes thinner, clearer, wetter and more slippery.

6. One egg, OVUM, pops out of the OVARY. This is called OVULATION and it happens about 12-16 days before your period.

7. OVARIES now make another hormone called PROGESTERONE.

8. PROGESTERONE makes the lining of the uterus (the endometrium) ready in case there is a fertilised egg. As progesterone increases, the mucus from the cervix gets thick and sticky and the body temperature rises.

9. While the levels of oestrogen and progesterone are building up, the egg or OVUM travels along the FALLOPIAN TUBE. The ovum lives for up to 24 hours.

10. If the egg doesn’t meet with any sperm, fertilization doesn’t take place.

11. Many women notice premenstrual signs.
Menstruation: Myths & Misconceptions

Decide whether each statement is true or false. Circle the correct answer.

1. It’s OK to have a shower when you’ve got your periods. True / False
2. You shouldn’t have baths when you’ve got your periods. True / False
3. You shouldn’t wash your hair when you’ve got your periods. True / False
4. People can tell when you’ve got your periods. True / False
5. You can’t swim when you are menstruating. True / False
6. Physical exercise is good for you when you’ve got your period. True / False
7. You shouldn’t get too hot when you’ve got your period. True / False
8. It’s OK to eat citrus fruit when you’ve got your period. True / False
9. Menstrual blood is bad blood. True / False
10. You should avoid the cold when you’ve got your period. True / False
11. It’s OK to have sex when you have your period. True / False
12. Virgins can use tampons. True / False
13. Applicators are a more hygienic way of putting tampons in. True / False
14. You shouldn’t leave a tampon in for more than 5 hours. True / False
15. You can’t get pregnant if you have sex during a period. True / False
16. It’s OK for boys to know all about menstruation. True / False

"Still Smiling Ch 2 P.73"
Relaxation Exercise

Guided visualisations are a powerful tool to enable people to relax. Once this method has been demonstrated it can be used alone by women.

Suggested Strategies
The following is an example which may be read aloud by the facilitator or you may make up your own:

Ask the group to sit comfortably or lie on the floor.

Close your eyes. Begin by taking several slow, deep breaths. Now let your breath flow naturally and imagine that you can use your breath to release any tension you may be holding. If there is pain or tightness in any part of your body, you can ease it by imagining that, as you exhale, you are breathing through that body part and the tension is riding out on the breath.

Bring your attention to your head. Let your thoughts go and allow your mind to become still. Focus on your breath and imagine that your breath is massaging your skull, your head, your face. Allow all the tension to be released and your head to become heavy. If there is headache or tension in the head, you can move that energy by focusing on your awareness.

Now bring your attention to your neck and shoulders. Notice where there is any soreness or tightness. Breathe through these body parts and allow the tension to flow away leaving them relaxed and soft.

Let your awareness travel to your arms. Breathing through your nose, visualise the breath flowing down your arms and out through your hands. Be aware of any tension in your arms and hands and allow it to flow away. Breathe out through the palms of your hands and allow the excess energy and tension to be released.

Let your awareness sweep over your body. Does it feel heavy or light? Is there pain or tension anywhere in your body? Focus on your body. Become aware of your heart beat. As you breathe out, release any tension you are holding in your body. Imagine that the tension is flowing away from your body leaving it relaxed and light.

Now focus your attention on your legs. Breathe deeply into the muscles in your thigh and allow any tension to be released. Follow the breath down your legs to your feet, releasing tension as you move your attention slowly down.

Now, as you lie here in this relaxed state, imagine yourself to be in a beautiful, safe, place somewhere. It could be in a rainforest or on top of a mountain. By a river, or by the beach. Allow yourself to picture this safe place with you in it. Where there is no other person. Where no one can hurt you. Feel the pleasure in your body as you view your safe place

(pause)

Feel yourself to be fully in your body. Sense your energy flowing through your body. Feel yourself to be firmly seated, rooted. Breathe in. And out. Continue to pay close attention to your body. Now, notice if there is any difference in your body from when you began this exercise. Be aware of
the pressure of your body against the seat on which you are sitting or the floor on which you are lying.

Try to keep with you the image of your safe space and go there whenever you feel you need time out, when you feel stressed or when you are not feeling safe.

When you are ready, take a big stretch and open your eyes.

Resources
Tape recorder and taped relaxation music (if required)
Module One. Sexual and Reproductive Health

Session: 1.2

Topic: Contraception and Conception

Goals: To explore and understand the process of conception
To gain an understanding of the need for healthy lifestyle during pregnancy
To analyse the need for contraception, the options available and their appropriateness
To practice a series of relaxation exercises
Conception

Suggested Strategies
Draw a large diagram on the whiteboard of the internal female reproductive system (This can be done by projecting the OHT 1.2.1 onto the board and drawing around its outline) or use the OHT 1.2.1
Invite the women to tell the story of how conception occurs and draw it on the board as they tell you.
Discuss conception

Key Points
- Ovulation usually occurs mid cycle
- Fertilisation occurs in the Fallopian Tube when an ovum has been released
- The fertilised egg travels down into the uterus and implants in the endometrium
- This develops into the fetus
- Pregnancy can be detected after one missed period

Resources
OHT 1.2.1  Projector  Markers  Body Flip Chart

Good Things/Bad Things in Pregnancy

Suggested Strategies
Brainstorm and invoke discussion about the good things to take in/do to your body when you are pregnant
Brainstorm the things which are not so good
List on whiteboard
Discussion to cover issues that whatever a mother takes in to her body can cross the placenta and affect the baby

Key points
- Good food - lots of fruit and veg, calcium, iron rich foods
- Exercise - walking, low impact exercise
- Rest and sleep
- Plenty of fluids
- Antenatal care with doctor/midwife
- Inform the doctor if using drugs (methadone) as dose may need to be increased
- Try to avoid or reduce:
- Drugs, Alcohol, Coffee, Tobacco
CALCIUM

Calcium is especially important during pregnancy because it is needed to build strong bones and teeth. A mum-to-be needs to look after her own body as well as build a whole, new little person.

If you’re not getting enough calcium, the baby’s bones may be given calcium ahead of yours. This may put you at risk of osteoporosis later in life.

The best food sources of calcium are dairy foods—which also provide protein, energy and vitamins essential during pregnancy. Other good calcium foods are salmon and sardines—although you must include the bones.

If you would like more information on calcium phone 008 044518 for a free calcium guide.

IRON

Iron is also important during pregnancy because it is a vital part of haemoglobin—needed for healthy blood.

During pregnancy, your blood supply increases by up to 30% to supply nutrients to your baby via the placenta. This extra blood, combined with your baby’s needs for iron, means that your total demand for iron increases dramatically.

The best food sources of iron are red meats, although poultry and fish are also reasonable sources. The iron in plant foods can be helped along by eating vitamin C foods, like fruit, at the same meal. (eg cereal with a small glass of juice).

If your iron level is low you may develop anaemia—a common problem in pregnancy. Your doctor may then prescribe a supplement, but you can help by eating more high iron foods.

GOOD READING

- Nutrition and Pregnancy
  by Susan Ash and Jane Allen
  (from bookstores and the Australian Nutrition Foundation
  ph 02 516 6516)

- And Now it’s Dinner for 3
  (small booklet) by the Dairy Foods
  Advisory Bureau (ph 02 743 3321)

- The Pregnancy Book
  by the Doctors and Staff of the
  Royal Hospital for Women, Sydney
  (from bookstores)

For more health and nutrition information contact:
Nutrition Education Service
Level 8, 55 Grafton Street,
Bondi Junction, NSW 2022.
Ph: 02 824 1515
INFORMATION EDUCATION SERVICE

EXERCISE

Breakfast

Amount Per Day

FOODS

FUNCTIONS

FOOD GROUP

The Five Food Groups for Mums-to-Be

EXERCISE

Breakfast

Amount Per Day

FOODS

FUNCTIONS

FOOD GROUP

The Five Food Groups for Mums-to-Be
Contraception

Suggested strategies
There are 4 contraceptive “show bags” with this program complete with samples and information about Condoms, The Pill, The IUD, Depo Provera. Hand these out to the small groups and ask the women to research their topic and report back to the large group. An information sheet is provided for facilitator covering a range of contraceptives.

Key points
• How it works
• When to use it
• Where to get it
• How safe it is
• Side effects
• What would stop women from using it

Resources
Contraceptive “show bags”, samples of other contraceptives, pelvic model, Body Flip Chart, butchers paper, pens

Exercises for Relaxation

(Adapted from Health Matters for Women Over 60. Produced by the Women’s Health Promotion Service. Northern Sydney Area)

Suggested strategies
Low impact, stretching exercises are good in that they can relax a tired and stressed body.
Encourage to women to participate and talk them slowly through the exercise routine. They may use these exercises alone when at home

Yoga
Sitting in a chair, become aware of your posture. Sit straight. Imagine a thread coming from the top of your head pulling you towards the heavens. Breathe deeply. Eyes closed. Become aware of your breath, follow it in and out.
Loosen up exercise
Start with your head, turn to the left as far as you possibly can. Keep your head straight. Hold. Return to the centre. Turn to the right. Hold. Return. Repeat twice.

Neck stretch
Bend your neck to one side, taking care not to twist your head or raise your shoulders. Feel the stretch. Hold. Return your head to the centre. Repeat on the other side. Repeat twice.

Windmills
Swing both arms together, crossing over in front of your face, then out and back in a large circle. Repeat. Reverse the direction of the swing and repeat.

Circles
Roll your shoulders in a big slow circle up to your ears, around to your back and then down and forward to your chest. Repeat. Reverse direction of roll and repeat.

Side Stretch
Supporting yourself with one hand on your hip, stretch the other arm up to the ceiling bending slightly and hold for at least 10 seconds. Return to the starting position. Repeat. Reverse arms and repeat.

Calf Stretch
Sitting in a chair, straighten one leg out in front of you. Point toes down, then up, slowly. Return to sitting position. Repeat for the other leg. Repeat several times.

Toe Raises
Holding the back of a chair, go up onto your toes. Hold. Relax. Repeat twice.

Thigh Stretch
Sitting on the floor, if possible, stretch your legs out in front. Slide your hands down your legs towards your feet, keeping your back straight. Hold. Repeat twice.

Wind Down
Stand up and shake.

Resources
Music (if required)
**Fertile Pattern**

This mucus change corresponds to the rising oestrogens from the developing follicle in the ovary. There is a sensation of wetness at the vulva and the mucus becomes more profuse, more watery, more clear and elastic over the next 5-6 days. The last day of fertile mucus corresponds to the PEAK or OVULATION in most women (85%). Any fertile sign, however small, must be considered significant.

**Post Ovulatory Pattern**

This mucus change corresponds to the rising progesterone from the corpus luteum in the ovary. It lasts until the onset of menstruation normally 12-16 days. The sensation of dryness returns and the mucus becomes scantier, more cloudy and sticky. The amount of discharge may change, but its consistency does not.

A couple can resume intercourse after 3 consecutive "dry" days.

To use this method correctly a couple must:

1. Avoid intercourse throughout a period.
2. Have intercourse in the evening only if mucus has been checked during the day.
3. Have intercourse on every alternate evening only as seminal fluid can interfere with mucus readings.
4. Any fertile signs mean abstinence until 3 "dry" days.
5. Intercourse can be resumed on fourth day after "peak".
6. Any bleeding or spotting during the cycle should be considered as potentially fertile.

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**SYMPTOTHERMAL METHOD**

Calculation of early "safe" days of cycle length history, calculating fertile (ovulatory) phase by cervical mucus observation, and confirming ovulation by temperature measurement.

This method uses a combination of calendar, temperature and mucus to calculate the fertile time of the cycle.

**Early Safe Days**

Calendar Method to calculate early (preovulatory) "safe" days

Subtract 20 from shortest cycle.

Mucus Method to detect early "safe" days

Intercourse on alternate evenings and abstinence once fertile mucus noted.

**Late Safe Days**

Mucus method to determine late (post ovulatory) "safe" days

Calculate peak (ovulation) as last day of fertile mucus and intercourse resumed on the 4th day after peak.

Temperature method to determine late "safe" days

Temperature must have 3 consecutive readings in this cycle. Intercourse resumed on evening of 3rd temperature cycle.

Other symptoms such as pain, bleeding, bloating can be recorded and used to support other symptoms of ovulation.

It has the advantage over single-index methods in that a woman can compare symptoms and signs to predict and confirm ovulation. Once mastered it also reduces the number of days when mucus and temperature recordings are necessary.

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September 1993
WHAT IS IT?
Natural Family Planning is a method of birth control based on abstinence from sexual intercourse during the fertile phase (and around the fertile phase) of the menstrual cycle.

Methods of predicting or calculating the fertile phase of the menstrual cycle are:
- Calendar or rhythm method
- Temperature method
- "Billings" ovulation method
- Symptothermal method

The Female Ovarian Cycle
The ovarian cycle starts on the first day of the menstrual period.

The pituitary (a small gland in the centre of our brain) secretes FSH (Follicle Stimulating Hormone) which travels to the ovary in the blood and causes the follicles in the ovary to develop and mature.

The developing follicles (one becomes the dominant follicle) secrete a hormone oestrogen which causes the breasts, uterus, cervix and vagina to develop and mature.

Oestrogen also switches off the FSH from the pituitary by negative feedback.

The developing ovum produces increasing amounts of oestrogen and it is believed that this causes another pituitary hormone LH (Luteinising Hormone) to be secreted. This surge of LH triggers OVULATION.

After ovulation the follicle which has lost the egg develops into a corpus luteum which secretes another hormone, progesterone. Progesterone acts on the breasts, uterus, cervix and vagina as well. Progesterone also increases the body's temperature.

If pregnancy does not occur the corpus luteum stops producing progesterone and the smaller amount of oestrogen and menstruation occurs, usually 12-16 days after ovulation. Breast, uterus, cervix, vagina and body temperature return to the preovulatory state.

Under the influence of progesterone the body temperature will rise at least 0.2°C (0.4°F) but up to 0.5°C. It will remain elevated until the next period (12-16 days). It continues to remain elevated if a pregnancy occurs.

**Taking the Temperature**
1. Immediately after waking and before arising at approximately the same time each morning.
2. Before eating, drinking and smoking.
3. Can be taken orally or vaginally. Vaginal readings are more accurate.
4. Must be left in at least FIVE minutes and read immediately. Digital thermometers need to be left until they register maximum reading (45 sec. approx.).

Additional Factors that Affect Temperature
1. "Sleeping in, ie later reading - false high
2. Alcohol the night before - false high
3. Little sleep - false high
4. Illness - false high
5. Tooth extraction - false high
6. Electric blanket on high setting - false high

Graphs should be calculated monthly and ovulation not assumed until 3 consecutive readings are higher than 6 previous consecutive readings. Intercourse is permitted on the evening of the 3rd consecutive temperature rise (3/6 RULE).

**MUCUS METHOD**
Calculation of fertile phase by mucus observation only.

This method uses the observation of the cervical mucus as its sole indicator of fertility. Mucus is divided into 3 distinct patterns.

**Basic Infertile Pattern**
This pattern is observed for a few days after a period in women with 28 day cycles. It can be extended in women with longer cycles or absent in women with short cycles.

There is a sensation of dryness at the vulva with no mucus or scant, dense, flaky mucus producing a sensation of stickiness.
THE MORNING-AFTER PILL
(EMERGENCY PILL)

The morning-after pill consists of a short course of special-dose oral contraceptive pills that are taken after unprotected intercourse (intercourse when no contraception has been used) to prevent pregnancy. The first dose must be taken within 72 hours (three days) of the first act of unprotected intercourse. If the pills are started after this time they may not work.

HOW IT WORKS
The morning-after pill can prevent pregnancy in one of two ways. If the pills are taken before the woman ovulates (releases her monthly egg cell), they can delay ovulation until the male sperm that have been ejaculated inside her have died. If the pills are taken after the woman has ovulated, and the egg cell has been fertilised, the pills can prevent the fertilised egg from implanting in the womb. This is possible because there is a five- to seven-day interval between the egg cell being fertilised in the fallopian tube and the fertilised egg travelling down the tube and implanting in the womb.

HOW YOU TAKE IT
The morning-after pill consists of two lots of pills that must be taken exactly 12 hours apart. So if you take the first dose at 11 a.m., you will need to take the second dose at 11 p.m.

POSSIBLE SIDE EFFECTS
Nausea About 50 per cent of women feel sick (nauseous) after taking the morning-after pill and a few actually vomit. When you are given the pills you will also be prescribed anti-nausea tablets and told how to take them.

Breast tenderness, headache and light bleeding These problems usually disappear within 48 hours and require no treatment. The light bleeding some women experience a few days after taking the pills is not a normal period.

WHEN TO EXPECT YOUR PERIOD
Your period could be early, on time or delayed. Most women have a period within three to four weeks of taking the morning-after pill.

IF YOU'RE ALREADY PREGNANT . . .
If you conceived in a previous cycle or earlier in your present cycle, the morning-after pill will not stop that pregnancy continuing. It will not damage the fetus, either, so there is no medical reason for you to have an abortion.

IF THE MORNING-AFTER PILL FAILS
If your period is late or unusually light or you suspect you may be pregnant, contact the clinic or your doctor immediately.

ONGOING CONTRACEPTION
The morning-after pill will not protect you from becoming pregnant from another act of intercourse later in the same cycle. If you think you may have intercourse again, and have no regular method of contraception, tell the clinic nurse or doctor. They will be happy to discuss methods that may be suitable for you.
WHAT IS DEPO-PROVERA?
Depo-Provera is a contraceptive injection of a chemical similar to the hormone called progesterone which is produced in your body by your ovaries. Each injection of Depo-Provera protects you from pregnancy for 12 weeks.

HOW DOES IT WORK?
Depo-Provera stops the release of an egg from your ovaries. If an egg is not released, you cannot become pregnant.

HOW EFFECTIVE IS IT?
Depo-Provera is a very effective contraceptive. If 1000 women were each to use it for a year, only four or five may become pregnant. It is more effective than the oral contraceptive pill. There are fewer accidental pregnancies with Depo-Provera than with oral contraceptive pills because you can forget to take a pill, but the injection lasts for 12 weeks.

CAN ANYONE USE DEPO-PROVERA?
Before you start using Depo-Provera you should tell your doctor if:
* you could be pregnant
* you are breast feeding
* you have any unusual or irregular bleeding or spotting from your vagina.
Also tell your doctor if you have had any of these health problems:
* cancer of the breast or genitals
* a history of severe depression
* disease of your heart, liver, kidneys or bladder.
Your doctor will discuss these issues with you to decide if you should use Depo-Provera.

HOW DO I USE DEPO-PROVERA?
Depo-Provera is given as an injection into the muscle of your upper arm or buttocks. Your first injection should be given only during the first seven days of your menstrual cycle (the first day of bleeding is day one). If it is given this way you are protected from getting pregnant as soon as you have the injection.
If you decide to use Depo-Provera after having a baby and you are breast feeding, you can have your first injection six weeks after the birth. If you are not breast feeding it can be given two weeks after the birth.
It is important that injections are repeated every 12 weeks, to make sure you do not get pregnant.
Depo-Provera does not protect you from STDs (Sexually Transmitted Diseases). You may decide to use condoms as well as Depo-Provera, because condoms help to protect you from STDs.

ARE THERE ANY SIDE EFFECTS?
The main side effect of Depo-Provera involves periods. Periods often become irregular and sometimes last longer. Bleeding is not usually heavy. You may have continual light bleeding, which can be treated if it does not settle down. After several injections your periods may stop.
completely. This is normal while using Depo-Provera and does not harm you. When you stop using Depo-Provera your periods will return to their regular cycle although this may take up to 18 months for some women. Some women experience weight gain, headaches or depression while on Depo-Provera. Side effects can last for three months or longer. Talk to your doctor if you have any symptoms.

GETTING PREGNANT AFTER USING DEPO-PROVERA
Most women find that it takes about 10 months after the last injection of Depo-Provera to become pregnant. Sometimes it takes a little longer. The number of Depo-Provera injections you have has no effect on how long it takes you to become pregnant. If you do not want to get pregnant after you stop using Depo-Provera you should use another form of contraception.

TELEPHONE INFORMATION NURSE
If you have other questions about Depo-Provera, ring the Family Planning NSW Telephone Information Nurse on (02) 716 6099.
Family Planning NSW also has a TTY for people who are deaf or hearing impaired (02) 9916 8360.

FAMILY PLANNING NSW CLINICS

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Full product information for Depo-Provera is available from your doctor or pharmacist. This Information Sheet is produced by Family Planning NSW, 328-336 Liverpool Rd., Ashfield NSW 2131 Australia. Ph (02) 716 6099  Fax (02) 716 6164  TTY (02) 9916 8360
ACN 000 026 335  June 1995
THE MINIPILL

The minipill contains a very small dose of the hormone progestogen (it is also called the progestogen-only pill), and works mainly by thickening the mucus at the entrance to the uterus (womb) so that sperm cannot get through to fertilise an egg. It also affects the lining of the uterus and in some women it stops the monthly release of an egg cell. It is slightly less effective at preventing pregnancy than the combined pill.

WHO CAN TAKE THE MINIPILL?
Most women can take the minipill. However, it may be inappropriate for you if:
- you have had an ectopic (tubal) pregnancy
- you have an undiagnosed vaginal bleeding problem
- you have cancer of the breast or reproductive system.
The minipill, unlike the combined pill, may be taken by women who are breastfeeding, have a history of blood clotting, stroke or heart attack, smoke heavily or are over 40 years old.

A PILL EVERY DAY
The minipill is taken every day without a break, so it always comes in a 28-day pack, every pill is a hormone (progestogen) pill and there is no break between packs.

STARTING THE MINIPILL
If you are having periods, you should take your first pill on the first day of your period. If you are not having periods (e.g. while breastfeeding) you can start the minipill at any time. You will have some protection from three hours after taking the late pill but it is best to use another form of contraception as well as the minipill for the next few days.
If you have had sex while unprotected because of missing pills, and you did not use another form of contraception, contact your doctor or an FPA clinic for further advice.

WHEN MIGHT THE MINIPILL BE INEFFECTIVE?
The minipill may not be absorbed properly if you have diarrhoea, vomiting or a fever. Assume that pills taken when this has occurred have not worked and follow the instructions given for missed pills.
Some antibiotics and other drugs may interfere with the effectiveness of the minipill. Check with your doctor or an FPA centre to be sure you are still protected. If you are not, use another form of contraception as well as the pill while taking the drug.

POSSIBLE SIDE EFFECTS
There are very few troublesome side effects with the minipill but it is fairly common to get irregular spotting or bleeding and unusually long intervals between periods.
If the minipill fails, there is a very slight risk that the pregnancy will be ectopic (the egg will implant in the fallopian tube). This occurs very rarely, but is dangerous. If you suspect you may be pregnant you should see a doctor straight away.

PERIODS AND THE MINIPILL
Your periods may come regularly, irregularly or not at all while you are taking the minipill. Many women get spot bleeding during their cycle. It is not possible to regulate, delay or cut out periods while on this type of pill.

MEDICAL CHECK-UPS
Arrange to have your blood pressure checked every six months and a breast check and Pap smear test every 12 months. Remember to check your breasts for lumps every month yourself.

GETTING PREGNANT AFTER THE MINIPILL
When and if you decide to become pregnant, simply stop taking the pill. There will be no delay in the return of your fertility.
THE PILL

This Information Sheet is about the combined pill, the one we usually mean when we talk about 'the pill'. The combined pill is made up of two hormones, oestrogen and progestogen. They stop the woman's ovaries from releasing an egg cell each month which means a pregnancy cannot begin. In this Information Sheet the combined pill is called 'the pill'.

WHO CAN TAKE THE PILL?
Most women can take the pill, but you should not take it if:
- you have had a deep venous thrombosis (blood clotting), stroke or heart attack
- you have severe liver problems
- you have focal migraine
- you have unusual bleeding from your vagina that has not been diagnosed.
You also may not be able to take it if:
- you are breast feeding
- you have high blood pressure, diabetes, gall bladder disease, kidney disease, some blood problems, tuberculosis, severe depression, or epilepsy
- you have had cancer of the breast, uterus, cervix or ovary (reproductive organs)
- you are over 35 and smoke, or you are under 35 and smoke more than 15 cigarettes a day.
If any of these things apply to you, talk it over with your doctor who will help you decide if you should take the pill.
Other pills you may have heard of are the mini pill and the morning after pill.
The mini pill is made of progestogen only. It is not quite as reliable as the combined pill, but is useful for women who cannot take oestrogen.
The morning after pill is taken to prevent pregnancy after you have had intercourse (penis in vagina sex).
It is an emergency method which can be used if you have had sex without using contraception. FPNSW (Family Planning NSW) has Information Sheets on both of these pills.

TYPES OF PILLS
There are many types of pills. Each woman needs to talk with a doctor or nurse practitioner to decide which pill is best for her. With some types, every pill in the packet has the same amount of hormones. With others, the amount changes through the month. But they all work the same way to prevent pregnancy.

21 AND 28 DAY PACKS
The pill comes in 21 day or 28 day packs. Both packs have 21 hormone pills. The 21 day pack gives you a break of seven days between each pack. The 28 day pack has seven pills that have no hormones (dummy pills) so your body has the seven day break while you keep taking a pill every day.
With both packs you will have a period during the seven days without hormone pills.

MISSING THE PERIOD BREAK
If you want to miss a period while you are on the pill ask your doctor or FP nurse practitioner what to do.

STARTING THE PILL
You should start your first pill packet when you have a period. The instructions that come in the packet will tell you exactly how to take it. Usually you need to use some other contraception like condoms, as well as the pill, for the first seven days of the first packet.
Ask your doctor about this. You may want to keep on using condoms with the pill because they help to protect you from sexually transmitted diseases.

IF YOU MISS A PILL
If you are less than 12 hours late taking a pill, take it as soon as you remember, and then take the next one at the usual time. You will still be protected against getting pregnant.
If you are more than 12 hours late, or have missed more than one pill, take a pill when you remember, and the next pill at the usual time. Then keep on taking the pills as usual, but use other contraception e.g. condoms, as well, for the next seven days.
If you have less than seven hormone pills left in the pack you are using, leave them and go straight on to the hormone pills in your next pack. Start at the beginning of the hormone pills and take all the pills. Do not have a break (and do not take dummy pills) until the end of that second pack.
You should always use other contraception as well, for seven days after missing pills.
Talk to your doctor or ring Family Planning as soon as possible if you have any worries about missed pills.

WHEN THE PILL MIGHT NOT WORK
If you have diarrhoea, vomiting or fever, the pill might not get into your system properly and you could get
pregnant. It is best to follow instructions for missed pills just to be sure.
Some antibiotics and other drugs may stop the pill from working. If you are taking anything, ask your doctor or Family Planning about this. If you are not fully protected use other contraception as well as the pill while you are taking the medication and for the seven days after stopping it. Remember to tell your doctor you are taking the pill, as sometimes it can cause problems with other medications.

THE PILL AND YOUR HEALTH
Most women feel fine while they're on the pill, but it is common to have some side effects at first. You could have 'break through' bleeding in between periods, sore breasts and nausea (feeling sick) for the first couple of months. This usually settles down during your third packet of pills. Some women find things improve if they take the pill at exactly the same time every day. Other side effects like putting on weight, less desire for sex, and feeling irritable are rare. They may be due to the pill, but can also be caused by other things in your life. If you are worried, talk to your doctor or a Family Planning nurse practitioner. They may suggest you try another type of pill, or you may need to change to a different method of contraception.

THE PILL AND THE SUN
The pill sometimes causes brown blotches in the skin on or near the face, especially if you are out in the sun. If you are on the pill you should always wear a hat and use a block-out sun cream (No.15+) when you are in the sun.

HEALTH RISKS
Serious health problems caused by the pill are rare. The most dangerous is blood clotting. Warning signs are severe sudden chest pain, severe pain in your calf or swelling in one leg, sudden blurred vision or loss of sight, or severe sudden headache. If you have any of these signs contact your doctor or Family Planning.

HEALTH BENEFITS
The pill does help some aspects of health. You have less chance of getting serious pelvic infection, cancer of the ovary, cancer of the endometrium (lining of the womb), anaemia, non-cancerous breast lumps, and cysts on the ovary.

When you are taking the pill, periods are less painful, bleeding is lighter and more regular and there is less premenstrual tension. Acne may also clear up.

IF YOU PLAN TO HAVE SURGERY
If you know you are going to have surgery, tell your doctor you are on the pill. You will probably be asked to stop taking it and to use other contraception eg condoms, for four to six weeks before you go to hospital for major surgery, unless the surgeon is going to give you an anti-clotting drug. You should also stop the pill and use other contraception if you are bedridden or have a leg in plaster.

MEDICAL CHECKUPS
It is good to have your blood pressure taken and a breast check when you have your prescription renewed each year. You should also have a pap smear every two years. Remember to check your breasts yourself each month. Ask at FP for a pamphlet on how to do this.

PERIODS AND THE PILL
Your periods will probably be darker in colour and you will bleed less while you are on the pill. Periods usually start a few days after you stop taking the hormone pills in your packet.

IF YOU MISS A PERIOD
You may sometimes miss a period while you are taking the pill. As long as you have taken it as directed and have no reason to think it might not have worked and you could be pregnant, just keep taking the pill as usual. If you miss a second period, contact your doctor or Family Planning.

GETTING PREGNANT AFTER TAKING THE PILL
Most women who want to have a baby get pregnant within six months after they stop taking the pill, just as if they had not taken the pill. Women whose periods have not started again after three or four months should talk with their doctor or a FP nurse practitioner.

TELEPHONE INFORMATION NURSE
If you have specific questions about the pill, you can ring Family Planning NSW.
Telephone Information Nurse Ph (02) 716 6099
TTY for deaf (02) 916 8360

Produced FPNSW Dec 1994
DIAPHRAGMS AND CAPS

The diaphragm and cap are barrier methods of contraception that are placed inside the vagina so as to cover the entrance to the womb. When the man ejaculates ('comes') inside the woman the diaphragm or cap stops the sperm getting into the womb and thus prevents pregnancy. The diaphragm or cap is left in place for a further six hours (or longer if wished) during which time any sperm remaining in the vagina die.

DIAPHRAGMS

A diaphragm is a shallow dome of thin rubber with a firm, flexible rim. It is placed in the vagina so that it covers the cervix (entrance to the womb) and tucks in behind the pubic bone. It is held in position by the pelvic muscles.

Three types of diaphragms are available in Australia, the flat-spring, coil-spring and arcing-spring or 'All-flex' diaphragms.

CAPS

A cap is a firm cup-shaped or dome-shaped device that fits snugly over the cervix and is held in place by suction. Three types of caps are used in Australia, the cervical, vault and vumile caps. The FPA has supplies of the cervical and vault caps and can arrange for vumile caps to be sent from the United Kingdom.

Throughout the remainder of this sheet the information given for diaphragms also applies to caps, except where specifically stated.

LOOKING AFTER YOUR DIAPHRAGM

After removing your diaphragm, wash it in warm water with mild soap, rinse it in clear water, dry it carefully and store it in a firm container away from heat. Remember that your diaphragm is made of rubber, which is perishable, so dry it thoroughly before you store it and keep in a cool place. Check it regularly for holes by holding it up to the light. Check for tackiness too; rubber becomes sticky or tacky when it is beginning to perish. As an extra precaution take your diaphragm along to be checked when you have your Pap smear. If it develops a hole or tear do not use it; get a new one as soon as possible.

If you want to wear your diaphragm continuously (removing it once a day for washing) it is a good idea to have two diaphragms so you can alternate them. This will reduce the likelihood of the diaphragm developing an odour.

SPERMICIDE AND THE DIAPHRAGM

Although traditionally the diaphragm has been used with spermicide, many women are now using the diaphragm on its own, and there is no firm evidence at present that it is less reliable used alone. However, some doctors argue that as the diaphragm is not watertight, spermicide is essential.

If you decide to use spermicide, you need add it only when you are putting your diaphragm in. There is no need to insert extra spermicide before each act of intercourse.

WEARING YOUR DIAPHRAGM 'ROUND-THE-CLOCK'

If you wish, you can leave your diaphragm in almost continuously, removing it only for washing once every 24 hours. Be careful, however, not to remove it before the necessary six hours have passed since intercourse. Note, too, that during menstruation it is best not to leave the diaphragm in for more than 12 hours at a time.

USING THE DIAPHRAGM DURING YOUR 'UNSAFE' TIME ONLY

Some women use their diaphragms only during their fertile ('unsafe') time and use no contraception during the rest of their cycle. If you want to do this, it is vital that you know how to recognise your 'safe' and 'unsafe' times. Don't guess. For information about this method contact the FPA or a Natural Family Planning centre.

USING THE DIAPHRAGM DURING YOUR PERIOD

You should continue to use your diaphragm while you are menstruating as it is possible to become pregnant at this time (but see above). It is best to remove it after 12 hours, as there is some evidence that wearing a diaphragm for long periods while menstruating could increase the risk of toxic shock.

IF YOUR DIAPHRAGM IS UNCOMFORTABLE

If your diaphragm has been fitted properly and is correctly positioned in the vagina, you should be unaware of it. Your partner may be able to tell it is there during intercourse but most men do not find this a problem. If your diaphragm is uncomfortable (for you or your partner) or you feel sore after using it, see your nurse or doctor. You may need a different size or type of diaphragm or you may find a cap or some other method of contraception suits you better.

SIDE EFFECTS

Very rarely a woman may be allergic to the rubber the diaphragm is made of, or to the spermicide, if this is used. If the spermicide is the problem, changing to a different brand may help.

ACCIDENTS

If you have had sex and forgotten to put your diaphragm in, or discovered after having sex that the diaphragm was not covering the cervix, you may get pregnant. A 'morning-after' contraceptive pill is available. It can be taken up to 72 hours after unprotected intercourse. Contact your doctor or an FPA clinic as soon as possible if you want to use it.

WHEN TO GET A NEW DIAPHRAGM

Your diaphragm should normally last about two years unless you are wearing it 'continuously', in which case it will deteriorate more quickly.

You should have your diaphragm refitted if you have a pregnancy or pelvic surgery. Have the fitting checked, too, when you go for your Pap smear.
FITTING THE DIAPHRAGM OR CAP

When you are fitted for a diaphragm or cap make sure you are shown how to insert it, check it is correctly positioned, and remove it. You should practice doing this in the surgery so that the nurse or doctor can help with any problems you might have.

The diaphragm or cap can be put in at any convenient time before you have sex, but it must be left in place for at least six hours after intercourse.

INSERTING AND REMOVING YOUR DIAPHRAGM

- If you are using spermicide, squeeze about a teaspoonful into the diaphragm bowl, avoiding the rim.
- Get into the position you find easiest (standing with a foot on a chair, squatting or lying down).
- Squeeze the opposite sides of the rim together so that the diaphragm is narrow enough to slide into the vagina. (If you are using spermicide, or have an arcing diaphragm, the inside of the bowl should face upwards.)
- Holding the diaphragm with one hand, spread apart the entrance to the vagina and slide the diaphragm in as far as it will go, slanting it towards the small of your back (A). Tuck the front rim up behind the pubic bone (B).
- Reach into your vagina and check that you can feel the cervix through the diaphragm. It will feel like a genily rounded, soft knob. If you cannot reach far enough, try squatting or bearing down to push the cervix forwards.
- To remove the diaphragm put your finger behind the front rim and pull it down and out.

INSERTING AND REMOVING YOUR CAP

- If you are using spermicide, squeeze about a teaspoonful into the cap, avoiding the rim.
- Get into the position you find easiest (standing with a foot on a chair, squatting or lying down).
- Squeeze the opposite sides of the rim together so that the cap will fit easily into the vagina (A).
- Spread apart the entrance to the vagina and slide the cap in, with the open end facing upwards, as far as it will go. The cap will grip onto the cervix when it reaches it (B).
- Reach in and feel around the edge of the rim to see that the cap is gripping firmly. If you cannot reach far enough, try squatting or bearing down to push the cervix forwards.
- To remove the cap, push or lift the rim off the cervix with a finger (C) before you pull it out.

Diagrams are reproduced with kind permission from Population Reports, H7, Population Information Program. John Hopkins University.
Safe use of an IUD

- Learn to check the string each month after a period to make sure the IUD is still in the right place. If you cannot feel the string or it appears to have lengthened, you should consult your doctor.
- See your doctor immediately if you have any unusual symptoms which could be due to PID.
- If your period is more than a week overdue see your doctor or clinic for a pregnancy test. Make sure you are checked for ectopic pregnancy.
- If you or your partner ever have casual sex or if you have a new sex partner use a condom every time until you both have had a check for sexually transmissible diseases.

This pamphlet will also be available in the following languages:

- Spanish;
- Cantonese;
- Vietnamese;
- Tagalog; and
- Arabic.

Copies can be obtained from:
Organon Australia Pty Ltd
Private Bag 25
Lane Cove NSW 2066
Phone (02) 428 9411

or your local Migrant Resource Centre.

This information was developed in conjunction with the Royal Australian College of Obstetricians and Gynaecologists and the Family Planning Association. It was approved by the Reproductive Devices Panel of the Therapeutic Goods Evaluation Committee on 27 July 1992.

The assistance of the Health Development Branch, Department of Health, Housing and Community Services, in the production of this pamphlet is acknowledged.
However, if the pregnancy is continued with the IUD in place, there is a risk of a serious infection or premature birth.

If you become pregnant with the IUD in place, you should discuss the pregnancy with your doctor as soon as possible.

**Who can use an IUD for birth control?**
The IUD is suitable for women who have had children and do not want any more children. If you do not have children and are thinking of having them in the future you should carefully discuss the option of using an IUD with your doctor or health adviser before deciding to be fitted with one.

If you have any of the conditions listed below you should not use an IUD:
- an active or recent genital infection (gonorrhoea, Chlamydial infection, cervical infection, pelvic inflammatory disease);
- have had pelvic inflammatory disease more than once;
- may be pregnant;
- abnormal vaginal bleeding, abnormal cervical smear or other signs of genital cancer.

The IUD should not be your first choice if you have any of these relative contraindications:
- painful or long menstrual periods;
- are not in a long-lasting, mutually faithful sexual relationship;
- want children but have none;
- have had an ectopic pregnancy;
- are very anaemic;
- have medical conditions that make an internal infection especially risky—rheumatic heart disease or treatment with steroids or other drugs that suppress the immune system;
- have fibroids or other conditions that change the shape of the uterus or cervix;
- have had repeated genital infections.

**Under what circumstances is an IUD inserted and what happens then?**
When you visit your doctor:
- Firstly your obstetric and gynaecological history is reviewed. You will then have a vaginal pelvic examination, a cervical smear and possibly tests for genital infections (these latter tests are more likely to be required if you or your partner have had more than one recent sexual partner).
- When these results are normal the IUD may be inserted.
- Sometimes a local anaesthetic or a muscle relaxant is used before the IUD is inserted but this is not always necessary. In rare circumstances a general anaesthetic may be necessary.
- Occasionally you may feel faint during or after the insertion and may need to rest before leaving the clinic or doctor’s room.
- Cramps or spotting sometimes occur in the first few days after insertion. This passes but can be relieved with aspirin or a hot water bottle. If cramps, spotting or pain persist you should see your doctor.
- A follow-up visit is necessary six weeks after insertion and after that a yearly follow-up visit is advised.

**Removal of the IUD**
The IUD may be left in place for several years—the less frequently it is changed the less risk of infection—however you should not neglect to have your yearly check-up. If you wish to become pregnant or if you decide not to continue with the IUD for other reasons, it can be removed earlier. The doctor removes the IUD from the uterus by gently pulling the string protruding through the cervix (neck of the womb) with a special instrument.
The good things
- Effective protection against pregnancy.
- No preparation needed before sex.
- No pills to remember.
- Protection against pregnancy for three years or more.
- Comparatively cheap.

The possible problems
- Pregnancy in the tube (ectopic pregnancy).
- Pelvic infection (infection in the tubes).
- Infection in the tubes which may cause inability to have children (infertility).
- Heavier and more painful periods.
- IUD may fall out leaving you at risk of pregnancy.

Who could use an IUD?
- Women wanting a reliable, easily removable method of contraception after having their children.
- Women who want to have a space of two or more years between pregnancies.

Who should not use an IUD?
- Women who have more than one sexual partner.
- Women with a male partner who has other partners.
- Women who have recently changed sexual partners.
- If you have not had children but would like a child later, talk to your doctor about using an IUD.

The Intraluterine Device (IUD)
Before deciding to use a birth control method it is important for you to understand how it works and what side-effects can happen. No method of birth control is absolutely safe so you need to weigh up the good things and possible risks of each method before deciding which is the best for you.

This pamphlet is to help you decide if an IUD is the best method of birth control for you. When you have read it you should talk to your doctor about the IUD and also what other methods you could use for birth control before you finally decide.

What is an IUD?
An IUD is a small plastic device which has copper wire wound around its stem. It is placed inside the uterus (womb) to prevent pregnancy. A fine nylon string is attached to the IUD which goes from the IUD through the neck of the womb (cervix) into the vagina. This allows you to check if the IUD is still in place and is also necessary for easy removal of the IUD by your doctor.

How effective is the IUD?
The IUD is 95-99 per cent effective. This means that for every 100 couples using the IUD for a year, one to five women will become pregnant during that year even though the IUD may still be in place. This makes the IUD as good at preventing pregnancy as the pill, which is about 96 per cent effective in general use.

How does the IUD work?
Although the IUD has been used for more than 30 years to prevent pregnancy, it is still not fully understood how it works. The IUD affects sperm movement and survival in the uterus (womb) so that they cannot reach the egg to fertilise it. The IUD and the copper released from it also change the lining of the womb (endometrium) so that it is not suitable for a pregnancy and prevents an egg—if it does become fertilised—from developing.
What about Pelvic Infection?
If you use an IUD you have a small increase in risk of developing a serious infection called pelvic inflammatory disease (PID). PID is an infection of the womb, fallopian tubes and ovaries, most often caused by an organism (bug) that is transmitted through sexual intercourse.

However, the latest evidence suggests that the main increase in risk of PID with an IUD is in the first three weeks following insertion. If you only have one sexual partner and he also has no other sexual partner, your chance of getting PID following this first three-week period is low.

PID is a serious infection which can cause infertility (inability to have a baby) by blocking the tubes, make you more likely to have an ectopic pregnancy (pregnancy in the tube) or cause you much pain. The symptoms of PID are easy to miss and sometimes there may be no symptoms.

You should see your doctor immediately if you have any of the things on this list:
- increased temperature;
- tenderness or pain in your pelvis (lower abdomen);
- abdominal cramps or lower back pain;
- bleeding between periods;
- more painful and heavier periods;
- pain with deep thrusting during sex;
- unpleasant or heavy discharge from the vagina;
- feeling unwell, weak or tired.

What about Ectopic Pregnancy?
This is a condition where the fertilised egg grows outside the womb, usually in the tube. If it is not detected early it can cause serious bleeding which can result in death. If you become pregnant whilst using an IUD it is more likely to be ectopic but remember the risk of pregnancy with an IUD is very low. If you miss a period or think you could be pregnant, see your doctor immediately and make sure you are checked for ectopic pregnancy.

Both of these serious conditions can cause infertility.
- It is important that if you or your partner ever have casual sex or if you have a new partner that you use a condom every time even though you have an IUD until you have both had a check for sexually transmissible diseases.

What are the other side-effects of an IUD?
Some women find that whilst using an IUD:
- periods are heavier and longer;
- sometimes periods are more painful;
- often the amount of vaginal secretions is increased;
- the IUD is sometimes pushed out of the womb into the vagina. This is more likely to happen in the first few weeks after the IUD is placed in the womb. It is important to check your vagina for the string every month at the end of a period to make sure it is still in place;
- very rarely—about six out of 1000 insertions—an IUD can pass into the wall of the womb or, even more rarely, into the abdominal cavity during insertion.

If any of these things happen you should have a check by your doctor.

What happens if a pregnancy occurs with the IUD still in the womb?
Occasionally a pregnancy can happen even if the IUD is still in the womb. If you have a positive pregnancy test soon after you miss a period the IUD can easily be removed. You will then have about a 30 per cent chance of having a miscarriage.

If the IUD cannot be removed, because the string has been drawn up into the womb as it enlarges with the pregnancy, the miscarriage risk is higher—about 50 per cent. If carried to term, healthy babies have been born to women where the IUD was left in the womb during the pregnancy. It does not cause abnormalities in the baby.
Module One. Sexual and Reproductive Health

Session: 1.3

Topic: Relationships and Communication

Goals: To explore how the women see themselves inside and outside
To practice giving and receiving compliments
To explore the types of relationships that exist
To explore individual responsibilities and expectations in both sexual and non sexual relationships
To explore the concept of assertiveness and self confidence
To practice assertiveness and negotiation skills
Self Image

Suggested strategies
This exercise will explore the perceptions and images we have of ourselves and how difficult it is to be confident enough to "show" ourselves to the world.

- Ask the women to draw a representation of their "inner self" and their "outer self" as they see themselves. This may be just colour, a flower, tree, clouds, abstract.
- Go around the group and ask each woman to discuss her picture.
- Be prepared to be supportive but not analytical.

Resources
Small pieces of butcher's paper, coloured pens and crayons

Compliments Exercise

Suggested strategies
- Ask the women to go around the group and say one or two positive things they like about their body, eg:
- "My name is ...... and one thing I like about myself is my......"
- The next participant uses this statement to compliment the first woman and then states her likes.
- Go around until all women have given and received a compliment

Key points
- Women find it difficult to say positive things about themselves.
- Saying nice things is not encouraged in our society - it's called 'bragging'.
- For others to have a high opinion of us we first need to have a positive sense of ourselves.
- Receiving compliments is a good start to accepting ourselves and improving self confidence.
- What are some things we can do to feel good about our bodies.
- Where does the notion of attractiveness come from.
- How can we feel comfortable with our bodies.
- Does our health affect the way we feel.
- Do other people's opinions affect the way we feel.

Resources
Nil
Relationships

Suggested strategies
Brainstorm with group all the relationships which may exist
Write up on whiteboard and discuss

Key points
- Family, lovers, friends, peer, parents, work, social, sexual, hetero/homosexual, wife, mother, daughter

Resources
Whiteboard markers

Suggested strategies
Graffiti sheets:
On large pieces of butchers paper, write at the top sentences about relationships, eg;
- In a relationship the most important things are...........
- What I want from a relationship...........
- See lesson plan for other examples

Place these around the room with pens and ask the women to move around and write on them to complete the sentence.
They are Graffiti sheets, so words may be written everywhere on the paper
Discuss each sheet in the large group

Key points
- We have many different relationships with many different people
- Our behaviour needs to change according to the relationship
- We have a responsibility to look after ourselves
- We need to be assertive to meet our needs
- We need to be confident

Resources
Butchers paper, pens
Self Confidence and Assertiveness

Self confidence

Suggested strategies
Background reading is essential for this subject
- Ask the women to describe what is necessary to be self confident
- Write up
- Discuss how self confidence and self concept can affect relationships

Key points
- Assertive
- Sense of identity
- Self esteem
- Gives to self
- Responsible for self
- Right to express feelings and beliefs
- Can interact
- Feel good about self
- Emotional well-being
- Good communication skills

Assertiveness

Suggested strategies
Background reading is essential for this subject
- Discuss assertiveness and what it means

Key points
- "Assertiveness is the ability to send clear messages by speaking up about you needs, opinions and feelings in order to gain cooperation to meet your own needs, reduce potential misunderstanding, work through conflict and promote honesty and trust" (Norfor 1968 p.12)
- Not being passive lose - win
- Not being aggressive win - lose
- Assertive = ready to negotiate = win - win

Resources
"Communication" and "Assertiveness" Books by Trish Nove
Both published by Western Sydney Area Health Promotion Unit
"Mentoring" by G. Shea.1992 Crisp Publications
"Personal Counselling" by R. Knowdell & E. Chapman Crisp Pub. 1993
Pressure Lines

Suggested strategies
- Discuss assertiveness in a relationship
- Ask the women to think of some pressure lines, they may call it emotional blackmail.
- Role play an exercise in being assertive

Key points
- If you really loved me you would....
- If you were my friend you......
- I thought you cared......
- Discuss being assertive in response to pressure lines
- Discuss negotiating for what you want
- Role play a situation, eg:
  - saying no to a friend who wants to borrow from you at buy ups
  - negotiating for safe sex
  - negotiating with a prison officer

Resources
Background reading
Self-talk

Self-talk is what we say to ourselves about what we experience.

Every waking moment we talk to ourselves about the things we experience. This self-talk affects how we feel about experiences and how we respond. We are often unaware of our self-talk, but it has a powerful influence on our lives. It is often not what happens or what others do that upsets us but what we say about that event or person that creates that feeling.

Self-talk can be either realistic or unrealistic. If we talk to ourselves rationally about how things really are, we can understand, accept and behave appropriately. However, if we talk to ourselves irrationally about how things should or ought to be, we can feel very uncomfortable or upset.

By changing irrational self-talk to more rational self-talk, we can feel more comfortable about what has happened and about ourselves, and choose how to act.

Self-talk also has to do with one's expectations, usually unrealistic, of ourselves and others.

IRRATIONAL SELF-TALK OFTEN CONTAINS TWO PARTS:

- The unrealistic expectation, eg. ‘I should ..... ’, ‘he must not ..... ’.
- The implied terrible result, eg. ‘ ..... because if I don’t then I am not worthwhile’.

The whole sentence may look like this: ‘He should not boss me around’ (part I) ‘because if he does I am inferior.’ (part II)

By changing the two parts of this sentence to something more realistic, we end up with: ‘I would prefer him not to boss me around, but if he does, it does not mean that I am inferior!’ Instead of feeling angry and upset, you can now feel a lot more self-accepting and handle the situation better.

Irrational 'shoulds' and their awful consequences are powerful ways in which people put themselves down.
<table>
<thead>
<tr>
<th>List of Irrational Beliefs</th>
<th>Rational Replacements</th>
</tr>
</thead>
<tbody>
<tr>
<td>I must have love and approval from all the people I find important in my life.</td>
<td>I will accept and value myself. If I also have love and approval from others - that's great.</td>
</tr>
<tr>
<td>I must be able to do most things well, or at least be thoroughly competent in one important area.</td>
<td>It feels good to do the best I can and if I don't always manage to do very well, I will work on either accepting myself as I am or improving what I do without punishing myself.</td>
</tr>
<tr>
<td>I must blame or punish people who harm me or others. They are bad and wicked and it is my duty to reform them.</td>
<td>It would be nice if there was a law that people have to behave as I think they should. But since there isn't I will accept the other person as they are and it's too bad if I don't like what they do.</td>
</tr>
<tr>
<td>Life should work out the way I want it to. If it doesn't I must be frustrated, rejected and unfairly done by. It's awful and catastrophic and therefore I cannot stand it.</td>
<td>It's too bad that things are not the way that I would like them to be. I will try to change them for the better. If I can't I will tell myself they are sad, unfortunate or a nuisance rather than terrible, awful and catastrophic.</td>
</tr>
<tr>
<td>Someone or something is making me feel depressed, utterly miserable; compelled to eat, smoke, drink; terrible; hard done by, therefore I must keep feeling that way.</td>
<td>I make myself feel those unpleasant feelings by my self-talk about someone or something.</td>
</tr>
<tr>
<td>I must keep worrying and be over anxious if something seems dangerous or fearsome.</td>
<td>Worrying prevents me from acting effectively. I will face the dangerous situation and either accept that it does involve some danger or attempt to change my feelings by self-talk.</td>
</tr>
<tr>
<td>It is better for me to avoid facing many of life’s difficulties than to risk failing or being rejected.</td>
<td>If I fail or get rejected I will still accept myself.</td>
</tr>
<tr>
<td>My feelings and behaviour today will continue to be strongly influenced by what has happened in the past.</td>
<td>The past only influences the present for as long as I tell myself that it does. Instead I will choose how I feel and behave today.</td>
</tr>
<tr>
<td>People and things should turn out better than they do. There are no solutions to life’s serious problems.</td>
<td>I will accept that people may act the way they wish and that things will happen that I do not like. Instead of looking for perfect solutions, I will look for compromises and for reasonable solutions.</td>
</tr>
<tr>
<td>I should be able to enjoy myself without going to a lot of bother.</td>
<td>Avoiding difficulties and responsibility will not bring happiness in the long run. I will be happiest when actively and vitally absorbed in living.</td>
</tr>
</tbody>
</table>
Increasing self-esteem and sense of identity is part of becoming more assertive. Becoming more assertive means choosing to think and behave in an effective way, satisfying way; not blindly reacting by running away (passive) or hitting out (aggressive).

The rich variety of personalities, of relationship styles and different customs is part of being human. No one style of behaviour is always ‘best’. However, when people find their style of relating with others results in conflict and are dissatisfied because their own needs are not being met, or others in the relationship are resentful, it is time to examine the way we relate to others. With this awareness, people can begin to make changes in areas where they see need for improvement.

There are risks and benefits in all relationship styles.

**PASSIVE STYLE OF RELATING**

Difficulties in relating to others usually arise because passive people rarely take action to meet their own needs. They expect others to meet these needs and often become depressed or take on a martyr role when others fail to do it. They tend not to believe they have the right to speak up.

- Being passive can mean:
  - ‘I don’t count, you can take advantage of me.’ ‘My feelings don’t matter, only yours do.’ ‘My thoughts aren’t important; yours are the only ones worth listening to.’
  - ‘I’m nothing - you are superior.’

- Consequences: ‘I lose - you win.’

- Increasing sense of hurt and anger. Somatic problems - head, stomach and backaches. General depression.
- Growing loss of psychic energy.
AGGRESSIVE STYLE OF RELATING

People relating aggressively tend to believe strongly in their own rights but do not see others as having the same rights. They usually meet their own needs and see themselves as responsible for making decisions on behalf of other people. Their style can be the result of strong conditioning to compete, achieve, be strong, to take initiative.

Being aggressive can mean:

'This is what I think, you’re stupid for believing differently.' ‘This is what I want, what you want isn’t important.’ ‘This is what I feel, your feelings don’t count.’

Consequences: ‘I win – you lose.’
Lack of relationship. Communication ceases or becomes distorted.

ASSERITIVE STYLE OF RELATING

People who relate in an assertive way accept and respect their own rights and the rights of others. They are able to express their needs, opinions, and feelings openly and appropriately in a relationship and are able to listen to the needs, opinions and feelings of others. People who are assertive have a sense of ‘give and take’ in a relationship and a willingness to negotiate when conflict occurs. Because they have a strong sense of self-worth and high self-esteem, they are not afraid to ask for what they want or to admit mistakes. They are not jealous of or threatened by the success of others.

This is an ‘ideal’ state which no-one can achieve all the time. Our feelings about ourselves vary, according to circumstances. Part of being assertive includes feeling confident enough about ourselves to accept that we do not have to be perfect, that we are human and will make mistakes.

Being assertive includes an awareness of risks and benefits which can result from each style of relating and being able to choose how to respond in any situation.

The key word is ‘choose’ because people can assertively choose to be passive and not speak up for their rights; or to act more aggressively on occasions. This is quite different from acting passively or aggressively as a habitual style of relating.

Situations when it is probably not wise to speak up:

- When the timing is wrong and may lessen the chances of clear communication, eg. the other person is having an ‘off day’ or is having temporary hassles.
- When the original situation has changed so that it would serve no useful purpose.
- With an authority, if and when this could lead to more trouble than it is worth.
- If we have made a conscious choice not to assert and we don’t feel manipulated.
Be specific about other’s behaviour, example of how behaviour is different from labels, eg. You’re inconsiderate VS. You didn’t ring me to let me know you were late.

Acknowledge the other’s feelings when appropriate. Keep in mind that the other person may have strong feelings in response to an assertive statement. Acknowledging the other’s feeling is a way of expressing acceptance and respect for the other’s rights, eg. ‘you seem rather upset by what I’ve said’. In this way the other person feels understood and is better able to listen in turn. Doing this also encourages co-operation and leaves the path open to negotiation if conflict occurs.

Keep the ‘we’ in the relationship and be prepared to negotiate, eg. ‘I can choose to be passive if the risk to the relationship is too great’.

The use of these steps becomes easier and less time consuming with practice. It is important to realise that communication is two-sided. Skills of listening and resolving differences are necessary to ensure that the other’s messages are also heard and considered.

RISKS IN BEING ASSERTIVE

- I may not get the result I want. However I feel better.
- I may overshoot and become aggressive.
- It is wise to proceed slowly and let family and close friends know what I am trying to change and ask for their understanding and co-operation.

EXERCISE

- Practise sending an assertive message to someone close to you. Start with a positive message, eg. ‘I really appreciate it when you volunteer to wipe-up without being asked’.

  Start with ‘I’ ____________________________
  ____________________________
  ____________________________
  ____________________________
  ____________________________
  (Make sure you are specific about the behaviour)
  ____________________________

- When would be an appropriate time.

  ____________________________
  ____________________________
  ____________________________
  ____________________________
  ____________________________

- Note the response. ____________________________
  ____________________________
  ____________________________
  ____________________________
  ____________________________
  ____________________________
6. What choices do I have.

________________________________________________________________________

7. My decision is.
   a) What do I say? (a message) ____________________________________________
   b) What do I do? (behaviour - to do something) ______________________________

________________________________________________________________________

8. How do I say it.
   a) Choose appropriate time ________________________________________________
   b) "I" Statement __________________________________________________________
   c) Congruent ______________________________________________________________________
   d) Be specific ______________________________________________________________________
   e) Ask others ______________________________________________________________________
   f) Negotiate where appropriate ________________________________________________

GETTING THE MESSAGE ACROSS WITHOUT BLAME

■ Careful timing
   Am I feeling OK. Is the other feeling OK? Do I need to relax first.

■ Use an 'I' statement
   My feeling what is the behaviour I wish to be assertive about check that it is a non-blameful message.
   I feel ..... when you ..... because ..... 

■ Be consistent (verbal matches non-verbal)
   The message is clearer when it is consistent, ie. non-verbal behaviour matches the words. For example, saying 'I'm not angry' in a tense, sharp voice is sending a conflicting message and is confusing to the other person who is more likely to respond to the body language.

[Image of a cartoon character holding signs that say 'NO - I'M NOT ANGRY...']
Identity

An individual's overall impression of who they are, what they want and where they are going. It is built up from our unique characteristics and our relationship with the world around us.

A sense of identity - knowing who I am, What I want and where I am going - is very closely related to a sense of well-being or self-esteem. If people know what they are and what they want, self-confidence is gained as well as a sense of being self-determined rather than controlled by others. Having a sense of identity is knowing:

- What we think, believe, value, feel about ourselves.
- What we really like to do.
- How others see us - appearance and personality.

HOW TO ESTABLISH AND LOOK AFTER MY IDENTITY

Inside: The first source of identity is our awareness of different characteristics of ourselves such as thoughts, feelings, self-talk, physical appearance and basic relationship style. How we see ourselves and how we react says a lot about us. Become fully aware of feelings, thoughts, opinions and values, and discuss with others. Notice gradual or sudden changes in outlook.

Outside: This consists of feedback from others on how we come across or appear to others either physically, emotionally or mentally. People may be quite unaware of quite obvious qualities unless told. For example, a person capable of coping with a number of guests at short notice may be totally unaware that this is out of the ordinary unless they get appreciative feedback. It is important to remember, however, that this particular person's feedback is only one perception of you, and that to get a more rounded picture of your behaviour it may be necessary to check with others. It is up to the person receiving feedback to accept or reject it as part of his/her own self-image.
Module One. Sexual and Reproductive Health

Session: 1.4

Topic: Safe Sex, STDs and BBCDs

Goals: To identify the principles and modes of transmission of HIV, HCV and HBV
To identify common STDs and principles of transmission
To explore issues relating to personal health, hygiene, self responsibility in regard to BBCDs and STDs
To define low risk/no risk practice involving BBCDs and STDs
To define safe sex and practice negotiation of safe sex practices
Blood Borne Communicable Diseases

Strategies
Background reading material on HIV, Hepatitis B and C is presented with this manual
Invoke discussion on BBCDs

Key points
- Mode of transmission: blood to blood
- BBCD must EXIT the body of the infected person
- BBCD must SURVIVE in its environment
- BBCD must be of SUFFICIENT quantity
- BBCD must ENTER the body of another person

Resources
Background reading, OHTs, Projector

Strategies
- Ask the women to form into 3 groups
- Hand out one Information kits on HIV, HBV, HCV to each group
- Ask the women to research their topic and ask the Hepatitis groups to report back to large group

Key points
- Hepatitis is inflammation of the liver
- It is caused by the Hepatitis virus
- Symptoms include: Nausea, Loss of appetite
  Jaundice, Dark urine
  Pain in liver, Lack of energy
  Diarrhoea and constipation
  Aching joints and muscles
- Types A. E. F. are non blood borne
- Types B. C. D. G. Are blood borne
- Testing is through a blood test
- Universal infection control is about protecting self and others from infected blood
- Prevention through: Clean needle use
  Use of gloves when handling blood
  Safe sex
- Liver friendly diet for Hepatitis positive people

Resources
Background reading, OHTs, Information Kits (provided with lesson plan)
Women and Hepatitis C

Women who have Hepatitis C need information about how this condition affects pregnancy and breast feeding, as well as the transmission of the virus to children, sexual partners and household members.

Women's experience of being infected with the hepatitis C virus is probably similar to that of men's however it is difficult to be confident of this as gender specific research is rarely undertaken. Women have a similar need for factual information about the progress of the infection, healthy lifestyle and avoiding transmission of the virus but they also need gender specific information.

Women have specific needs for information about hepatitis C and pregnancy, breast feeding, hormonal effects and the use of hormonal contraceptives and hormone replacement therapy. Women may also experience minor but distressing side effects to interferon treatment such as weight gain, hair loss and menstrual irregularities. They want detailed information regarding transmission of the virus to children, sexual partners and household members. Women with hepatitis C also have the dilemma of whether or not to have their children tested. There is the potential for discrimination to both themselves and their family to be considered if they disclose their positive hepatitis C status as there is considerable misinformation and fear about hepatitis C.

Hepatitis C is a viral infection of the liver that is thought to have been prevalent in Australia for over twenty years although the viral agent was not identified until 1988. Hepatitis C accounts for approximately 95% of cases of nonA nonB hepatitis. It is estimated that between 50,000 and 200,000 Australian are infected with the Hepatitis C virus and many are unaware of the condition as it is a chronic, slowly progressing inflammatory condition. 1

Transmission

The virus is spread through blood to blood contact. The risk factors for being infected with hepatitis C include intravenous drug use, transfusion of blood or blood products prior to 1990, tattooing, body piercing and occupational exposure through needle stick and similar injury. The virus is not thought to be spread sexually except during acute infection or traumatic sexual practices. Interferon alfa - 2b is the only medical treatment currently available under strict criteria guidelines on the Commonwealth Pharmaceutical Benefits Scheme. It has long term efficacy in 30% of people treated. 1 Some people with hepatitis C have reported an improvement in their health after using herbal preparations and Traditional Chinese Medicine.

A study is currently being undertaken at Newcastle University to investigate these claims. As the medical treatment is only effective in less than a third of people treated the maintenance of a healthy lifestyle is vital to avoid further damage to the liver.

Women are more susceptible to liver damage from excessive alcohol use than men.2 Therefore avoiding harm to the liver is very important information for all women and they need to know about safe levels of alcohol use. One to two standard drinks of alcohol in 24 hours, three to four times a week is considered safe for women who do not have liver problems. Women with hepatitis C need to consider not drinking alcohol at all, or only on very rare occasions, as alcohol may further damage their livers.

Menstrual Irregularities

Women who are hepatitis C positive may experience menstrual irregularities particularly at times of acute hepatitis C symptoms. Abnormal vaginal bleeding may occur at these times so it is important that a woman's general health is checked as well as her liver function, for example, having Pap smears to exclude cervical cancer. Women can use oestrogen containing contraceptive pills except during acute exacerbation of the hepatitis C, when they are experiencing a lot of symptoms and or their liver enzymes levels are significantly elevated.

Progesterone only contraceptives are thought to be less irritating to the liver but caution should be used at times of acute liver problems. Prior to commencing hormone replacement therapy, women with hepatitis C need to have their liver functioning assessed before using oestrogen replacements.

Sexual transmission of the virus is thought to be uncommon. 1 For monogamous couples safe sexual practices are recommended only during menstruation and if either partner has any genital lesions. Traumatic sex can be avoided by ensuring adequate lubrication. Transmission of the virus to household members is thought to be extremely unlikely. Avoiding the sharing of objects that may be contaminated with blood such as toothbrushes and razors will further reduce the risk of spreading the virus.

Pregnancy and breast feeding

Vertebral transmission (spread of the virus from woman to baby during pregnancy and delivery) is thought to be very low, less than 10%. It depends on the woman's viral load at the time of pregnancy.3 Women who are hepatitis C positive do not need to consider termination of pregnancy, as some misguided people suggest, on grounds of their hepatitis C status. Counselling for women who are pregnant and hepatitis C positive is available from the Drugs in Pregnancy Service social workers at King George V Hospital, 02 5157882 or from the author at Royal Prince Alfred Hospital, 02 515 7529.

Breast feeding remains a controversial topic. If breast and bottle feeding provided the same benefits to the infant then the decision would be easier. Women who are hepatitis C virus positive would be safer to bottle feed, however there are many advantages of breast feeding over bottle feeding, and the possibility of spreading the virus through breast feeding is thought to be unlikely. Health authorities do not recommend against breast feeding for women who are hepatitis C positive.4,5 The final decision needs to be made by

By Jennifer Holmes RN, Grad. Dip. Hlth. Counselling, Bach. Hlth. Science (Nurs) Clinician/Project Officer Drug and Alcohol Service Royal Prince Alfred Hospital Telephone 02 5167529
Women and Hepatitis C

- The hepatitis C virus is spread through blood-to-blood contact. High risk activities such as sharing of drug injection equipment should be avoided by obtaining clean injecting equipment from needle and syringe exchanges. Casual or household contact such as the sharing eating utensils or touching will not spread the hepatitis C virus.

- Women who are hepatitis C positive need to cover all cuts with waterproof dressings and wear plastic gloves when tending children’s cuts and abrasions if have open wounds on their hands. It is recommended that they clean up blood spills with bleach and dispose of sanitary products with care.

By following these health practices women with hepatitis C will have opportunities for an improved quality of life especially when they are assisted by well informed nurses.

Nurses and other health care workers are important distributors of factual information to people who are infected with the hepatitis C virus or at risk of becoming infected. As with all new health problems information is rapidly changing therefore it is vital that we update our knowledge regularly.

More information, brochures and support are available from the Hepatitis C Council of NSW, telephone 02 3321599.

References


5. NSW Health Department ‘Antenatal and neonatal / infant screening for hepatitis C’ Information Bulletin 93/5.

HEPATITIS C PROGNOSIS

100 Hepatitis C antibody positive people

20 will clear virus and have no infection ongoing

80 will have long term Hepatitis C infection

20 will have no symptoms, will have normal liver function tests (LFTs) but will be infectious

40 will have chronic symptoms, with abnormal LFTs; will be infectious; may have signs of liver damage

20-25 will develop cirrhosis

5-10 of people with cirrhosis will develop liver failure

Diagram taken from Hepatitis C Council’s information pack (developed from presentations by Dr R Batey, John Hunter Hospital)
A liver friendly diet

Lots of:

Vegetables
Fruit
Pasta, bread, rice, cereals

Avoid:

Alcohol
Tobacco,
Amphetamines, Benzodiazepines, Heroin
All fats, fried foods
Chocolate
Coffee
Cakes
Nuts
Coke
Common symptoms of acute hepatitis

Nausea

Loss of appetite

Yellow skin (jaundice)

Dark urine

Pain in the liver area

Alternating diarrhoea and constipation

Lack of energy

Aching joints and muscles
'Show Bag' Question Sheet for BBCDs.

Describe the virus/ what it affects.

Describe how it is transmitted (Exit - Entry)

What are the risk behaviours associated with this virus?

How can you tell when you get it?

How do you arrange for testing?

What tests can be performed?

How can you protect yourself and others?
HEPATITIS A

What can be done to avoid infecting others?

If you have hepatitis A then:

- **wash your hands** thoroughly in soap and warm running water, after going to the toilet;
- **do not** prepare food or drink for other people;
- **do not** share eating or drinking utensils with other people;
- **do not** share linen and towels with other people.

Eating utensils, linen and towels can be decontaminated by washing in warm, soapy water. Linen and towels should be machine and not hand washed. Once eating utensils, linen and towels are decontaminated they can be used by other people.

Oral sex can easily transmit hepatitis A. Condoms or latex barriers make oral sex safer.

What can be done to avoid catching hepatitis A?

If there is a problem with hepatitis A in your household then you should:

- **wash your hands** thoroughly in soap and warm running water: **before** preparing food and drinks; and **after** handling objects and materials such as nappies and condoms.
- **avoid sharing** food, drinks and cigarettes with other people in your household.

When hepatitis A is spread in households it is usually confined to people caring for the infected person and to the sexual partners of the infected person.

People who live in the same household as an infected person, and sexual partners of an infected person, can have an injection of immunoglobulin. The injection will not prevent infection, but may prevent or reduce illness if given within 2 weeks of contact with the infected person.

For travellers to developing countries, a course of hepatitis A vaccine may be advisable. Consult your doctor for further information.

Should people who have hepatitis A be excluded from work?

People who handle food or drink must be **excluded** from work for at least 1 week after the onset of jaundice.

Generally, people whose work involves close personal contact, such as childcare and healthcare workers, should **not work** while they are infectious. They should discuss this with their doctor.

If you have further questions, consult your doctor or telephone your local Public Health Unit

Public Health Units in NSW

<table>
<thead>
<tr>
<th>Region</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Northern Sydney</td>
<td>(02) 477 9400</td>
</tr>
<tr>
<td>Eastern Sydney</td>
<td>(02) 313 8322</td>
</tr>
<tr>
<td>Western Sydney &amp; Wentworth</td>
<td>(02) 840 3603</td>
</tr>
<tr>
<td>Central &amp; Southern Sydney</td>
<td>(02) 556 9322</td>
</tr>
<tr>
<td>Southern Sydney</td>
<td>(02) 583 1077</td>
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<tr>
<td>Central Coast</td>
<td>(043) 202 404</td>
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<tr>
<td>Hunter</td>
<td>(049) 291 292</td>
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<tr>
<td>Illawarra</td>
<td>(042) 264 677</td>
</tr>
<tr>
<td>Central West NSW</td>
<td>(063) 328 505</td>
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<tr>
<td>South East NSW</td>
<td>(048) 273 420</td>
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<td>(066) 217 231</td>
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<tr>
<td>Northern Districts NSW</td>
<td>(067) 662 288</td>
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<tr>
<td>South West NSW</td>
<td>(060) 230 350</td>
</tr>
<tr>
<td>Western NSW</td>
<td>(068) 812 235</td>
</tr>
</tbody>
</table>

Public Affairs and AIDS Bureau, NSW Health Department.
State Health Publication No. (PA) 94–015.
For further copies of this publication, please ring or fax the Better Health Centre,
Phone: (02) 391 9010, Fax: (02) 955 6196.
Wash hands thoroughly

Hand washing is the most important way of preventing infections. Hands should be washed thoroughly in soap and warm running water, for at least 10 seconds, then dried thoroughly.

What is hepatitis?

Hepatitis is inflammation of the liver. Hepatitis can be caused by viruses, alcohol, or chemicals and drugs.

One major cause of hepatitis is the hepatitis A virus.

What is hepatitis A?

Hepatitis A is a viral infection of the liver with symptoms of feeling unwell, aches and pains, fever, nausea, lack of appetite, abdominal discomfort and darkening of the urine, followed in a few days by jaundice (yellowing of the eyeballs and skin).

The illness usually lasts for 1 to 3 weeks and is followed by complete recovery.

Children under the age of 5 years who become infected with the virus usually have no symptoms at all or mild gastrointestinal symptoms.

Hepatitis A does not cause long term liver disease.

What is the incubation period?

The period from contact with the virus to the development of symptoms is usually 4 weeks, but can range from 2 to 7 weeks.

How long is a person infectious?

People are infectious for only a short period of time.

Infected people can pass on the virus to others from 2 weeks before the development of symptoms until 1 week after the appearance of jaundice, approximately 3 to 4 weeks.

Consult your doctor for further information.

What body substances contain the hepatitis A virus?

Very large amounts of the virus are found in faeces during the infectious period.

How is hepatitis A spread?

The virus is usually spread when faeces from an infected person is transferred to another person’s mouth. The virus is passed in our community by:

- food, drink and eating utensils that have been handled by an infected person;
- hands after touching nappies, linen and towels soiled with faeces;
- oral/anal sex.

Outbreaks of hepatitis A have been reported as a result of:

- sewage contaminated water (including drinking and bathing water);
- sewage contaminated shell fish such as oysters and mussels;

but, effective decontamination can eliminate the virus.

Hepatitis A continues to be a problem for people travelling overseas, especially those people visiting developing countries.

How long can the virus survive outside the body?

The virus can survive on objects and surfaces for several weeks and in natural water for up to 100 days.

Who can get hepatitis?

Anyone who has not had hepatitis A in the past is at risk of catching the disease. One attack of hepatitis A provides life-long protection.

Hepatitis A, hepatitis B and hepatitis C are caused by different types of viruses. Infection with one type of hepatitis does not give any protection against the other types of hepatitis.
Hepatitis B
What is hepatitis?

"Hepatitis" means inflammation of the liver. This can be caused by a number of things, including alcohol, chemicals, drugs and infection by viruses.

What is hepatitis B?

Hepatitis B is one of the viruses that cause an infection in the liver.

Many people who get hepatitis B either don’t become ill, or recover completely, and the virus disappears from their blood.

However, between 5 and 10 people in every 100 who are infected, keep the virus in their body for many years and can infect other people.

These people are known as hepatitis B carriers.

If you are a carrier it is important to:

- tell your health care worker (including doctor and dentist) that you are a hepatitis B carrier
- carefully follow medical advice
- avoid drinking alcohol.

How do you catch hepatitis B?

Hepatitis B is caught by:

- contact with infected blood
- sharing needles and syringes with infected people
- sexual contact with an infected person
- a new baby (from its mother at birth).

You cannot catch hepatitis B through:

- normal activities such as shaking hands, hugging or kissing (even with infected people)
- food preparation

What can you do to stop passing the virus to others?

Don’t

- share personal care items, such as toothbrushes or razors, with anyone. The smallest drop of infected blood getting into their skin through a cut, may cause infection.

Take care!

Don’t

- share needles and syringes with other people. If you have to do so, reduce the risks by cleaning them carefully first.

Take care!
To clean
Flush the needle and syringe twice with cold water, then twice with household bleach, and twice again with cold water.

Do
- Put any blood-stained items into a plastic bag before placing them in the garbage.
- Clean up spills of blood on floor coverings or furnishings, immediately. Wash blood-stained surfaces with household detergent.

Your own family can be protected by having hepatitis B immunisation.

Take care!

Sexual partners can be protected by having hepatitis B immunisation. If you want to have sex with someone who is not immunised, you should warn them that you are a hepatitis B carrier. Use a condom to lessen the risk of infecting them.

High risk groups

There are some groups in the Australian community which contain a specially high number of hepatitis B carriers. Anyone from these groups has a stronger-than-usual chance of catching the infection.

These groups include:
- people who inject drugs
- people who have more than one sexual partner
- people from ethnic groups which contain a large number of hepatitis B carriers
- health care workers such as nurses, doctors and dentists.

Your doctor or community health centre will be able to tell you if you belong to a high risk group.

Hepatitis B vaccine is available free to:
- newborn babies of mothers who are hepatitis B carriers and
- newborn babies, where either parent is in a high-risk group
- their brothers and sisters who are less than five years old
- people who live in the same house as a hepatitis B carrier.

It's OK
Common STDS - Causes and Treatment

Chlamydia

Symptoms include:

- Discharge:
- Urethral discharge
- Vaginal discharge

- Pain:
- Pain on urination
- Pain during intercourse

- Infections:
- Pelvic inflammatory disease
- Infertility

Causes:

- Sexually transmitted disease
- Can be transmitted at any age

Diagnosis:

- Physical examination
- Urine test
- Blood test

Treatment:

- Antibiotics
- May require treatment for a longer period

- Sexually transmitted disease

Gonorrhea

Symptoms include:

- Discharge:
- Urethral discharge
- Vaginal discharge

- Pain:
- Pain on urination
- Pain during intercourse

- Infections:
- Pelvic inflammatory disease
- Infertility

Causes:

- Sexually transmitted disease
- Can be transmitted at any age

Diagnosis:

- Physical examination
- Urine test
- Blood test

Treatment:

- Antibiotics
- May require treatment for a longer period

- Sexually transmitted disease

Non-Gonococcal Urthritis

Symptoms include:

- Discharge:
- Urethral discharge
- Vaginal discharge

- Pain:
- Pain on urination
- Pain during intercourse

- Infections:
- Pelvic inflammatory disease
- Infertility
patients getting back several months.

Diagnosis When infection begins - It may be necessary to contact
since in women the lack of symptoms makes it difficult to

Patient's An infected male must tell all sexual partners in the

is what

If symptoms do appear, the infection is still there, so treatment

hoping to discern any will go away without treatment. But even

when infection can spread to the tissues causing noticeable pain

in the thighs or bid in women. This may make them feel uncomfortable in


What if it is not treated? Condoms can cause information

been taken to use the infection has resolved.


treatment. Condoms are easily and reliably used by the

are immediate, others take a few days.

Diagnosis: A test of sections from the cervix, brought

with an uncircumcised partner

the cervix. Minima. Cancellation of output after sexual contact

they can also take months to appear.

It is possible to have no symptoms of any kind.

that can also cause months to appear.

cases: Clinical and gonorrhea are the two most likely

even months after infection

Symptoms: Lower abdominal pain and indigestion, deep pain

Peptic ulcer disease is usually not caused by an

Common STDs: Causes and treatment
Causes: 

- The warts may be caused by a virus or by a direct skin-to-skin contact with an infected person or object.
- Sexual contact is when herpes is active, even if your partner is not.
- Other causes may be contact with objects or skin that is infected.

Diagnosis: 

- The warts are usually visible, and the doctor may take a sample for testing.
- If you have a skin lesion, it is important to consult a doctor for diagnosis.

Treatment: 

- The treatment for genital warts depends on the type of wart and the location.
- Treatment options may include surgery, laser treatment, or topical medications.
- Vaccines are available for some types of warts.

Infection: 

- Many warts may be caused by a virus or from contact with infected objects or skin.
- Treatment for infection may include antiviral medications or surgery.
- Vaccines are available for some types of warts.
Thrush

Common Herpes

| Causes and Treatment | Causes | Transmission can occur in women on abdominal white or creamy yellow

Diagnosis: By doing an abnormal discharge of drop-like secretions.

Candidiasis is not sexually transmitted, so partners don't need to be treated.

Candida in the peel of the fruit is an infection that can develop. Some of these factors include: antibiotics, diabetes, and immune system. The yeast can be detected under the microscope from swabs.

Treatment: Candida may be treated with antifungal creams or

With your partner:

If there are no apparent symptoms, can occur. If this is over

Condins of the sex:

Frequent office (about 3 to 10 days). If in doubt use a

Prescription does exist. Avoid sexual contact with symptoms. If you suspect an infection can be passed or during an outbreak. To protect

Partners: The most recent sexual partner should be advised.

Sometimes further tests should also be advised. A chest x-ray is essential forfering the test. If the test is positive, a different antibiotic should be prescribed.

General Herpes continues.

Sequence and Inflammation: (irrespective of some herpetic virus is not

Common Herpes - causes and treatment
as this could alter the management.

• Women should advise the doctor if they could be pregnant.

• Treatment has caused thrush

may be reduced to 1% if the infection persists or if the

• if the symptoms persist after the treatment an alternative

• person very sick

• combination of the antibiotics and acidophilus may make the

• Avoid alcohol until 24 hours after the treatment as the

• are treated

• do not take unrequired medications until sexual partners

• When advice should be given in a person with HIV

• should be treated as well to avoid transmission

• should be treated as well to avoid transmission

• antibiotics. Therefore, physicians usually give antibiotics.  

• treatment: that is usually cured by taking a single dose of

• there are no serious complications of either.

• diagnosis: through the symptoms may become more severe.

• Immune changes in the woman

• and antibiotics where taken for another purpose or because of

• a long standing infection is much more disabling because

• transmitting vaginal discharge on hands or feet. Sometimes

• from woman to woman is also common – possibly

• cause: This is usually transmitted by vaginal sex without using

• their vaginal discharge. Symptoms in women are:

• are: a thin, yellowish vaginal discharge and itching in the

• women who have no symptoms. Some may have

• Trichomoniasis

• Common STDs - causes and treatment

• Patients: Standard treatment is usually cure. However:

• Powder:

• diaphragm, female condom, diaphragm, and apply potential

• People prone to excess sweating should take extra care

• Avoid foods high in cholesterol and fats.

• are more prone to treatment

• keep healthy when people are stressed or run down they

• when prescribed antibiotics

• minimise the use of antibiotics of resistant candida treatment

• shield of body parts exposed

• Avoid excess of soap, vaginal deodorants, deodorant spray

• and dry under area, protect daily

• Uncircumcised men should wash (with water only)

• use condoms when having sexual

• to the back (enough) after urination.

• Women should always wipe from the front (vagina)

• perforation of organs

• some of the following suggestions may be helpful:

• Yet less contact underwear and avoid tight pants

• Truth continued
Rough infection is so long a sensation has been recorded.

First two years the body shortens much about to give a

intensity. An intense sensation is usually produced in the

and even years depending how long a sensation has been

Partners: For both sexes, recognizing patterns can back months

unintentionally from the mother to the offspring child.

TREATMENT: Oral disodium vitamin is effective immediately by

What if not treated: It is fatal untreated for many years the

on the stages of infection and range between 1 to 16 days.

TREATMENT: Oral disodium vitamin is effective immediately by

until 6 weeks after infection.

DIAGNOSIS: Swabs can be taken from the source to be examined.

When does the disease.

of the infection.

usually occur from 7-10 weeks after infection.

TREATMENT: Oral disodium vitamin is effective immediately by

on the second stage symptoms if they appear.

usually occur from 7-10 weeks after infection.

TREATMENT: Oral disodium vitamin is effective immediately by

symptoms.

References: When organisms multiply in the body

Common STDs - causes and treatment

Bacterial vaginosis (Gardnerella)
weeks.

*Partner* and family members

Infection will continue and the sores will spread to sexual

What if it's not treated

Unlikely! The itching is so severe.

Transmitted: Have a full STI check-up

(Transmission): Just in case, if you think the sores are spread.

Treatment: Special lotions from the chemist or apply usually

Diagnosis: Examine the area.

Scabies: Insecticide creams and dusting powders.

Cause: Mites (larvae) are not killed by soap, water or steam.

Common STDs - Causes and Treatment

Would love a physical exam?

*Partner* wishes to be treated but he is already treated.

Please come to the doctor.

(Prevention): Regular behavior.

Advice: Regular behavioral.[1]

Diagnosis: Cheeky looking.

Clothes or personal products.

Cause: Clothing.

Cleaning of the perineal area.

Spots in the area.

Common STDs - Causes and Treatment

Would love a physical exam?

*Partner* wishes to be treated but he is already treated.

Please come to the doctor.

(Prevention): Regular behavior.

Advice: Regular behavioral.
Infection (a concern if it is important to have future parents). 

Diagnosis: By blood test.

Complications: Symptoms may appear within 2 months after infection. 

Symptoms: fever, rash, swollen lymph nodes, muscle and joint pain, fatigue, vision problems.

Hepatitis B

Vaccination (not the vaccine). 

Partners: Partners of the previous two weeks may be helped.

Vaccination: If it is necessary, usually it resumes itself in 2 to 3 months. 

What if it is unexpected? 

If unexpected, several months later, is the only STI which has a fever, rash, swollen lymph nodes, muscle and joint pain, fatigue, vision problems.

Treatment: Rest and avoid alcohol and other drugs seen in the blood test 2 weeks after injection. 

If the body were to contract occipital, appear after 2 to 7 weeks. 

Caused: usually is limited by direct contact. The parties appear with a way appearance.

Sexual partners also have molluscus.

What if it's not treated? They may clear by themselves.

Diagnosis: By distinct appearance, but sometimes may be contracted with cuts.

Treatment: Scarring to remove the core, and painting with a special cream.

Sexual partners also have molluscus.

What if it is unexpected? 

If unexpected, several months later, the only STI which has a fever, rash, swollen lymph nodes, muscle and joint pain, fatigue, vision problems.

Treatment: Rest and avoid alcohol and other drugs seen in the blood test 2 weeks after injection. 

If the body were to contract occipital, appear after 2 to 7 weeks. 

Caused: usually is limited by direct contact. The parties appear with a way appearance.

Sexual partners also have molluscus.
How does someone get infected with HIV?

HIV is most often transmitted by:

• Sex without a condom (both partners are at risk)
• Sharing drug injection equipment
• Sharing dirty needles or syringes
• Sharing住在 hitting equipment

HIV is commonly transmitted by:

HIV has never been reported as being transmitted by:

• Toilet seats or mousses
• Sharing knives and forks, cups or glasses
• Sharing hands
• Cuddling
• Kissing

Symptoms: Most people with HIV look and feel perfectly healthy. However, the immune system begins to weaken. Common symptoms include: fever, fatigue, weight loss, night sweats, diarrhea, rash, mouth ulcer, and swollen lymph nodes. It is important to note that these symptoms may not occur in all cases.

What are HIV and AIDS?

Common STDS - Causes and Treatment
What to do now

You may wish to have a medical check. Free and confidential treatment and advice may be obtained from the following clinics (most offer day and evening times).

Sexual Health Services in NSW
Providing free and confidential counselling, information and treatment.

Sydney Sexual Health Centre
Sydney Hospital
(Macquarie St)
PO Box 1614
SYDNEY 2001
Ph: (02) 223 7066

Kirketon Road Centre
Sydney Hospital
(Victoria St)
PO Box 22
KINGS CROSS 2011
Ph: (02) 360 2766

Sexual Health Clinic (Clinic 16)
Royal North Shore Hospital
Pacific Highway
ST LEO NARDS 2065
Ph: (02) 9926-7414/5

Sexual Health Clinic
St George Hospital
1st Floor, 36 Belgrave Street
KOGARAH 2217
Ph: (02) 350 2742/3

The Livingstone Road Clinic
182 Livingstone Road
MARRICKVILLE 2204
Ph: (02) 560 3057

Sexual Health Clinic
Parramatta Health Service
Cnr George & Marsden Street
PARRAMATTA 2150
Ph: (02) 635 6851/4595

Bigge Park Centre
Liverpool Hospital
Elizabeth Street
LIVERPOOL 2170
Ph: (02) 827 8022

Sexual Health Service
The Royal Newcastle Hospital
Pacific Street
NEWCASTLE 2300
Ph: (049) 23 6929/6535

Manly Sexual Service
8/18 Whistler Street
(entrance up stairwell in Market Lane)
MANLY 2095
Ph: (02) 9977 3288

Canterbury Hospital
28A Tudor Street
BELMORE 2192
Ph: (02) 718 7655

Wentworth Sexual Health Centre
Nepean Hospital
(Somerset St)
PO Box 63 PENRITH 2751
Ph: (047) 242 507

Sexual Health Clinic
PO Box 361
Gosford Hospital
(69 Holden St)
GOSFORD 2250
Ph: (043) 202 114

Sexual Health Clinic
Port Kembla Hospital
Cowper Street
WARRAWONG 2502
Ph: (042) 762 399

Sexual Health Clinic
Nowra Hospital
NOWRA 2541
Ph: (044) 213 111

Sexual Health Service
93 High Street
TAREE 2430
Ph: (065) 511 315

The Lakes Clinic
2nd Floor, Bridgepoint Building
Manning Street
TUNCURRY 2428
Ph: (085) 556 822
Thurs 10am-2pm

Lismore Sexual Health & AIDS Service
(66 Hunter St)
PO Box 419
LISMORE 2480
Ph: (066) 202 980

The Orana Sexual Health Clinic
Orana Community Health Centre
Palmer Street
DUBBO 2830
Ph: (068) 858 999

Bligh Street Clinic
PO Box 83
(6 Bligh St)
TAMWORTH 2340
Ph: (067) 663 095

South-Eastern Sexual Health Service
Jennings House
Koulburn Hospital
Koulburn, Young, Bega
Ph: (048) 273 148
Appointments Only
Ph: 008 654 340

Wagga Sexual Health and HIV Clinic
Wagga Wagga Community Health Centre
Ph: (069) 38 6411
HIV/AIDS

Suggested strategies
Ask the HIV group to report back to the large group

Key points
- HIV is a virus
- It can be carried in: blood products, vaginal fluid, breast milk, semen
- Testing is through a blood test
- The window period - it may be up to 3 months to seroconvert to become HIV positive
- Prevention through: Clean needle use, Use of gloves when handling blood, Safe sex
- Diet and lifestyle for HIV positive people

Resources
Background reading, OHTs, Information Kits

Sexually Transmitted Diseases

Suggested strategies
Ask the women to list the common STDs and discuss.

Key points
- HIV, Hep, Chlamydia, Gonorrhoea,
- Herpes, HPV, Lice, Thrush,
- Trichomonas, Syphilis
- Discuss symptoms - Visible, Invisible
- Screening
- Treatment
- Prevention
- Negotiating safe sex: Being assertive, Condoms, Dental dams

Resources
Background reading, Whiteboard and markers,
WHAT IS CHLAMYDIA?

Chlamydia are bacteria that cause sexually transmissible disease (STD) similar to, but often more serious and common than, gonorrhoea (the clap). They can infect both men and women.

In women chlamydia can infect the cervix (the passage from the vagina into the uterus or womb) causing "cervicitis". Symptoms can include an abnormal vaginal discharge and painful intercourse, though many women get no symptoms at all.

The infection can spread up into the uterus and Fallopian tubes, causing pelvic inflammatory disease (PID). A woman with PID may have abdominal pain and fever and feel very ill, or she may have very mild symptoms or no symptoms at all. PID can damage or block the Fallopian tubes and cause infertility, ectopic (tubal) pregnancies or chronic pain.

Chlamydia can live in a woman's cervix, undetected, for many months. Infection can flare up at any time in the future. Chlamydia can pass from the cervix to a baby at birth, and cause eye and ear infection and pneumonia.

In men chlamydia can infect the urethra, (the tube along which urine and semen pass through the penis) This infection is called "nonspecific" or "nongonococcal urethritis" (NSU or NGU). Symptoms include pain when passing urine and a discharge from the penis, though some men get no symptoms at all. The infection can spread to the prostate and epididymis (sperm-carrying tubes) and may cause chronic pain and fertility problems.

HOW DO YOU CATCH CHLAMYDIA?

Chlamydia are passed on during sexual intercourse. The bacteria that cause it cannot live outside the body so you cannot catch it from toilets, swimming pools, spas or normal social contact with people.

You can reduce the chance of catching chlamydia and other STDs by using condoms.

HOW DO YOU FIND OUT WHETHER YOU HAVE CHLAMYDIA?

Chlamydia is often symptomless and it will not be picked up during routine health checks or by Pap smears. If you suspect you may have been exposed to infection ask your doctor for a chlamydia swab. This is a simple test and only takes a few minutes.

Chlamydia commonly occurs together with other STDs, and tests for these should be done at the same time.

WHEN IS A CHLAMYDIA TEST ADVISABLE?

You should have a chlamydia test if:
- you have signs or symptoms of genital infection
- you have been diagnosed as having another STD, for example gonorrhoea, herpes or wart virus
- you have a sexual partner who has been diagnosed as having chlamydia or another STD
- your Pap smear test suggests you may have an infection
- you have more than one sexual partner or have recently changed partners
- you sexual partner has had sex with a person who could be infected.

HOW IS CHLAMYDIA TREATED?

Chlamydial infection is treated with antibiotics taken by mouth, or in severe cases by intravenous injection in hospital. The full course (14-16 days) of treatment must be completed and a test done afterwards to check that the infection has gone. Your sexual partner should be checked and treated as well. It is important to avoid sexual intercourse during the treatment and until the "all clear" is given so that you don't pass on the infection or become reinfected yourself.

WHERE TO GO FOR ADVICE AND TESTING?

- Your family doctor
- Any Family Planning Association clinic: (02) 211 0244
- Sydney Sexual Health Clinic:
  - male clinic: (02) 27 3634
  - female Clinic: (02) 27 4851
- Parramatta Sexual Health Clinic: (02) 635 03 33, Ext. 324.

JUNE 1987
WHAT ARE GENITAL WARTS?
Genital warts, known medically as condylomata, are warty growths which appear, often in clumps, in any part of the male and female pubic area, for example on the penis, around the anus, on the labia (vaginal lips) or in the vagina itself. Some people find genital warts irritating but others feel nothing and may not be aware they have them.

WHAT CAUSES THEM AND HOW DO THEY SPREAD?
Genital warts are caused by a virus and are usually passed on during sexual activity. They grow well in a warm, moist environment so they tend to spread more easily in women.

HOW CAN I PREVENT MY PARTNER GETTING THEM?
Using condoms is a good way of helping to prevent your partner becoming infected or, if he has the warts, of him infecting you.

HOW CAN THEY BE TREATED?
With external warts the usual treatment is to apply a chemical (podophyllin paint) to the warts twice a week. Podophyllin is absorbed through the skin and can damage healthy tissue so it is not a good idea to treat warts with this chemical yourself. The person who is treating you will use petroleum jelly (e.g. Vaseline) to protect the skin around the warts. The podophyllin is washed off six hours after it is applied.

Some people are sensitive to podophyllin and get a burning sensation from it. If it affects you in this way, wash it off straight away and tell the clinic staff on your next visit. Podophyllin can cause abnormalities in unborn babies and should not be used if you are pregnant.

If the warts have not disappeared after four applications of podophyllin it is unlikely that they will go away with this treatment. You may be referred to a gynaecologist who can remove the warts by ‘burning’ or ‘freezing’ them off under a general or local anaesthetic. Warts inside the vagina are also treated in this way.

CAN I HAVE SEX DURING TREATMENT?
Sexual intercourse during treatment and while the tissue is healing can be painful and is therefore best avoided, particularly when the warts are around the vaginal opening.

ARE GENITAL WARTS DANGEROUS?
Of the 40 or so genital wart viruses, two or three are thought to be associated with precancerous changes in the cervix (the entrance to the womb in the vagina). However, these two or three viruses produce flat warts, not the lumpy warts that are discussed here. Nevertheless, if you have had genital warts you should make sure you have a Pap smear test once a year.
Module One. Sexual and Reproductive Health

Session: 1.5

Topic: Health Screening and Menopause

Goals: To identify health issues for women in later life
To identify preventive health screening for women
To identify community services available for women
Menopause

Suggested strategies
Brainstorm in the group to find out the changes to a woman's body during menopause.
Write up and discuss

Key points
- It is when menstruation ceases
- It is normal and marks the end of a woman's fertile years
- It occurs between 45 and 55 years of age
- It happens because the ovaries cease producing oestrogen and progesterone
- It may be asymptomatic
- Body changes include: hair, skin, shape, weight increase, bones become brittle
- Symptoms may include: hot flushes, palpitations, dry vagina, headaches, insomnia, weight gain bladder problems, irritability, anxiety, joint pains, muscle aches,
- Management includes: Natural therapies
Hormone Replacement Therapy
Healthy diet - high in calcium
Exercise

Resources
Background reading, whiteboard, markers, samples of HRT

Preventive Health Screening

Suggested strategies
Ask the women to name the health screening available for women

Key points
- Pap tests
- Breast checks
- STD screening
- Blood tests
- Mammogram and ultrasound

Resources
nil
Menopause simply means that menstruation (monthly period) stops. It occurs in a normal life stage called the “Climacteric.” The climacteric is similar to other life stages, for example, adolescence.

Menopause:

☐ is a normal and natural event that marks the end of a woman’s fertile years;
☐ occurs for most women between 45 and 55 years of age;
☐ occurs because the ovaries cease producing the required levels of oestrogen and progesterone;
☐ happens suddenly as a result of the surgical removal of the ovaries regardless of age.

Many women will experience a few symptoms of menopause, some will experience no symptoms at all, a few will experience severe symptoms which will disrupt their life-style.

Today the terms “menopause”, “the change of life”, the “climacteric” and “mid-life” are often used to refer to this time in a woman’s life.

A TIME OF CHANGE

Menopause occurs at that time in our life when many other changes are taking place. Many of the changes that occur during this life stage are due to society’s image of the status and role of older women in our community. Some of these changes are:

☐ body changes, e.g. skin, hair, shape, weight increase;
☐ work situation, e.g. many older women return to work after child rearing, others may become redundant.

Some women experience loss and associated grief with:

☐ loss of fertility and, for many, loss of youth;
☐ children leaving home, loss of partner, siblings or parents;
☐ loss of job, income or health;

Low self esteem may occur and a woman feels she lacks an identity of her own, is unassertive and has feelings of self doubt.

RECOMMENDED READING

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THE RISK OF DEVELOPING OSTEOPOROSIS.

It would be helpful to know if there are any risk factors for the development of osteoporosis. The following questions may help. A bone density test [X-ray] of your arm, hip or spine may also be helpful to determine this risk more accurately.

Are you underweight? Yes/No

Have any of your elderly female relatives lost height, become stooped or had broken bones? Yes/No

Did your periods stop before the age of 45? Yes/No

Did you often miss menstrual periods during your life? Yes/No

Did your ancestors come from Northern Europe or Asia? Yes/No

Do you smoke? Yes/No

Do you drink more than an average of 1 glass of alcoholic beverage a day? Yes/No

Do you drink more than 3 cup of coffee or 6 cups of tea a day Yes/No

Do you take little regular exercise outside your normal duties? Yes/No

Is your diet low in milk, cheese, yoghurt or ice cream? Yes/No

Do you take fluid tablets (diuretics), antacids, steroids or phenytoin? Yes/No
WHAT IS OSTEOPOROSIS?

Osteoporosis is a condition in which the bones become fragile and break more easily. This is because calcium and bone tissue, the major building blocks of bone, are being lost. Bones are more dense on the outside and have an open honeycomb structure on the inside. When calcium and bone tissue are lost, the outer shell becomes thin and the "honeycomb" develops larger holes. This weakens the bone which is then more likely to break. The process of bone loss begins from about the age of 35 onwards as part of the normal aging process.

WHO GETS OSTEOPOROSIS?

Osteoporosis is very common and is a major cause of skeletal problems worldwide. About one-third of women in Australia and New Zealand will suffer fractures by the time they reach their seventies. Osteoporosis is also found in men, but is much less common.

HOW IS OSTEOPOROSIS CAUSED?

There are different stages of bone changes throughout life. The first stage occurs up to the age of 35 when bone reaches its maximum strength. From 35 years of age onwards, there is a slow loss of bone strength in both sexes. In women the fall in oestrogen levels at menopause leads to loss of bone calcium and structure over several years. In younger women, oestrogen is important in preventing calcium being lost from the bones.

HOW DO YOU KNOW IF YOU HAVE OSTEOPOROSIS?

You often show no sign of osteoporosis until you have a fall and break a bone. Breaks are more common in the bones of the spine, the hip and the wrist. These breaks can occur even after a minor fall. In the spine, osteoporotic fractures lead to loss of height and acute episodes of back pain. These vertebral crush fractures give a forward tilt or bend to the spine producing the ‘Dowager’s hump’ appearance and preventing the maintenance of posture.

WHO IS AT RISK OF OSTEOPOROSIS?

There are a number of factors that make you more likely to develop osteoporosis. Some of these factors you may be able to alter while others you cannot.
Bone Mineral Analysis

There are two types of bone mineral analyser. One machine uses radio active iodine to emit a Single Beam of gamma irradiation which passes through the wrist to be detected by a scintillation counter on the other side. This is a very accurate machine for estimating the density of mineral in the wrist but cannot accurately predict what the calcium level may be in the hip or the back. However, it has been shown that women in the upper 20% of the range of calcium estimations have little or no risk of fracturing a bone whilst those in the lower 20% have a very high risk. To determine the calcium content of the bones in the back and the hip, a Dual Beam machine is used which utilises radioactive gadolinium. This is also very accurate and women with a low level of calcium in their bones are found to be at increased risk of fractures.

Radioactivity

Both machines use an amount of radioactivity which is well below the levels of normal X-rays (less than 6 milli rems) and has been shown to produce no harm in the dosage used.

Value of Bone Mineral Analysis

The value of the bone mineral analysis is in predicting which women have an increased risk of fracture as well as those with little or no risk of osteoporosis. It also allows doctors to monitor the affect of therapy in arresting or delaying the progress of osteoporotic changes and ideally it assists women to decide whether they should begin hormone replacement therapy and other measures to prevent osteoporosis.

Cost of the Analysis

The single beam analysis takes approximately 15 minutes to perform and a charge of $60 is considered to be a reasonable recompense for the investigation. However, until a Medicare rebate is allowed, we have agreed to charge all patients a base rate of $40. No profit is made at this charge.

The dual beam analysis takes 45 minutes -1 hour to perform and requires more technical and medical involvement. It is considered that $250 is a reasonable charge for the test but until a Medicare rebate is allowed, we have agreed to charge $150 for this test.

Who Should Have the Test

Post menopausal, Anglo-Saxon or Asian women, those women with a family history of osteoporosis, those who are on chronic cortisol therapy and those who are chronic alcohol consumers should have the dual beam analysis estimation to determine their bone status. The single beam machine may be of value in determining if the rate of bone loss has varied. It is likely that women who take calcium, hormones and exercise will reduce the risk of osteoporosis and may even increase the amount of calcium deposited in their bones.
BONE DENSITY MEASUREMENT

IS A BONE DENSITY MEASUREMENT?

This test determines the mineral content of your bones to assess whether you have osteoporosis (bone thinning).

WHAT DOES A BONE DENSITY MEASUREMENT INVOLVE?

* When you arrive at reception in Nuclear Medicine and Ultrasound, a receptionist will record your name, medical record number and certain other details.

* A doctor will then check your scan request form and authorise the study to proceed.

* A technologist will call you into a room and ask you to lie on a bed.

* While you lie on the bed, the scan will be performed.

* No injections are necessary. We require you to lie still; otherwise no discomfort is involved.

* The entire study will require up to 60 minutes to perform.

* Once the scan is complete you are free to leave the department.

NOTE ON PREGNANCY

* If you are pregnant or think that there is a chance you may be, you should notify the staff BEFORE PROCEEDING WITH THE SCAN.

NOTE

* The doctors in the Department of Nuclear Medicine and Ultrasound will not give you your test results. This is because the test results will not be available at completion of the scan. A full report will be sent to your doctor as soon as possible.

DEPARTMENT OF NUCLEAR MEDICINE AND ULTRASOUND, WESTMEAD HOSPITAL, WESTMEAD

FOR ANY REASON YOU ARE UNABLE TO KEEP THIS APPOINTMENT, PLEASE TELEPHONE 633 6533
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OSTEOPOROSIS

- Osteoporosis is a condition that makes bone weak, fragile and easily broken (fractured). Both men and women can develop osteoporosis.
- One important part of bone is calcium. As we age we lose calcium from our bones faster than it is replaced. This makes our bones less dense (thinner). This process starts in our late thirties.
- After menopause or after the loss of their ovaries women are more prone to osteoporosis. Women with osteoporosis are more likely to break their hip, wrist, bones of the spine or for that matter any bone in the body. By the age of 65, one in four women will have had a fracture due to osteoporosis.

**MAIN FACTORS INVOLVED IN CAUSING OSTEOPOROSIS**

**Family History**

If there is a family history of osteoporosis you are more likely to develop that condition — however it does not mean that you definitely will get it. Women of northern European or Asian descent are also more at risk of developing osteoporosis. The greatest risk is for post-menopausal, small framed and slender women who have little or no calcium in their diet, take little exercise and who smoke.

There are many factors involved that can contribute over time.

**Hormones**

After their periods stop at menopause, or their ovaries are removed during hysterectomy, women are the most at risk group for osteoporosis. Until this time the hormone oestrogen has had a protective effect, stopping too much calcium being removed from the bones. During menopause the body produces less and less oestrogen and the protection stops.

**Lack of Exercise**

Regular exercise helps make bone thicker and stronger. Exercise moves muscle and muscle moves bone. This movement stimulates bone and helps it become strong. Exercises must be the strengthening type such as walking, aerobics, tennis, cycling, weight-lifting or dancing.

**Not Enough Calcium**

If a person is not getting enough calcium in their daily diet the body will automatically take the calcium it needs from the bones to be used for other important functions. These include: the contraction of muscle, particularly to help our heart beat, the clotting of blood and nerve function.

**Others**

- *Not enough sunshine:* Sunshine provides Vitamin D in the body to help utilise calcium, about 15 minutes a day on exposed limbs is plenty — but don't burn.
- *Smoking:* It has been found that smoking reduces the action of oestrogen in the body.
- *Alcohol & caffeine:* Minimise the absorption of calcium from the food that we eat.
- *Certain diseases and drugs:* Can lead to bone loss. Discuss this with your doctor.

**WHAT YOU CAN DO TO PREVENT OSTEOPOROSIS**

**Eat plenty of calcium**

We should ensure we all get plenty of calcium every day throughout life. The daily requirement for an adult is 800-1000 mg of calcium per day (see chart). With a little attention to what you are eating it is possible to increase the amount of calcium in your diet without increasing your fat intake.

**Hormone Replacement Therapy**

For women at risk of osteoporosis (eg. early menopause, family history) oestrogen and the hormone progesterone should usually be prescribed. Research has shown that women who have begun taking oestrogen within a few years after the onset of menopause have fewer fractures than women who do not take oestrogen.

The decision to use hormone replacement therapy is one that should be carefully considered by a woman and her doctor. There are some women who are unable to take hormone replacement therapy because of some pre-existing medical conditions and for others there are side effects. Find out as much as you can about hormone replacement therapy and discuss with your doctor (see "Hormone Replacement Therapy" fact sheet).
Many traditional dishes which you prepare for your family use the above ingredients and are good sources of calcium. So are some take-away foods. However the following foods contain significant amounts of fat and should only be eaten in moderation.

<table>
<thead>
<tr>
<th>Serve</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Quiche Lorraine 1 slice</td>
<td>390</td>
</tr>
<tr>
<td>Cheese Souffle   100 g (1/2 cup)</td>
<td>240</td>
</tr>
<tr>
<td>Lasagna/Cannelloni 200 g</td>
<td>130</td>
</tr>
<tr>
<td>Moussaka        200 g</td>
<td>180</td>
</tr>
<tr>
<td>Tahini paste    25 g (1 tablespoon)</td>
<td>230</td>
</tr>
<tr>
<td>Pizza           1/2 medium</td>
<td>350</td>
</tr>
<tr>
<td>Cheeseburger    1</td>
<td>100</td>
</tr>
<tr>
<td>Fish in batter  100 g</td>
<td>75</td>
</tr>
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</table>

Cakes, desserts and sweets can contribute to calcium intake: **But they contain large amounts of fat and sugar and should be avoided if you are overweight.**

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<tr>
<td>Yoghurt — flavoured     200 g (1 carton)</td>
<td>260</td>
</tr>
<tr>
<td>Custard tart            120 g (small)</td>
<td>132</td>
</tr>
<tr>
<td>Ice cream               50 g (1 scoop)</td>
<td>70</td>
</tr>
<tr>
<td>Cheesecake              100 g (1 slice)</td>
<td>70</td>
</tr>
<tr>
<td>Thickshake              250 ml (1 cup)</td>
<td>530</td>
</tr>
<tr>
<td>Plain chocolate         20 g (4 squares)</td>
<td>110</td>
</tr>
<tr>
<td>Sesame bar              40 g</td>
<td>135</td>
</tr>
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With a little attention to what you are eating it is possible to increase the amount of calcium you eat every day in your diet without putting on weight.
Pap Tests

Suggested strategies
Demonstrate a speculum and cervix sampler, using a pelvic model or diagram
Invoke discussion

Key points
• Pap tests look for abnormal changes in the cervical cells
• Any time except during menstruation and not usually during pregnancy or soon after giving birth
• Pap tests are done usually every 2 years unless there is a problem
• They can be done by GP, WHN, Sexual Health Centre
• "Positive" results do not necessarily indicate cancer
• may indicate infection or presence of wart virus
• May need follow up with colposcopy

Resources
Speculum, cervix sampler, pelvic model, diagram of reproductive system

Breast Checks

Suggested strategies
Using model of the breasts, demonstrate how to do a breast self examination.
Invoke discussion

Key points
• How to do it correctly
• Best to do after a period
• Can be done in bed, in the shower or bath
• Can be done every month
• Breast exam can be done by GP, WHN
• Where to go when a lump is found: first to GP who may arrange mammogram

Resources
Model of lumpy breasts (available from the Women’s Health Nurse in your Community Health Centre)  List of Community Health Service providers in your area
Mammogram

Suggested strategies
Show pictures of a mammogram and invoke discussion. There may be 
women in the group who have had a mammogram and may be willing to tell of 
their experience

Key points
- It is an x-ray of the breast which can show lumps the size of a grain of rice
- It is performed at Mobile Screening Unit, Breast Screening Unit at 
Parramatta, local radiology centres
- Mobile Units screen all women over 50 years for free
- Routine mammogram is every two years once over 50 years of age
- For a lump - Mobile Unit will not X-ray. You need to go to Radiology Dept
- Ultrasound may be used as well

Resources
Pictures/photos of mammogram. Information on where to access a 
mammogram in your area

STD Screening

Suggested strategies
Ask the women to name the STDs which can be screened. Write them up. 
Discuss how they may be screened eg, blood test or swabs. Demonstrate 
use of speculum and swab sticks on pelvic model or diagram

Key points
- Include: HIV, Hep, Herpes, HPV, Lice, Trichomonas, Chlamydia, Gonorrhoea, Thrush, Syphilis
- It can be done by GP, WHN, Sexual Health Centre
- To be done when you have put yourself at risk
- If a sex worker, every 3 - 6 months
- Treatment is essential as left untreated may lead to Pelvic Inflammatory 
  Disease
- Vaginal discharge and odour may or may not be present
- Unexplained lower abdominal pain, abnormal bleeding, feeling ‘unwell’ 
  must be checked out
Resources
Speculum,  swab sticks,  pelvic model or diagram,  pictures of diseases (if available)
Sex Workers Handbook (available from SWOP, Riley St. Surrey Hills)
List of Community Health Service providers in your area

Community Health Services for Women

Suggested strategies
Ask the women to name the health services available for women. List on board.
Provide a telephone directory and ask the group to look up some numbers.

Key points
- Community Health Centres
- Women’s Health Nurses
- GPS
- Family Planning Clinics
- Women’s Health Centres
- Sexual Health Clinics

Resources
Telephone directory,  List of women’s health services in your area, whiteboard and markers
Skin Cancer Facts

☐ Skin cancers are mostly caused by over-exposure to the sun.
☐ They are the most common cancers in Australia.
☐ Australians have the highest rates in the world and these are increasing.
☐ Melanoma results in about 700 Australian deaths each year.
☐ There are about 140,000 new cases of skin cancer in Australia in a year.
☐ Most skin cancer can be prevented by protecting the skin from the sun.
☐ Nearly all skin cancers can be cured if detected and treated early.

THE FUNCTION OF THE SKIN
The skin protects the inside of the body from outside dangers, such as the sun. Squamous cells are constantly being rubbed off the surface and replaced by new cells. The melanocytes produce more dark pigment (melanin) which partly protects the skin from too much sun. Most Australians have skin which can’t produce enough melanin to protect them from our very strong sunlight.

CANCER OF THE SKIN
There are three major types of skin cancer. The two most common are Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC). These rarely spread to other parts of the body and are seldom fatal. They can be very disfiguring if not treated early.
Malignant Melanoma, the third type of skin cancer, behaves like an internal cancer. It will usually spread to other parts of the body if not detected early and properly treated. It usually starts looking like a mole, unusual freckle or birthmark.

WHO IS AT GREATEST RISK?
☐ People who don’t protect their skin from the sun.
☐ People with fair skin.
☐ People whose job, sport or recreation involves a lot of time in the sun.
☐ People who burn easily and cannot easily develop a tan.
☐ People who have a family history of skin cancer.
☐ People who were born and/or spent their childhood in Australia.
Skin Cancer Facts Continued

HOW CAN I PROTECT MY SKIN?

☐ Slip on a shirt — choose a fabric that casts a dense shadow.
☐ Slop on a sunscreen — 15+ broad spectrum, water resistant.
☐ Slap on a hat — wear a wide brimmed hat, not just a sun visor.
☐ Encourage indoor or shade activities between 11.00 am and 3.00 pm in Summer.

SLIP SLOP SLAP!

HOW CAN I PROTECT MY FAMILY’S SKIN?

☐ Set a good example yourself.
☐ Get them to Slip Slop Slap.
☐ Take extra care with babies and young children.
☐ Start good habits when your children are young.

WHAT ARE THE SIGNS AND SYMPTOMS OF SKIN CANCER?

☐ Any unusual skin condition that doesn’t heal in four weeks; this includes:
☐ any sore, ulcer or red scaly patch on the skin, or white patch on the lips that doesn’t heal,
☐ any unusual freckle or mole that seems to grow quickly,
☐ any unusual freckle or mole that changes shape or colour,
☐ any unusual freckle or mole that bleeds or repeatedly itches,
☐ any unusual freckle or mole which is new.

IF YOU NOTICE ANY OF THESE EARLY WARNING SIGNS, GET YOUR DOCTOR TO CHECK IT OUT.

HOW IS SKIN DAMAGED BY THE SUN?

Ultraviolet rays from the sun do the damage. These rays penetrate the skin and injure living cells, making them swell and the skin burn.

In an effort to prevent further injury, your skin develops a tan. But the damage accumulates, tan after tan, year after year.
When you are still quite young, your skin can become old looking — dry, wrinkled and blotchy.
It can also develop skin cancer.

HOW IS SKIN CANCER DIAGNOSED?

Your doctor will examine your abnormal skin condition closely. If he suspects a BCC or SCC he should remove a small sample and send it to a pathologist, or you may be referred to a skin specialist.
If your doctor suspects that it could be a Melanoma he will usually refer you to a dermatologist or specialist surgeon.

HOW IS SKIN CANCER TREATED?

The treatment depends on the type and size of the cancer and where it is on the body.
Most BCCs and SCCs are easily cured by simple means, most often not even requiring a stay in hospital.
Melanoma should always be treated by a skilled specialist. In nearly all cases, it is removed by surgery. It is never “burnt” off.
You may, if you wish, request a second opinion from another doctor about the best method of treatment.

For further information or advice, please contact:

N.S.W. Cancer Council, 500 George Street, Sydney, N.S.W. 2000
or
G.P.O. Box 7070, Sydney, N.S.W. 2001
Phone: (02) 264 8888         Toll-free line: (008) 42 2760
Module Two. Drugs and Alcohol

Session: 2.1

Topic: The facts about drugs and alcohol

Goals: To give a definition of a drug
To state the three different effects alcohol and other drugs have on the central nervous system, and give examples
To describe how drugs enter the body
To identify ways of minimising the harm associated with drug use
To practice a visualisation relaxation technique
Drugs in Perspective

Suggested strategies
Drugs in perspective:
Ask the group to name the first drug they ever took and at what age:
eg. panadol at 5, drink of tea at 2, alcohol at 7
Reinforce we are a drug taking society, we start young, and use a wide range
of drugs.

Ask the group to describe what a drug is (they may start to name drugs)

Key points
• What is a drug?
• What drugs do you know?
  Stimulants, depressants,
  medications, hallucinogens
• What do they do?
• The World Health Organisation definition: "any chemical substance
  which when taken into the body affects the natural way a person's body
  and mind works".

Resources
OHT, Projector

Drug Groups

Suggested strategies
Ask the women to describe how drugs may be grouped
Describe how health workers describe drugs

Key points
• Groups like: legal/illegal, Hard/soft, over-the-
  counter/prescription, uppers/downers.
• Health workers talk about drugs affecting the central nervous system.
• Some drugs have a stimulating effect on the body - (it speeds it up) heart
  rate increases, breathing increases.
• Some drugs have a depressant effect on the body - (it slows it down)
  heart rate decreases, breathing decreases.
• Some drugs have an hallucinogenic effect - (distorts reality)
• Some drugs do not effect the central nervous system but they still change
  the natural way the body works, these are called non-psycho active.

Resources
nil
Picture Cards

Suggested strategies
- Using the picture cards 'stimulant, depressant, hallucinogen, non-psycho active'.
- Lay out headings on floor and hand out the cards.
- Ask the group to name the drug on the card they are holding, state what effect that drug would have on the central nervous system (slow down, speed up or distort brain messages), then place the card in the corresponding column.

Key points
- Discuss the drug and its effect on mind and body

<table>
<thead>
<tr>
<th>STIMULANT</th>
<th>DEPRESSANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;upper&quot;</td>
<td>&quot;downer&quot;</td>
</tr>
<tr>
<td>tobacco</td>
<td>cannabis / marijuana</td>
</tr>
<tr>
<td>amphetamines</td>
<td>heroin</td>
</tr>
<tr>
<td>speed</td>
<td>morphine / pethidine</td>
</tr>
<tr>
<td>cocaine</td>
<td>codeine</td>
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<tr>
<td>crack</td>
<td>opium</td>
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<tr>
<td>ecstasy</td>
<td>minor tranqs</td>
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<tr>
<td>caffeine</td>
<td>Valium</td>
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<td>megaron</td>
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<table>
<thead>
<tr>
<th>HALLUCINOGEN</th>
<th>NON-PSYCHO</th>
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<tbody>
<tr>
<td>'trips'</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>LSD</td>
<td>anabolic steroids</td>
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<tr>
<td>magic mushies</td>
<td>antibiotics</td>
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<tr>
<td>datura</td>
<td>ventolin</td>
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<tr>
<td>marijuana</td>
<td></td>
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<tr>
<td>ecstasy</td>
<td></td>
</tr>
<tr>
<td>psilocybin</td>
<td></td>
</tr>
</tbody>
</table>

Resources
Alcohol and other drugs picture cards
Causes of Death

Suggested strategies
Ask the women to consider the drugs which cause the most number of deaths in Australia. Discuss

Key points
• Tobacco - out of all the people who die from drugs, 72% die from tobacco related illness.
• What things do people die from? (cancers - lungs, heart disease, circulatory problems).
• Alcohol - 26% die from alcohol.
• What things do people die from? (motor vehicle accidents, cirrhosis of the liver, kidney damage).
• That leaves 2% from the other drugs.

Resources
OHT, Projector

How do drugs Enter the Body

Suggested strategies
Ask the women to describe how drugs get into the body
Using "THE BODY" mannequin, hand out the body parts.
Follow the path of food and water (ask any of the women to describe this process if they feel confident).

Key points
• Swallowing
• Injecting
• Sniffing
• Smoking
• Suppository
• The quickest route to the brain is via the lungs:
  oxygen, pollution, tobacco smoke, cannabis, anything sniffed - will go into the trachea or windpipe, bronchial tubes, lungs and gets picked up by the blood and goes straight to the brain in a matter of seconds.
• Some other ways things get into the blood and brain are via injection:
  vein, muscle, under the skin - absorbed through the skin
Resources
Whiteboard and whiteboard markers, mannequin

Brain Damage
Suggested strategies
• Explore the effects of alcohol on the body
• Use 5 minutes of the video "The Devil You Know" (where they slice the brain of an alcoholic to demonstrate brain damage)
• Discuss

Key points
The brain is a powerful organ which can influence the body without the use of drugs.
Introduce visualisation as a relaxation technique - can be used easily

Resources
TV/VCR - "The Devil You Know" Video

Visualisation

Suggested strategies
Ask the women to sit or lie on the floor comfortably.
Close their eyes and relax their breathing.
Read from the sheet or create your own guided visualisation.

Key points
Close your eyes. Begin by taking several slow, deep breaths. Now let your breath flow naturally and imagine that you can use your breath to release any tension you may be holding. If there is pain or tightness in any part of your body, you can ease it by imagining that, as you exhale, you are breathing through that body part and the tension is riding out on the breath.

Bring your attention to your head. Let your thoughts go and allow your mind to become still. Focus on your breath and imagine that your breath is massaging your skull, your head, your face. Allow all the tension to be released and your head to become heavy. If there is headache or tension in the head, you can move that energy by focusing on your awareness.

Now bring your attention to your neck and shoulders. Notice where there is any soreness or tightness. Breathe through these body parts and allow the tension to flow away leaving them relaxed and soft.

Let your awareness travel to your arms. Breathing through your nose, visualise the breath flowing down your arms and out through your hands. Be aware of any tension in your arms and hands and allow it to flow away.
Breathe out through the palms of your hands and allow the excess energy and tension to be released.

Let your awareness sweep over your body. Does it feel heavy or light? Is there pain or tension anywhere in your body? Focus on your body. Become aware of your heart beat. As you breathe out, release any tension you are holding in your body. Imagine that the tension is flowing away from your body leaving it relaxed and light.

Now focus your attention on your legs. Breathe deeply into the muscles in your thigh and allow any tension to be released. Follow the breath down your legs to your feet, releasing tension as you move your attention slowly down.

Now, as you lie here in this relaxed state, imagine a colour; a beautiful colour, coming from your belly. The colour is so beautiful, as it radiates out of your belly, it sweeps over your body, leaving it shrouded in the mist of the colour. Feel the pleasure in your body as this beautiful colour envelops your body. It is swirling slowly and gently around your head, your shoulders, your lower body. Imagine it to be like a bubble enclosing you and keeping you safe. (pause)

Feel yourself to be fully in your body. Sense your energy flowing through your body. Feel yourself to be firmly seated, rooted. Breathe in. And out. Continue to pay close attention to your body. Now, notice if there is any difference in your body from when you began this exercise. Be aware of the pressure of your body against the seat on which you are sitting or the floor on which you are lying.

Try to keep with you the image of your colour and use it to protect yourself, when you feel stressed or when you are not feeling safe.

When you are ready, take a big stretch and open your eyes.

Resources
Tape recorder and taped relaxation music (if required)
Module Two. Drugs and Alcohol

Session: 2.2

Topic: Controlled use / safe use

Goals: To identify short and long term effects of some drugs
To describe some ways of reducing the harm associated with drug use
To explore alternatives to drug use
Short and Long Term Effects

Suggested strategies
Using OHT outline short and long term effects of some drugs
Encourage questions - some women may like to discuss their personal experience/s.

Key points

- **Minor tranquillisers**
  Short term effects  -- relaxation, calmness, relief from anxiety
  -- drowsiness, lethargy, blurred vision, vertigo
  -- confusion, mood swings, sleep

  Long term effects  -- lethargy, irritability, nausea, headaches
  -- lack of motivation, disturbed dreams
  -- increased appetite, weight increase

Withdrawal symptoms  -- panic attacks, nervousness, tension,
  -- sleeplessness, depression, flu like illness

- **Analgesics**
  Short term effects  -- pain relief, may be stimulant

Long term effects  -- kidney disease, bleeding in stomach & intestines

- **Caffeine**
  Short term effects  -- Increased alertness, sleeplessness

Long term effects  -- Restlessness, upset stomach, heart palpitations

- **Cannabis**
  Short term effects  -- relaxation, increased appetite, loss of concentration,
  -- hallucinations, decreased coordination

Long term effects  -- respiratory complications, Psychiatric problems

- **Alcohol**
  Short term effects  -- slurred speech, loss of inhibitions, happiness,
  -- depression, unconsciousness in large doses,
  -- hangover

Long term effects  -- brain damage, nervous system damage
  -- heart, pancreas, stomach, liver damage

Withdrawal  -- sweaing, tremor (DTs) convulsions, delirium

Resources
OHT, Projector

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Good Things / Bad Things

Suggested strategies
• Divide the group into 4 smaller groups
• Hand out butchers paper and pens
• Giving one heading to each group, ask each group to brainstorm and make a list:
  • good things about playing sport
  • bad things about playing sport
  • good things about using drugs
  • bad things about using drugs

Ask the women to draw conclusions from the butchers paper displayed

Put the 2 butchers paper apart and brainstorm suggestions on the whiteboard in the middle)

Key points
• There are positives and negatives about lots of things we do.
• Good things include:
  - make you feel good,
  - stress relieving,
  - share the experience with others
  - bury your feelings
• bad things include:
  - aggression and violence,
  - harm to your body,
• How can we reduce these bad things but still maintain the good?
• How to minimise harm with drug taking:
  - using one drug only
  - clean needles & gear
  - check out supplier
  - use small amount
  - do not mix drugs

Resources
Butchers paper/markers,  Overhead projector and relevant overheads
Giving Up

Suggested strategies
- Show short segment of “60 Minutes” video about women in detox from minor tranquillisers / anti depressants
- Discuss the difficulties of giving up
- Discuss Nicotine and its addictive qualities
- Show short segment of “Confessions of a Simple Surgeon”
- Ask the women to share their thoughts on this.

Key points
- Difficulties of giving up
- The videos reinforce how difficult giving up must be
- Effects of nicotine on the body - cancers, etc

Resources
TV/VCR, “60 Minutes” video, “Confessions of a Simple Surgeon” video

Options

Suggested strategies
Ask the group to consider options to drug taking
What can we do to maintain the good things

Key points
To make you feel good: meditation, relaxation, exercise,
friendships, reduce stress

Resources
Whiteboard and markers
Stages of Change

Suggested strategies
Demonstrate the "stages of change model"
Invoke discussion

Key points
- precontemplation
- contemplation
- determination
- action
- maintenance
- relapse

Resources
OHT, Projector

Visualisation

Suggested strategies
Ask the women to sit or lie on the floor comfortably.
Close their eyes and relax their breathing.
Read from the sheet or create your own guided visualisation.

Key points
Close your eyes. Begin by taking several slow, deep breaths. Now let your breath flow naturally and imagine that you can use your breath to release any tension you may be holding. If there is pain or tightness in any part of your body, you can ease it by imagining that, as you exhale, you are breathing through that body part and the tension is riding out on the breath.

Bring your attention to your head. Let your thoughts go and allow your mind to become still. Focus on your breath and imagine that your breath is massaging your skull, your head, your face. Allow all the tension to be released and your head to become heavy. If there is headache or tension in the head, you can move that energy by focusing on your awareness.

Now bring your attention to your neck and shoulders. Notice where there is any soreness or tightness. Breathe through these body parts and allow the tension to flow away leaving them relaxed and soft.

Let your awareness travel to your arms. Breathing through your nose, visualise the breath flowing down your arms and out through your hands. Be aware of any tension in your arms and hands and allow it to flow away. Breathe out through the palms of your hands and allow the excess energy and tension to be released.
Let your awareness sweep over your body. Does it feel heavy or light? Is there pain or tension anywhere in your body? Focus on your body. Become aware of your heart beat. As you breathe out, release any tension you are holding in your body. Imagine that the tension is flowing away from your body leaving it relaxed and light.

Now focus your attention on your legs. Breathe deeply into the muscles in your thigh and allow any tension to be released. Follow the breath down your legs to your feet, releasing tension as you move your attention slowly down.

Now, as you lie here in this relaxed state, following your breath, you may notice thoughts come into your mind. Let these thoughts become clouds, so they arise and float away into the sky. Become like the sky, open and vast. Your thoughts are clouds and you are the sky. Continue to focus your attention on your breathing. When a thought pops in, observe it and then let it float away. If there are dominant thoughts, ones that keep coming in, notice them, then let them go. There is no need to think, or plan, or hold on to any thoughts.

Feel yourself to be fully in your body. Sense your energy flowing through your body. Feel yourself to be firmly seated, rooted. Breathe in. And out. Continue to pay close attention to your body. Now, notice if there is any difference in your body from when you began this exercise. Be aware of the pressure of your body against the seat on which you are sitting or the floor on which you are lying.

Try to keep with you the image of being the sky, with your thoughts as clouds. Whenever you feel stressed or the need to escape from your thoughts you can imagine that you are the sky and your thoughts are clouds.

When you are ready, take a big stretch and open your eyes.

Resources
Tape recorder and taped relaxation music (if required)
Candles and incense (if permitted)
Stages of Change Model

Prochaska and Di Clemente 1986
STAGES OF CHANGE - READINESS TO CHANGE

One way to think about how somebody (including adolescents) go about making changes is demonstrated by the Stages of Change model developed by psychologists James Prochaska and Carlo DiClemente (1982).

The first stage and entry point to the process of change is the Precontemplation stage.

When in the Precontemplation stage a young person:
- is not yet considering the possibility of change
- is likely to be surprised if it is suggested that they have a problem
- seldom ask for treatment or any form of intervention
- needs non-threatening information to raise their awareness about the effects of their drug use
- needs information about the possibility of change, in a way that is not prescriptive

When working with a young person in Precontemplation the worker should:
- remember not to aim to make the young person change - instead the worker can aim at having the young person consider some of the issues around their drug use
- raise doubt in the young person regarding their choice to continue to use drugs
- increase the young persons perception of risks and problems associated with the continued use of drugs
- provide information about the effects of drugs in a non-threatening way

The second stage to the process of change is the Contemplation stage.

When in the Contemplation stage a young person will:
- both consider change and reject it
- go back and forward between reasons for concern and justification for unconcern
- see-saw between reasons to change and reasons to stay the same
- commonly ask for help, however if moved too quickly into 'quit' strategies may tip the balance back to no change
- need help in resolving the ambivalence, in talking through the issues and working out their options
When working with a young person in Contemplation a worker should:

- remember that ambivalence is normal
- aim to tip the balance in favour of change
- strengthen the young persons self efficacy to change
- rather than argue for change, ask for more detail about the reasons for no change and the reasons for change

The third stage to the process of change is the Determination stage.

**The young person in the Determination stage:**

- has made a resolution to change their behaviour
- is receptive to hearing about ways of how to stop using alcohol and other drugs
- may make moves to put their resolution into action, or change their minds and move back to contemplation or even Precontemplation

When working with a client in the Determination stage:

- there is a window of opportunity which opens for a period of time
- the task is to help the young person determine the most acceptable, accessible, appropriate and effective strategy for change
- help set a time/date for action

The fourth stage to the process of change is the Action stage.

**When in the Action stage the young person**

- puts their change strategy into action and actually carries out the behaviour change

When working with a young person in the Action stage the worker should:

- provide support and practical suggestions to help put their decision into practice
- help the young person recognise their achievements and maintain enthusiasm
- remember that ambivalence does not automatically disappear when a person has taken action to change

The fifth stage to the process of change is the Maintenance stage.

**The young person in the Maintenance stage**

- needs to sustain the change and prevent relapse

With a young person in Maintenance the worker should:

- help anticipate the young persons 'weak points' and work out ways of dealing with any difficulties
• remember that ambivalence can still arise at this stage and may tip the balance back to 'no change'

The sixth stage to the process of change is the Relapse stage. **When in the Relapse stage the young person will:**
• swing from their decision to change back to 'no change'
• resume the original behaviour to some degree
• slip back into one of the previous stages of change

**With a young person in the Relapse stage the worker should:**
• remember (and remind the young person) that slips and relapses are normal, and to be expected
• support the young person in seeing that a lapse does not necessarily mean a full blown relapse
• the young person needs to see that the decision to take drugs or not take drugs remains theirs
• encourage the young person to re-evaluate their reasons for taking drugs and their reasons to stop taking drugs.

**NOTES**
SUMMARY - STAGES OF CHANGE

PRECONTEMPLATION

CONTEMPLATION

CONSCIOUSNESS RAISING
MOTIVATIONAL ACTIVITIES
CATHARSIS
SELF - EVALUATION

ACTION

MAINTAINANCE

HELPING RELATIONSHIP
REINFORCEMENT MANAGEMENT
COUNTER - CONDITIONING
ALTERNATIVES
STIMULUS CONTROL
SELF - MONITORING
BUILDING MOTIVATION FOR CHANGE

Ask Open-Ended Questions

Open-ended questions provide the young person with an opportunity to explore their thoughts, issues concerns etc.... How you respond to the young person's initial answers will strongly influence what happens next. Here are some examples of open ended questions:

Elicit Self-Motivational Statements

Self-motivational statements fall into three general categories.

1. PROBLEM RECOGNITION
2. EXPRESSIONS OF CONCERN
3. DIRECT OR IMPLICIT INTENTION TO CHANGE

These three kinds of statements reflect cognitive (recognition), affective or emotional (concern), and behavioural (intention to act) dimensions of commitment to change. Every statement of this kind tips the balance a little further in the direction of change.

Eliciting these statement is usually a matter of asking the right questions, usually open-ended ones. Don't ask if the person has such concerns, eg. "Don't you think that you should be worried about drinking so much/getting kicked out of school/the damage your doing to your body? Assume the young person does have such concerns. The overall purpose here is for the young person to take responsibility for the "problem/change" side of the conflict.
Listen Reflectively

This is the most challenging skill in motivational interviewing.
REPEAT - The simplest reflection simply repeats an element of what the speaker has said.
REPHRASE - Here the listener stays close to what the speaker said but substitutes synonyms or slightly rephrases what was offered.
PARAPHRASE - This is a more major restatement in which the listener infers the meaning in what was said and reflects back in new words. This adds to and extends what was actually said.
REFLECTION AND FEELING - Often regarded as the deepest form of reflection, this is a paraphrase that emphasises the emotional dimension through feeling statements, metaphor, etc.

Each of the following sentences is a reflective listening statement.

Young Person: I’m worried about catching AIDS. I work at the wall and I haven’t been using condoms.
Worker - :So you’re worried about your health.
YP - Yeh, I don’t know for sure how you get aids and I don’t know if I can get it from what I’ve been doing
Worker: - And not having the right information really bothers you.
YP - :Mmm. That’s right. And I’ve got a boyfriend and I don’t want him to catch anything from me.
Worker - So, you’re concerned about your boyfriend’s health too.
YP - Yes, I’ll have to try and have a talk with my boyfriend James, and perhaps have an AIDS test.
Worker - So you want to find out if you’re boyfriend is OK and also think that you should have an AIDS test to make sure you’re OK.
YP - Yeh, I’m seeing him tonight. I’ll come back tomorrow to see what you think I should do but I’ll have to go now.
Worker - OK. I look forward to having a chat about this with you tomorrow.
Affirm

These are complementary statements of appreciation and understanding which are part of the process of creating the right atmosphere and encouraging young people to consider change.

"I think it's very hard to make sure you always use a condom, especially when you say that you've had a few beers."
"I think it's great that you want to do something about this problem."
"That's a good suggestion."

5. Summarise

Summary statements can be used to link together material that has been discussed. This reinforces what has been said, shows that you have been listening carefully and prepares the young person to move on. A summary also allows a young person to hear his or her self-motivational statements a third time!

Traps

THE QUESTION ANSWER TRAP

THE CONFRONTATION - DENIAL TRAP

THE LABELLING TRAP

THE PREMATURE FOCUS TRAP

THE BLAMING TRAP

NOTES
Module Two. Drugs and Alcohol

Session: 2.3

Topic: Community Support and Self Responsibility

Goals: To identify a range of community services relating to drugs, alcohol and other addictions
To explore the concept of self responsibility
To explore and practice priority setting and goal setting
To explore the concept of self confidence
Community Services

Suggested strategies
Ask the women to list the community services relating to drug and alcohol use
Make a list of all the possible resources available for help
Ask the women to share experiences of “what works for me”

Key points
Include services in your area:
- NUAA
- Alcoholics Anonymous
- Narcotics Anonymous
- D&A workers - at Community Health Centres
- WESDARC
- Youth Health Centres

Resources
Whiteboard and markers, list of services in your area

Self Responsibility

Suggested strategies
This exercise pursues self talk (what we say to ourselves about what we experience) and accepting self responsibility. These are both important in developing assertiveness and self confidence.
- Ask the women to form pairs
- Hand out the “Broken Eggs” exercise (attached)
- Ask the women to list their responses if different
- Discuss.
- Pursue the line of accepting responsibility, changing the self talk and being assertive.

Key points
- How does it feel to be responsible
- What would you do?
- What is the self talk? Is it rational? Is it irrational?
- Who would you ‘blame’?

Resources
Exercise 26 from “Assertiveness” book (Enclosed)
Decision making

Suggested strategies
Explore with group what is involved with making decisions

Key points
- Often approached at an emotional level
- May be an intuitive response
- May be rational - think about: choices, consequences
- May feel decisions are made for us - have no choice
- There are always choices - even though restricted
- To make decisions we need to set priorities:
  - Discover what we want
  - Organise them in order of importance
  - Think about them
  - Choose ones that are satisfying
  - Make plans to achieve them
  - New priorities will arise

Resources
Whiteboard and markers

Goal Setting

Suggested strategies
- Ask the women to consider what is involved in setting realistic and achievable goals.
- Ask them to think about a situation in goal which can be used as an example.
- Use this to draw up the decision tree on whiteboard
- Brainstorm as many options as possible

Key points
To set and achieve realistic goals:
- Need to know what we want
- Make decisions
- Prioritise them first
- Make a decision tree to help prioritise
- Accepting responsibility for our decision
- Helps to build self confidence
- Gives freedom of choice
- Helps give direction in our life
An example of a Decision Tree (Adapted from "Greater Expectations: A source book for women's groups" Szirom & Dyson. 1987)

Being offered a drug in gaol

- take it
  - feel good
    - get caught
      - have a bodgy urine ready
        - access it
          - have to produce a urine
            - try to access bodgy
              - have a dirty urine
                - get tipped
                - boxed visits
                - affect C3 classo
  - no problem

- don't take it
  - no problem
  - feel good /confident

- At each level it is important to ask oneself what are the options here?
- What are the consequences if I choose this option?
- Writing can be helpful in setting priorities / goals

Resources
Whiteboard and markers
Self Confidence

Suggested strategies
• Explore “Confidence” with the group and find ways we can build confidence in ourselves
• One technique is to separate “doing” from “being”. Eg. Changing “I am stupid” to “What I did was stupid”.
• Ask the women to discuss some of the labels they place on themselves and others:
  take note of how they feel when these labels are used
  take note of how they feel when the statement is changed from “what I am” to “what I do”

Key points
• Confidence is the belief in one’s ability
• To build self esteem we need to build self confidence
• Describe someone who has confidence
• Describe someone who doesn’t have confidence
• How can we obtain confidence: - being kind to self
  self praise
  self encouragement
  being fair to oneself
  taking responsibility for self
  changing self talk

• Help each other develop confidence - encouragement
• How does it relate to drug use?
• What impact does drug use have on confidence?
• Can you be confident and not look after your body?

Resources
Background reading: “Assertiveness” and “Communication” books
ALCOHOL & OTHER DRUGS RESOURCE LIST

Drug & Alcohol Counsellors
Community Health Centres  Sydney Yellow Pages p.669

Drug Information & referrals
ADIS (24hr.)  029 9331211 or 1800 422599

WESDARC  029 6239000

Group Support
A.A. (Alcoholics Anonymous)  029 7991199
N.A. (Narcotics Anonymous)  029 2123444
G.A. (Gamblers Anonymous)  029 7449525

Al-Anon (for Family of user)  029 6731638
Nar-Anon (for Family of user)  029 4188728

Accommodation
Women's refuge & referral  029 5188379

Drugs In Pregnancy Service  029 5167583
Can you list some more reasons?

- 
- 
- 

It is important to accept that there are so many different factors influencing people's use of drugs. It is best not to make blanket value judgements about drug use — but to look behind the use at the reasons and the consequences.

One way of explaining different types of drug use was developed by Shafer (1973). This model describes five patterns of drug use:

**Experimental** (single or short term use)
Use is motivated by curiosity or desire to experience new feelings or moods. This may occur alone or in the company of one or more friends who are also experimenting.

**Social/recreational** (controlled use in a social setting)
Use on specific social occasions by experienced users who know what drug suits them and in what circumstances.

**Circumstantial/situational** (use for a specific purpose)
Use when specific tasks have to be performed and special degrees of alertness, calm, endurance or freedom from pain are sought eg. truck driver, shift worker, sportsperson.

**Intensive** (major, usually daily, doses)
Use similar to last category but more intensive. Often related to an individual's need to achieve relief or to achieve a high level of performance.

**Compulsive** (persistent, frequent, high doses)
Use leads to psychological and physiological dependence where the user cannot at will discontinue use without experiencing significant mental or physical distress.

Each of these patterns can occur with any drug. People's use does not always fit neatly into one of these categories and can change between categories over time.
Socio-cultural aspects of drug use

Differences between subcultures

Patterns of consumption differ between subcultures in society — between men and women, social classes, religious groups, occupations, educational levels, ethnic groups. These sub-cultural differences can be reflected as differences in:

- the type of drug used
- the quantity consumed
- frequency of use
- behaviour when intoxicated
- location of consumption
- rituals associated with consumption
- reasons for consumption.

Some subcultures see intoxication as providing an excuse for failing to comply with the normal social standards and behaving in an anti-social way. In contrast, other subcultures encourage moderate drinking and strongly disapprove of drinking that leads to antisocial behaviour.
Illicit drugs

While it is impossible to get reliable statistics on the incidence of illicit drug use, we can get a broad picture from a number of sources such as treatment figures, law enforcement data and surveys. It is clear that use of illicit drugs is very low in comparison to alcohol and tobacco. In a survey of drug treatment agencies, opiates were the second most frequent problem drug after alcohol; amphetamines were the major drug problem for 4% of primary clients as were cannabis and benzodiazepines; cocaine was a problem for less than one percent of clients seen on the days of the census.

The 1991 NCADA Household Survey came up with the following findings:

- marijuana is the most commonly used illicit drug in Australia
- an increase in amphetamine use was noted, particularly amongst males aged 25–39 and females aged 14–24
- in general, a greater proportion of males have ever tried illicit drugs than females
- the proportion of people aged 40 and over who use illicit drugs is significantly lower than younger age groups.

In 1990, there was an estimated 527 deaths due to illicit drug use, representing about 2% of all drug related deaths.

The annual economic cost attributable to illicit drug use during 1988 was more than $1.441 million — about 10% of the cost of all drug use in that year. In 1990 dollar terms, this represents a cost of $1,663 million.

Pharmaceutical products

As with illicit drugs, estimates of the use of this group of drugs are not precise. One major study in 1988–89 found that in the previous four days, 44% of respondents had used over the counter drugs and 37% had used prescribed drugs. Females were significantly more likely to have used a prescription medication than were males and the use of prescription medication increased with age. Of the people using prescribed drugs, it was found that cardiovascular drugs were the most frequent with psychotropic drugs being the second most frequent. The benzodiazepines were the most frequently used psychotropic drugs.

Figures are not readily available in the booklet on which the above information is based (Statistics on Drug Abuse in Australia, 1992) for the morbidity of these drugs or the economic costs and revenue associated with them.
See if you can identify some of the other stereotypes:

- 
- 
- 

Hawkins, Lishner and Catalano (1985) reviewed the literature on childhood predictors of later drug use and found there were many areas that could predict later behaviour. Some of these were:

- early antisocial behaviour eg. aggressiveness, rebelliousness
- family factors eg. communication and role modelling within family
- school factors eg. early adjustment to school and performance at school work
- peer factors eg. association with drug using peers
- attitudes, beliefs and personality traits.

What is important to bear in mind is that there are no clear cut traits of individuals that will lead to them developing problems related to drug use. Many factors will contribute to a persons behaviour — often without apparent connection.

The most useful way to look at this may be to say that the higher number of risk factors such as those above, the greater chance there will be of developing problems later on.

*Typical drug users*
While opium was made illegal after the turn of the century, alcohol, tobacco and prescription drugs continued to be a normal and accepted part of our society during this century.

Concerns started to be raised during the 1960's about the hazards of alcohol, tobacco and prescription drugs. At the same time, there was a lot of media attention to problems associated with an increasing illicit drug use in society. During the 1970's there were a number of major government enquiries and reports into drug use and drug related problems. 1985 saw the “Drug Summit” which led onto the National Campaign Against Drug Abuse — which still provides the national framework for drug policies and strategies.

Political and economic aspects of drug use
The social acceptability and legality of specific drugs has always been linked in some way to where that drug fits into the power structures of the society.

It is no accident that drugs deemed illicit are those taken by minority groups within society. Currently, opioids such as heroin are illegal and users of this drug are considered anti-social and deviant. However, this same class of drugs — in the form of oral patent medicines such as cough mixtures and general tonics — was widely used last century by a cross section of people. At this time, the opioid drugs were considered quite legal. This demonstrates that the legality or illegality is strongly linked to how the society perceives the drug rather than the simple properties of the drug.

Drug use is also closely tied to economic structures and concerns. In our contemporary society, alcohol, tobacco and pharmaceutical companies are large multinational conglomerates. They bring a large economic benefit to the country by way of investment, employment and government revenue.

The political and economic concerns are linked because these large corporations have considerable influence in the political process. This is demonstrated by the difficulties that health activists encounter when advocating restrictions in advertising, reduced trading hours, increased sales tax on alcohol or tobacco.

The other side of the coin in discussion of economic issues is the cost of drug use to Australian society. Collins and Lapsley (1991) conducted a major economic analysis of these costs. They concluded that the total economic cost of drug abuse in Australia in 1986 was a minimum of $14,390 million. Of this total, 42% was attributable to alcohol, 47% to tobacco and the remainder to illicit drugs.
### DEPRESSANTS

<table>
<thead>
<tr>
<th>1. Sedative Hypnotics</th>
<th>2. Opiate analgesics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethyl alcohol</td>
<td>* opium</td>
</tr>
<tr>
<td>Benzodiazepines (minor tranquillisers)</td>
<td>* morphine</td>
</tr>
<tr>
<td>* chlordiazepoxide (trade name: Librium)</td>
<td>* codeine</td>
</tr>
<tr>
<td>* diazepam (Valium, Ducene, Propam, Antenex)</td>
<td>* heroin</td>
</tr>
<tr>
<td>* nitrazepam (Mogadon, Alodorm, Dormicum, Nipam)</td>
<td>* pethidine</td>
</tr>
<tr>
<td>* oxazepam (Serepax, Benzotran, Murelax, Alepam)</td>
<td>* methadone</td>
</tr>
<tr>
<td>* flunitrazepam (Rohypnol)</td>
<td>3. Non-opiate analgesics</td>
</tr>
<tr>
<td>* temazepam (Euhypnos, Normison)</td>
<td>* aspirin</td>
</tr>
<tr>
<td></td>
<td>* phenacetin</td>
</tr>
<tr>
<td></td>
<td>* paracetamol</td>
</tr>
</tbody>
</table>

#### Non-barbiturates
- methaqualone (Mandrax)
- glutethimide (Doriden)
- chloral hydrate (Dormel)

### STIMULANTS

<table>
<thead>
<tr>
<th>1. Nicotine</th>
<th>2. Amphetamines and related drugs ('speed')</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* dexamphetamine (trade name: Dexametone)</td>
</tr>
<tr>
<td></td>
<td>3. Cocaine</td>
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<td></td>
<td>4. Caffeine</td>
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<td></td>
<td>methamphetamine</td>
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<tr>
<td></td>
<td>methylphenidate (Ritalin)</td>
</tr>
<tr>
<td></td>
<td>methylenedioxymethamphetamine or MDMA ('ecstasy')</td>
</tr>
</tbody>
</table>

### HALLUCINOGENS

#### 1. LSD-type effects (psychedelics acting on serotonin)
- lysergic acid diethylamide or LSD ('acid')
- dimethyltryptamine or DMT ('businessman's LSD' or 'businessman's lunch')
- bromo-DMA
- psilocybin ('magic mushrooms')
- psilocin ('magic mushrooms')
- lysergic acid amide (active ingredient in Morning Glory plant)

#### 2. Amphetamine-like in low doses, LSD-like in high doses (psychedelics acting on norepinephrin)
- mescaline (peyote cactus)
- DOM or STP (a synthetic mescaline derivative)
- methylenedioxymethylamphetamine or MDMA ('ecstasy')
- mescaline and elemicin (active ingredients in nutmeg and mace similar in structure to mescaline)

#### 3. Psychedelic anaesthetics
- phencyclidine or FCP (angel dust)
- ketamine

#### 4. Other drugs in high doses
- general anaesthetics
- strophone (belladonna)
- atropine (datura)
- antihistamines
- cannabis
Class differences

Peele (1985) says that while social class has little relationship to initiation to drug and alcohol use, it is strongly related to problem drinking, to overweight and to health behaviours in general. He says "Social class differences in addiction appear to be persistent and substantial and to be based in differences in attitudes as well as behaviour." (Peele, 1985, pg 105)

There is evidence that social class is one factor that influences incidence of drug use and health consequences of drug use. A study by Hill (1988) showed that across the board, blue collar workers smoke more than white collar workers. Australian and New Zealand data from the 1970's showed that both respiratory and digestive disorders were increasingly common in the "lower" social groupings (Hetzel and McMichael, 1987).

Gender differences

There is widespread acceptance that there are different dynamics involved in drug use for men and women. This is seen in society's attitudes about drug use eg. it is less socially acceptable for women to be publicly intoxicated than men. Women tend to drink more on their own or to depend more on prescription medications.

Women's dependence on substances is often contributed to by a history of sexual or physical abuse. Lastly, access to treatment services is greatly reduced for women — especially those with children.

Recent research by Copeland and Hall (1992) has highlighted some of the above and suggested that services need to be sensitive to the needs of women if they are to be successful.

Characteristics of the user

Nearly all of us use something to change our mood or to meet our various emotional needs. It may be alcohol, tobacco, coffee, tea, marijuana, food, love relationships, driving fast, aerobic exercise, working excessively. In the search to understand the nature of drug use, it is too easy to concentrate on only those people who have been stereotyped as having drug problems.

“All junkies have low self esteem...”

“All heavy drinkers are out of touch with their feelings...”
What to do in the event of an overdose

If you are faced with a possible overdose you will need to...

1. **Make a preliminary assessment:**

   Is there a life threatening situation?
   If you are unable to rouse the person and they appear to be unconscious, institute immediate action:
   • ensure that airways are clear
   • check to see whether breathing is regular
   • if they are breathing regularly, roll them onto one side
   • if breathing has stopped, commence mouth to mouth resuscitation and have someone call an ambulance immediately
   • check the pulse
   • if the pulse is absent commence cardiac massage
   • if the person is conscious and their pulse and breathing are regular, make them comfortable while transport arrangements are made for their assessment at a hospital emergency department.

2. **Make a more thorough assessment:**

   Try to find out:
   • what drug(s) have been taken
   • when
   • how much was taken
   • how much is normally taken
   • by what route was it taken

3. **Continue to treat the problem**

   • monitor any changes
   • take responsibility
   • stay calm

4. **Refer and follow up**

   Everyone, especially people working in the alcohol and other drugs field should have basic first aid skills. If you have never attended a first aid course, arrange to do so NOW. If it has been a long time since you used your first aid skills, take time to refresh your memory and practise the key elements — taking a pulse, mouth to mouth resuscitation and cardiac massage.
Characteristics of the substance — an introduction to pharmacology

How do drugs work?

Basically, psychoactive drugs need to get into the central nervous system (brain and spinal cord) and somehow interfere with the normal functioning of this system. In most cases this is done by increasing or decreasing the amount of "neurotransmitters" in the system.

These neurotransmitters are chemical substances which allow electrical messages to be passed across the tiny gap or "synapse" that exists between nerve cells throughout the brain and spinal cord. Broadly speaking, psychoactive drugs can be broken down into three groups:
1. **depressants** — which dampen down the central nervous system (CNS)
2. **stimulants** — which stimulate the CNS
3. **hallucinogens** — which distort the CNS.

The effects of any drug will depend on a number of things, including:
- the drug used
- the amount taken
- the manner taken (duration, frequency, route of administration, use of other drugs)
- the individual (age, sex, weight, tolerance, past experience, mood and activities of the user)
- circumstances in which the drug is taken (the place, the presence of other people).

How the body deals with drugs

Pharmacokinetics is the study of what the body does to drugs — how it absorbs, distributes, metabolises and excretes drugs.

Transporting a drug from outside the body to its ultimate site of action is a complex process. The drug is administered, absorbed into the bloodstream, distributed by the circulating blood to all regions of the body, the drug acts and then is eventually broken down into an inactive compound and excreted.
Patterns of substance use in Australia

The following information is taken from Statistics on Drug Abuse in Australia (AGPS, 1992).

Alcohol

Alcohol is one of the most widely used drugs in Australia. In 1990–91, each Australian drank an average of 7.9 litres of absolute alcohol. In 1989 Australia was ranked fifteenth in the world in terms of absolute alcohol consumption and had the highest per capita consumption of absolute alcohol of the English speaking nations. However, it must be noted that the trend since the mid-1970’s has been toward a decrease in the per capita amount of alcohol consumed and a marked increase in consumption of low alcohol beer.

Approximately 6,600 deaths (26% of all drug related deaths) were attributable to alcohol in 1990.

It has been estimated that the economic cost of alcohol use in 1988 totalled $6 billion while the total estimated government revenue from alcohol in 1989–90 was $2.7 billion.

Tobacco

Tobacco use has been falling consistently over the years. In the adult population, the proportion of those who smoke has fallen from 72% in 1945 to 30% in 1989. In terms of sex differences, the proportion of women smoking had increased up to the 1980’s but is decreasing again. In terms of age differences, the peak prevalence of smoking in 1989 was found among 20–24 year olds.

Approximately 18,000 deaths (71% of all drug related deaths) were attributable to tobacco use in 1990.

In economic terms, the cost of tobacco use to the Australian community in 1988 was about $6.8 billion, while the total government revenue from tobacco in 1989–90 was $2.1 billion.
Routes of administration and absorption of drugs:
The way a drug is administered determines how well and how quickly it acts on the C.N.S. There are five main ways a drug may be administered to the body:
- oral dose — through the mouth
- injection — directly into veins, muscles or under the skin
- inhalation — through the lungs
- mucous membranes — in sites such as the nose, mouth and rectum
- absorbed through the skin — as in nicotine patches.

What is tolerance?
A person can be said to have developed tolerance to a drug when increased doses of the drug are needed to get the same effect. Tolerance is a state of progressively decreasing responsiveness to a drug which occurs as the body adapts to the presence of the drug.

What is neuroadaptation/physical dependence and withdrawal
Neuroadaptation is a state in which the body has adjusted to the presence of a drug, so that when the drug is withdrawn, there are clear physical withdrawal symptoms usually involving discomfort or pain. In some cases (e.g. rapid withdrawal from alcohol or barbiturates) this can even be life threatening.

Withdrawal symptoms tend to be generally the opposite of the effects produced by the presence of the drug in the body. For example the normal effect of amphetamines is stimulation, the effect of withdrawal is emotional depression; the normal effect of barbiturates is sedation — the effect of withdrawal is hyperexcitability. While a small number of people will go through severe or obvious withdrawal, a larger number will go through more subtle experience which may include symptoms such as anxiety, confusion, insomnia and depression.

What is overdose?
An overdose is a higher than recommended normal or therapeutic dose that exceeds the individual's tolerance. This type of intoxication presents some degree of physical or psychological harm.

The effects of overdose vary with different drugs. CNS stimulants will cause anxiety and extreme excitability. CNS depressants may cause increased activity initially because of the disinhibiting effects, but will lead on to sedation and stupor. In extreme situations, this will progress to unconsciousness and cessation of breathing (respiratory arrest).
Defining drugs and drug use

What is a drug?

It is difficult to get a completely water tight definition of what constitutes a drug. One reason for this is the different ways in which a society defines drugs eg. in the past, alcohol and tobacco were not seen as drugs. Some substances eg. petrol and aerosols are generally not considered as drugs but are used by some people — in this case by inhaling the fumes — as any other drug.

Although all definitions have some shortcomings, we will opt for a simple one put forward by Julien (1985, pg 286): “any chemical substance used for its effects on bodily process”.

When looking at the alcohol and other drug field, we are mainly concerned with those drugs which effect the central nervous system ie. brain and spinal cord. These are the drugs that effect mood, perception and consciousness — the psychotropic or psychoactive drugs.

Our discussion of drugs includes all psychotropic substances — including alcohol, tobacco, solvents and prescription medicines.

Why do people use drugs?

Since the earliest times, people have used many different kinds of drugs. This has happened so consistently throughout history that one could argue that drug use is a normal part of human behaviour. Certainly many forms of drugs have become an integral part of our modern society. There are countless reasons why people use drugs:

- as part of either a formal or informal social event
- to help them relax
- for the pleasurable effects
- to control stress
- to obtain relief from physical or psychological pain
- as a response to peer pressure and to feel part of a group
- as a response to loneliness or social isolation
- as a form of social rebellion
- as part of a religious ceremony.
RESUSCITATION FLOW CHART

unconscious victim

open the airway

breathing present

breathing absent

5 full breaths of E.A.R.* (10 seconds)

check carotid pulse

breathing absent pulse present

breathing absent pulse absent

unconscious breathing absent pulse absent

E.A.R.

cardiopulmonary resuscitation

recovery (lateral position)

observe: airway breathing circulation

check carotid pulse regularly

check for spontaneous carotid pulse

* Expired Air Resuscitation

Illustration derived from Resuscitation Notes, The Royal Life Saving Society, NSW Dept of Sport and Recreation
Most clients presenting to alcohol and other drug agencies will have a moderate to severe level of dependence. However, many people will have problems with drugs without demonstrating high levels of dependence. As workers, we need to put our judgement on hold and attempt to find out the type and severity of problems the person is having and how we can most effectively help them.

Models for understanding drug use and dependence

There are many differing views of what causes drug use dependence and other problems. Similarly, there have been many attempts to describe different models of drug use (e.g. Hester and Miller, 1989; Henry-Edwards and Pols, 1991) which all use slightly different terminology. Following is a description of some of the general ways of understanding drug use, including a brief summary of the principles underlying the main approaches and how each approach addresses treatment and prevention.

Moral Model

Underlying principles
- Using drugs is morally wrong, deviant and anti-social

Treatment
- Spiritual direction
- Jail
- Provide an environment that promotes pro-social values

Prevention
- Make it well known that jail and social rejection is the consequence of using
- Hold the individual responsible for their actions (intoxication/addiction is not an excuse for anti-social behaviour)
- Promote pro-social values like social consciousness, health, self control, moderation, achievement
- Control the availability and supply of substances

Disease Model

Underlying principles
- As with other diseases, some people have a natural predisposition to addiction
- Addiction is controlled by physiological/genetic forces beyond the person's control
Sociopolitical Model

Underlying principles
- People who lack power and are alienated are more likely to experience substance use problems
- Society labels the disadvantaged users of certain substances as deviants, thereby creating problems

Treatment
- Treatment of the individual may not be helpful or necessary
- Empower the powerless by building support networks and enabling them to make decisions about their own lives

Prevention
- Provide information on safe practices
- Community development to address poverty, poor housing, discrimination amongst powerless groups
- Legislation to produce change in the social environment

The Public Health Model — An integrated approach

Each of these models put different emphasis on the importance of the person, drug and environment. In reality, no one of these models can explain all aspects of drug use and drug dependence. The most useful approach — sometimes referred to as the new public health model — is to develop a broad all-encompassing model which accepts an interplay between the many factors related to the person, environment and the drug. Strategies to combat drug related problems should address each of these key areas.
The overall objectives of this policy are:
- to prevent the uptake of tobacco use, especially in young children
- to reduce the number of tobacco users
- to reduce the exposure of users to the harmful effects and health consequences of tobacco substances
- to reduce involuntary exposure to tobacco smoke.

**NCADA**

The National Campaign Against Drug Abuse is the major national policy and planning framework that affects prevention and treatment services in the alcohol and/or other drug area. The overall objective of this campaign is harm minimisation.

NCADA has been operating since 1985 and the current phase of the campaign has seen the development of a National Drug Strategic Plan.

**National Health Policy on Alcohol**

This policy aims to minimise the harm associated with alcohol use. It stresses the need for all health and welfare workers to assist in the identification and treatment of people with alcohol related problems. It also advocates a range of treatment options and recommends outpatient treatment in the majority of cases.

**National Aboriginal Health Strategy**

The National Aboriginal Health Strategy identifies alcohol and other drugs as a major source of health problems for Aboriginal people. This report highlights the fact that the majority of treatment available is not designed for Aboriginal people and that — being socially and culturally inappropriate — it is consequently ineffective.

**HIV/AIDS National Strategy**

This strategy aims to eliminate the transmission of the Human Immunodeficiency Virus (HIV) and to minimise the personal and social impact of HIV infection. While the strategy acknowledges the best way of reducing transmission is to reduce the number of injecting drug users, it has been realistic in its recommendations to implement harm reduction strategies such as needle and syringe exchange programs.
• providing abstinence based as well as non-abstinence based treatment services
• providing information and equipment to people who intend to keep using drugs that will reduce the dangers of such use eg. needle and syringe exchange programs.

**Prevention, early intervention and treatment**

Much has been written about “prevention” and “treatment” and in the past there have been arguments about how much resources should be invested in each area. While the earlier emphasis had been on treatment services, taking a preventative approach was increasingly seen as more productive in the long-term.

Current thinking is that there needs to be different types of interventions to match the variety of ways that drug use problems present. It is useful to plot these interventions on a continuum rather than as completely distinct and separate approaches. To illustrate this point, random breath testing may act for one person as a deterrent from ever drinking and driving; it may make another person recognise they have an early drinking problem and do something about it; for a person heavily dependent on alcohol, it may act as the final straw which brings them before the law.

Although we are suggesting these approaches lie on a continuum, it is still useful to describe the differences between them.

**Primary prevention**

This is action which attempts to ensure that a problem will not occur in the first place. Within this framework, four broad areas of strategy can be described: community development, drug education, media-based strategies and control policies.

Within the alcohol and other drug area, public education campaigns such as “Quit”, peer support programs aimed at school children and changes in laws about advertising of tobacco products are examples of primary prevention.

Within the HIV prevention area, one example is the needle and syringe exchange program. While this program is catering to people already injecting drugs — some of them in a heavily dependent way — the aim is not to prevent
Basic assessment skills

All workers will be involved in some level of assessment — ranging from the unstructured day to day observations of clients by a residential worker through to the structured assessment interview. The following comments are directed more at the structured type assessment situation.

The purposes of assessment are threefold:
  • diagnosis of what is happening in the life of the client
  • an important step in engaging the client in the process of change
  • it may be a sufficient form of intervention by itself.

Some points to consider in doing assessments

  • Have a physical setting that is comfortable and non-threatening
  • Make a real effort to develop rapport with the client
  • Understand that some people do not present for assessment by their own choice and there may be considerable resistance
  • Follow a systematic approach used by the whole agency
  • Make sure the assessment information is relevant to the type of service you are providing
  • Keep a written record of assessment for each client
  • Make sure that assessment leads to action and does not become an irrelevant document gathering dust.

Areas to cover in a wholistic assessment

The scope and depth of this will vary between agencies and workers eg. psychologists will probably look at cognitive and psychological areas more deeply than other workers. Following is a general outline:
  • reasons for presenting for assessment
  • the quantity, frequency and patterns of substance use
  • extent and severity of previous drug problems
  • degree of dependence
  • level of motivation to change behaviour
  • family relationships and family drug history
  • financial, occupational and legal factors
  • medical and psychological factors
  • history of attempts to change behaviour in the past.
WOMEN AND CHILDREN IN THE THERAPEUTIC COMMUNITY: WHERE HOPE STARTED: BETTY D.

BY

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PRESENTATION TO INTERNATIONAL CONFERENCE
DRUGS AND SOCIETY TO THE YEAR
MONTREAL CANADA
WEDNESDAY, SEPTEMBER 25, 1991

HOPE STARTS WITH A STORY. As women we have accustomed ourselves to listening to and understanding the story of our world through the eyes, ears, mouths and writings of men. We have studied the men’s story of the history of the world we live in: “HIS - STORY”. There are those who have called it “Adam’s world.” There is a larger story and this is the story not only of the great men but of the great women.

We find ourselves in our relationship to the world where we can no longer live successfully with half of the story. To move honestly into the future we need the whole perspective. The animus; the masculine, surrounds us; the systems of power, hierarchical relationships and logic. The feminine has been objectified, rejected, ridiculed, wounded, forgotten, exploited and lost.

We need to restore to our world and relationships the feminine qualities of nurturing; of connectedness. To do that we need to acknowledge the larger story that includes us. We need to heal wounds that have been dealt to the feminine in this patriarchal society—not from a platform of anger but through
the steady weaving process of building community; caring for each other and
the planet. We need to grow beyond the wounds.

The story of the history of the sobriety movement is no different than other
histories we have been taught. The telling of the story has been told exclusively
through men. The story of the Oxford Group and Frank Buchman in the 1920's
with the FIVE C's for personal change:
• Confidence; speaking truthfully,
• Confession; saying the true and difficult things,
• Conversion; fully acknowledging the need for a different way of life,
• Commitment; to that way of life, and
• Continuance, helping others as you have been helped.

The 12 Steps of AA grew out of Buchman's "FIVE C's and the story emerges
with Bill Wilson and Dr. Bob in the 1930's. Aside from the revolution of
recovery from alcoholism AA may have been the first psychological construct
in the century in the U.S. where it was safe for Anglo-American men to gather
in community, leaving their "rugged individualism" at the door, express their
feelings and weep.

The year 1958 saw the formation of Synanon, it was the first time that addicts,
criminals, white, black and brown together discarded their addiction and
criminality. The story was told primarily through Chuck Dederich and
Dr. Lew Yablonsky. We witnessed the evolution of Daytop and Phoenix
House as told through Dr. Dan Casriel, Dr. Mitch Rosenthal, Dr. George
Deleon, Monsingor O'Brien, Dr. David Deitch and Charles Devlin. All anglo
men, most academically educated.

The men have listened well to each other and we have
listened well to them. These are good and important
stories. These stories provided hope and effected change.

But what of the larger story in the therapeutic
community—in the sobriety movement. Where did hope
start for women? What of the woman who was not
welcome in AA meetings in the 1950's, years when even
alcoholism in anglo women was talked about in hushed
tones, let alone drug abuse. What of the woman who was
addicted, battered, bruised, sold, convicted, shunned, who had lost her children, and was considered more “damaged” than her male counterparts in society’s eyes? What of the woman of color with these problems.

There was another vision. A feminine vision. To move honestly into the future with a fuller understanding of the identity of Therapeutic Communities this vision needs to be remembered, restored and moved forward in time. Like so many of the forgotten stories of women, this vision provides a reference point.

In Therapeutic Communities we start with the story of Betty Jean Coleman-Dederich of Synanon, the tall proud African American woman who married Chuck Dedench. The woman who, unlike Dederich, had been a criminal addict, a prostitute; a woman who had stood on the street corners of South Central Los Angeles; her “accomplishment” her beauticians license. A woman who started using drugs as an adult; whose younger brother was also an addict. A woman whose mother was blind, who was raised a “hard shell Baptist”; born in Kansas. She was a woman who told her story. She gave her story as testimony before a U.S. Senate Hearing committee in 1963, a year in which it was hard to get a hotel room in Washington D.C. because of her inter-racial marriage.

She was one of a small group of former addicts who told of their transformation. She was the only black person. This was the first public record of testimony by ex-addicts. Senator Thomas Dodd referred to their work in California as “the miracle on the beach”. It was after this first White House Conference on Narcotics in 1963 that public funding was made available for “drug programs”. The year 1964 found her working in Terminal Island with convicted women sharing her experiences. Betty Dederich publically dedicated her life to others, and lived that life extending hope. She used her years of sobriety as a symbol for the possibility of change. She made the journey from degradation to dignity and kept going; re-learned how to read, teaching English as a second language. Ever the student, she relentlessly participated in and helped develop the Synanon Community; the nations revolutionary breakthrough in successfully
overcoming addiction. She was a master at constructing chances and motivating the unmotivated. Her message was that through community, through connecting to others, a second chance was possible if people would take the time to take the journey.

Known as “Betty D.”, she was a member of the founding Board of Directors of Synanon. There is no doubt that the best of Synanon would never have existed without her; certainly the worst emerged after she died. By 1963 women who came into Synanon had the option of being able to bring their children with them. It is clear looking at our therapeutic communities today that this part of her vision was never emulated. Betty D. believed that the issues of sexuality, drugs, friendship and family could never be fragmented. She was a woman who taught the need for women to be liberated into competence; that the daily disciplines that one engaged in were a means to reinforce the change process. Each demonstration made was a step towards centering and balancing oneself; each day one did “first things first” — the trick was learning which was first.

Usually she would start with the physical; how did it represent and facilitate the relationships and events that were to occur in space—in a bedroom there are two chairs for conversation; in the common room multi-purpose furniture that could be used several different ways. She created spaces for people to be able to experience their new found life in. She could take any room in any setting, whether storefront or warehouse, and make it feel like home, no matter how meager the furnishings.

Betty D. made it clear that it was possible to change the world if one started by changing the world of the Self; expanding the personal circle, no matter who you were or where you started. She was a very hard worker. She rarely closed her office door and did not need to raise her voice to make a point; perhaps because she had the ability to listen so well that the words she did speak made personal contact. The years she spent as a teacher utilizing all her experience communicated with grace and dignity one irrefutable fact: hope starts with one story and if
that story is told in detail, in naked truth, hope becomes contagious... for through the process of the telling and listening, the teller can grow beyond the pain of the story, and the listener can find comfort and a path for herself out of a circle of despair. A meeting occurs and both find forgiveness and humor in the human condition.

Betty D. was a woman who was comfortable with all of her "selves". She shared her mistakes and made it easier for others to learn from their own. Her human, African, Baptist, dancing, creative, sorrowful, joyful, pretty and sexual self were available and present in such a way that it made any woman who knew her more comfortable inside her own female skin. She was a great teacher regarding sexuality; counseling women who had come from the streets (and many others who had not) to develop for themselves in their relationships a different language for describing sex; a language that was neither street related nor clinical; that would give the act, so frequently degraded, a new specialness, playfulness and ceremony.

Ultimately Betty D. demonstrated-starting with her interracial marriage, how to be inclusive. She was childless yet raised hundreds of other peoples children of all colors. She taught that Love had no color; and that love is a verb; that we all desperately need to find ways to respect each others talents. She would insist that the Jewish attorney from Harvard, the Italian construction foreman, an ex-addict from the Bronx; and the black streetwise hustler from Texas all learn about each others talents and respect them. She would ask them "How do you bank character if not in each others hearts? ". She demonstrated wherever she worked with groups of people that there was a need and a role for each person; acknowledging the contributions of the most quiet and withdrawn — her gift was not only seeing these contributions but presenting them in such a way that others could see and appreciate them as well.

Betty D. disagreed with some of the strict male hierarchical structure of the TC. She was quick to acknowledge that growth patterns vary for each person. She developed an encounter group based solely on
affirmations. Instead of the “Synanon Game”, it was called “Betty’s Game”. She said that in our society —

“We have a great vocabulary for hostility, but people need new ways to say I love you; receiving affection throws people into more of a crisis than being yelled at, people need both; it is the sound of two hands clapping”.

Former addicts, prostitutes, and convicts were taught by her that they needed to develop ceremonies to acknowledge the rites of passage made as they moved through life—that without ceremony and acknowledgement life lost grace and dignity. She taught that there was a great lesson to be learned for our time contained in the relationship between Anne Sullivan and Helen Keller. Helen Keller, who had been considered to live outside the circle of hope and humanity... Helen Keller, who as an adult went back to her home state of Alabama and spoke out against segregation. Helen Keller, who was reached by the persistence of a caring teacher who would not quit. Anne Sullivan, who like Betty D. had the ability to be intimate but yet an immovable boundary representing standards of excellence and a position of no compromise.

When Abraham Maslow visited with Betty and Chuck Dederich, he commented that he was honored to have met a living person who embodied all of the axioms he had laid out for self-actualizing individuals: Betty D. She was a woman who was over shadowed by her husband; whose voice was not heard as clearly as his. We listen well to the male voice.

This human being existed inside a female skin; a female black skin and she was not widely heard; her story and her vision has been largely forgotten. It is a story that today needs to be remembered. It needs to be remembered for the crack-using mother who has no hope. It needs to be remembered in the United States, a country where the women’s prison population has grown 200% in the last ten years, driven by drugs. It needs to be remembered for those who do not think that their
prejudice is a problem. It needs to be remembered for the 13 year old mother, whose own mother uses drugs, who throws a part of her self, her child, in the trash. It needs to be remembered and told-to remind us that re-socialization and re-education are a reality. It is a story that needs to be told to reinforce the knowledge that if a chance is provided in the spirit of personal revolution, a woman who is a criminal addict can give up drugs, a prostitute can find dignity, can overcome prejudice, self-hatred, and develop new ways of relating. These are women who can find a place, and a meaning, a philosophy, and a second chance in life. These are women that can be included in our communities. Her story needs to be remembered because in our frustration today with the overwhelming problems of drug using women we will move into the future most successfully if we have the whole story. There is much to be learned from the life journey of Betty Dederich.

As women in the drug treatment field who care about women we must remedy this. We can start by listening to each other. We must tell the story of what Dr. Sushma Taylor is doing in California, what Shirley Coletti is doing in Florida, what Carina Molle is doing in Italy, what Elena Gotti is doing in Argentina, what Mary Lou Gonzales-Posada is doing in Peru and Venezuela, we need to study the work of Dr. Nancy Jainchill; the pioneering efforts of New York's Sonja Paige. We need the whole story and must start with our own story; the vision of community and the demonstration made by the first lady of the therapeutic community movement who believed that teaching was the most important adult function.

For the most part Therapeutic Communities have been run by men, for men with great emphasis on structure, verbal skills, and earned responsibility. The researched addiction profile that exists is primarily a profile of the male addict. Although there have been virtually no process studies it has been generally thought that the hierarchy and structure of the TC have a great deal to do with recovery. Perhaps these forms are totally irrelevant and the recovery is more a function of living in
community, in concert with others and becoming connected.

Who are the women who come into Therapeutic Communities in the United States? Although fewer women access Therapeutic Communities than men; those who do access TC's do better than their male counterparts. Women tend to enter TC's more depressed than their male counterparts. In most places women tend to enter treatment without their children. In order to become well, women must risk exposing their children to the unknown. Approximately 70% of the women who enter TC's have been raped or molested prior to their addiction.

One of the most significant predictors for addiction and criminality is a substance abusing criminal parent; women are still the primary caregivers to the young. If we are to turn the tide of self-destruction we can no longer afford to ignore the woman AND her child. That we have ignored her for so long constitutes a moral felony. That we pay political lip service to the importance of children in our American society just highlights the pain of the ignored. Today's juvenile institutions are full of the sons and daughters of the last generation of untreated women. We live in an age which bears witness to the feminization of poverty; women and children of all colors slip below the poverty line faster than any group. We are bearing witness to the acceleration of violation; more violent rapes were reported in the U.S. in 1990 than ever before, the drug cartels of Columbia grow as do the street gangs of Los Angeles, in our hemisphere increasing numbers of children are abandoned with the attendant issues of child prostitution, AIDS and inhalant abuse. In Peru, 80% of the women incarcerated are cocaine users. In Bogota, Columbia, children of drug using mothers live in sewers. In Cochabama, Bolivia children under the age of six are living in the streets and using cocaine. In Brazil, death squads have been formed to "exterminate" abandoned street children. Within the same month in Phoenix, Arizona and New York City, drug using teenagers literally threw their newborn babies away. A population of women who feel like garbage and have treated themselves as such.

A generation of women is engaging in a war of annihilation against themselves;
perhaps this is the true meaning of the "drug war". It will not be the mechanics of war that will aid women and their children. The language of war identifies, rejects, and objectifies the enemy; there is no mechanism for embracing the enemy, building bridges back into community. It is this embracing that is ultimately needed.

Golda Meir told Anwar Sadat that peace would exist in the middle east when people could love their children more than they hated each other. The question remains whether our generation will be able to extend itself enough to the young and their mothers to stop the war of self-destruction with which we are surrounded. We can start by stopping the condemnation of these women, for it only leads them to further condemn themselves.

We must make radical changes now; but will we?

There is much to be learned from the story of Betty Dederich; A woman at war with herself, who became a peacemaker.

HOPE STARTS WITH A STORY.

Betty Dederich
Born Aug. 24, 1922 / Died April 1977
Module Three. Exercise and Nutrition

Session: 3.1

Topic: Nutrition and healthy diet

Goals: To discuss women and cooking and explore why we eat
To consider the health benefits of eating a healthy diet
To explore what foods constitute a healthy diet
To explore self image as a means to self love
Why We Eat

Suggested strategies
• Ask the women to consider why we eat.
• Introduce food as a way of meeting our needs
• List on whiteboard
• Discuss

Key points
• Hunger
• Makes us feel good
• Suppress our feelings
• Eating "naughty" foods makes us feel better
• Boredom
• When we feel depressed
• It is a social event

Resources
Whiteboard and Markers

Favourite Foods

Suggested strategies
• Discuss with the group why food is important
• Ask them to interview each other
• Discuss in large group

Key points
• Find out from each other:
  My favorite food is ....
  What I like to cook is ....
  Why I like to eat ....
• Is our favourite food healthy?

Resources
Buthers paper, pens
Meeting Our Needs

Suggested strategies
Brainstorm what can we do to meet our needs apart from eating?
List on board and discuss

Key points
- Exercise
- Meditate
- Talk with a friend
- Take time out
- Talk with a counsellor
- Watch TV
- Have a big drink of water

Resources
Whiteboard and markers

Healthy Diet

Suggested strategies
Brainstorm why we need to eat a healthy diet
Discuss

Key points
- Effect on liver, especially for Hep C positive women
- To prevent osteoporosis,
- For energy,
- To sleep better,
- For regular bowels
- To raise resistance to infection

Resources
Whiteboard and markers, liver friendly diet handout
The Food Pyramid

Suggested strategies
Draw the food pyramid on the board
Discuss where certain foods sit

Key points
Sugar, salt
Butter, oil, fat, margarine
cheese, eggs, lean meat, fish, chicken, nuts
fruit, breads, grains, vegetables, rice, pasta, legumes, dried beans

Resources
Whiteboard and markers

Healthy Eating

Suggested strategies
Discuss what healthy eating includes
Discuss “health foods”

Key points
• Eat a variety of foods
• Drink lots of water, it keeps you healthy on the inside
• Chew your food well, it’s important for proper digestion
• Avoid processed foods, many contain sugar, salt and additives
• How to eat healthier: - Low salt, low fat
• Learn to read food labels
• “health foods” from the “health food” shop are not necessarily healthy

Resources
Whiteboard and markers
Reading Labels Exercise

Suggested strategies
Exercise in pairs: - hand out a variety of food packets
Ask the women to read the labels and report back to the group

Key points
- Where in the food pyramid does it sit
- Is it healthy?
- Did you think it was healthy before you read the label
- What is its sugar content?; fat content?

Resources
Whiteboard and markers, Food pyramid on the board,
Assorted food packages

Self Image Exercise

Suggested strategies
Ask the women to interview 4 others in the group and complete the worksheet
Discuss

Key points
Self image is about how we feel about ourselves and our bodies

* Were you happy with the food you ate this week?
* Did you eat any “naughty” treats? Why?
* Did it make you feel better?

Peer support
We can encourage and support each other.
Using the information you collected in your interviews, fill in the answers below.

What did the people interviewed think were the most attractive things about themselves?

What did the people interviewed think was the most unattractive thing about themselves?

What did they generally find attractive in other people?

What do the people interviewed think are the things that women think are attractive about men?

GROUP DISCUSSION QUESTIONS

What sort of things were hard to say?

Why do we sometimes find it hard to say good things about ourselves?

Where do ideas about what is attractive come from?

Why does the media present an image of the perfect body?

Has the perfect body remained the same over the years?
Ask four people in the group the following questions. Write their responses in the boxes below.

1. What piece of clothing do you feel best in?
2. Why do you like it?
3. What do you think is the most attractive thing about you?
4. What is not so attractive about you?
5. What do you find attractive in other people?

<table>
<thead>
<tr>
<th>Person 1</th>
<th>Person 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
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<td>3</td>
<td>3</td>
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<td>4</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person 3</th>
<th>Person 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
A liver friendly diet

Lots of:

Vegetables
Fruit
Pasta, bread, rice, cereals

Avoid:

Alcohol
Tobacco,
Amphetamines, Benzodiazepines, Heroin
All fats, fried foods
Chocolate
Coffee
Cakes
Nuts
Coke
### GETTING ENOUGH CALCIUM
Here are some easy and delicious ideas to ensure the whole family gets enough calcium each day.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Ideas for 1 day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-11 years</td>
<td>1 Glass + 1 Tub + 1 Slice</td>
</tr>
<tr>
<td>16 years to menopause</td>
<td></td>
</tr>
<tr>
<td>19 years +</td>
<td></td>
</tr>
<tr>
<td>12-15 years</td>
<td>1 Glass + 1 Slice + 1/2 Cup</td>
</tr>
<tr>
<td>Post-menopause</td>
<td></td>
</tr>
<tr>
<td>16-18 years</td>
<td></td>
</tr>
<tr>
<td>Pregnant &amp; while breastfeeding</td>
<td>2 Glasses + 2 Oranges + 1 Tub</td>
</tr>
<tr>
<td>12-15 years</td>
<td></td>
</tr>
</tbody>
</table>

For more health and nutrition information contact:
Nutrition Education Service
Level 8, 55 Grafton Street,
Bondi Junction, NSW 2022.
Phone: 008 044 518

Use this calcium guide to check that you and your family are getting enough calcium-rich food.
### DO YOU GET ENOUGH EACH DAY?

1. Check below to see how much calcium you need each day.

### How to Get Enough Calcium

- **Milk and dairy foods are packed full of easily absorbable calcium.**
- **Vegetables** and **fruits** are rich in calcium, but they also contain **phytates** which may interfere with calcium absorption.
- **Supplements** can be used to ensure adequate calcium intake, especially in individuals with limited dietary intake.

### Extra Calcium is Very Imporant for Pregnant Women and For Both Men and the Growing Bones of Children.

### We All Need Calcium

- **Children** need extra calcium to support rapid growth.
- **Pregnant women** require extra calcium to support the growing bones of the fetus.
- **Adults** and **older adults** benefit from adequate calcium intake to maintain bone health.

---

**Calcium is essential for building and maintaining strong bones and teeth.**

---

**Calcium is also important for heart health and nerve function.**

---

**Calcium helps regulate blood pressure and supports muscle function.**

---

**Calcium aids in the absorption of iron from plant-based sources.**

---

**Calcium is crucial for proper blood clotting.**

---

**Calcium plays a role in muscle contraction and relaxation.**

---

**Calcium is needed for nerve impulses and muscle movement.**

---

**Calcium helps maintain the balance of the body's fluids.**
EATING WHOLESOOME FOOD PROVIDES A FOUNDATION FOR MORE EFFECTIVE MANAGEMENT OF STRESS

THE FIVE FOOD GROUPS

<table>
<thead>
<tr>
<th>FOOD GROUP</th>
<th>RECOMMENDED DAILY SERVING</th>
<th>PROVIDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 BREAD/CEREAL GROUP</td>
<td>4 OR MORE SERVINGS</td>
<td>CARBOHYDRATE VITAMINS (B Group)</td>
</tr>
<tr>
<td>Bread &amp; Cereals</td>
<td></td>
<td>PROTEIN</td>
</tr>
<tr>
<td>Rice, Spaghetti</td>
<td></td>
<td>ROUGHAGE</td>
</tr>
<tr>
<td>Flours</td>
<td></td>
<td>(If Wholegrain)</td>
</tr>
<tr>
<td>Wholegrain varieties are better</td>
<td></td>
<td>MINERALS</td>
</tr>
<tr>
<td>2 FRUIT/VEGETABLE GROUP</td>
<td>4 OR MORE SERVINGS</td>
<td>VITAMINS A, C</td>
</tr>
<tr>
<td>To Include:</td>
<td></td>
<td>MINERALS</td>
</tr>
<tr>
<td>1 Serve Vitamin C rich</td>
<td></td>
<td>ROUGHAGE</td>
</tr>
<tr>
<td>Citrus or Tomatoes</td>
<td></td>
<td>CARBOHYDRATE</td>
</tr>
<tr>
<td>1 Serve Vitamin A rich</td>
<td></td>
<td>(Energy)</td>
</tr>
<tr>
<td>leafy green or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>orange-yellow vegetables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 MEAT GROUP</td>
<td>1 OR MORE SERVINGS</td>
<td>PROTEIN</td>
</tr>
<tr>
<td>Size According To Age</td>
<td></td>
<td>IRON</td>
</tr>
<tr>
<td>Meat, Fish, Poultry</td>
<td></td>
<td>VITAMINS B, D</td>
</tr>
<tr>
<td>Eggs, Cheese</td>
<td></td>
<td>ENERGY</td>
</tr>
<tr>
<td>Soya Beans, Nuts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dried Peas &amp; Beans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peanut Butter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Textured Vegetable Protein</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 MILK GROUP</td>
<td>2 OR MORE SERVINGS</td>
<td>CALCIUM</td>
</tr>
<tr>
<td>Adults</td>
<td>300 ml</td>
<td>VITAMINS A, B, D</td>
</tr>
<tr>
<td>Kids</td>
<td>600 ml</td>
<td>PROTEIN</td>
</tr>
<tr>
<td>teeners</td>
<td></td>
<td>ENERGY</td>
</tr>
<tr>
<td>Pregnant and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Mothers</td>
<td>600 ml</td>
<td></td>
</tr>
<tr>
<td>5 BUTTER/MARGARINE GROUP</td>
<td>1 Tablespoon Or More</td>
<td>ENERGY</td>
</tr>
<tr>
<td>(Minimal Whilst Dieting)</td>
<td></td>
<td>VITAMINS A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ESSENTIAL FATS</td>
</tr>
</tbody>
</table>

Acknowledgements: A & J Borushek, "Heart Disease Prevention Manual"
FAMILY HEALTH PUBLICATIONS
WHAT ARE THE DIETARY GUIDELINES FOR AUSTRALIANS AT THE PRESENT TIME?

The Healthy Diet Pyramid

Eat Least
Sugar
Butter Margarine Oil

Eat Moderately
Lean Meat Poultry Eggs Fish Legumes Milk Cheese Yoghurt Nuts

Eat Most
Vegetables Fruits

Bread and other foods made from cereal

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IS IT TRUE THAT VITAMIN B IS AN ANTI-STRESS VITAMIN?

It is often said that when people are stressed the level of Vitamin B in their blood (and thus the amount available or use in the tissues) is lowered. There is no evidence to support this belief, nor that Vitamin B taken as a supplement helps people cope better with stress.

Small quantities of these vitamin supplements are probably not harmful though very large doses have been shown to have toxic effects.

You can increase your Vitamin B intake naturally by eating wholegrain cereals and bread. This seems a healthier approach than taking vitamin tablets as a supplement unless medical tests have shown you are deficient in these vitamins.
Module Three. Exercise and Nutrition

Session: 3.2

Topic: Exercise and Self Management

Goals: To explore what exercise can do to benefit the mind, body and spirit
To discover the health benefits of different types of exercise
To explore the concept of peer support as a way of meeting our needs
To consider and practice the skills necessary for conflict resolution
Exercise

Suggested strategies
Promote discussion in the group to discover:
• what exercise the women do
• why they like to exercise
• what stops them from exercising
• what exercise programs exist in gaol
• why our bodies need exercise

Key points
How exercise improves body functions and what it can do for you:
• high energy
• fun
• keep fit
• relieve stress and pain
• improves circulation
• can help depression
• promotes healthy bones - reduces risk of osteoporosis
• lose weight
• It can improve your balance and coordination
• it promotes sleep

Resources
OHT, projector

Choosing Exercise for You

Suggested strategies
Discuss the different types of exercise and their effects on the body
Refer to sheet enclosed

Key points
Aerobic raises efficiency of heart and lungs
Stretching keeps muscles supple
Strengthening encourages muscles to become strong
Fat Loss working the body at an increased heart rate to burn fat

Resources
Exercise sheet
Exercise...

Different strokes for different effects

It goes without saying that there are many different forms of exercise. But to many people it's not as clear that there are different levels of the same exercises for many different purposes. Exercise for gaining cardiovascular fitness is not the same as that for losing body fatness; exercise for competitive sport obviously has different requirements than that for recreation and even resistance training varies according to the desired end result — power, strength, or bulk.

The table below lists some of the basic parameters for the different purposes of exercise. To get the most from your exercise routine first look to what you want to get out of it.

<table>
<thead>
<tr>
<th>FREQUENCY</th>
<th>CARDIOVASCULAR FITNESS</th>
<th>FATNESS</th>
<th>MUSCLE</th>
<th>FLEXIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2–3 times daily</td>
<td>3-4 days/week</td>
<td>6–7 days/week</td>
<td>varies in season</td>
<td>alternate days (most muscle groups)</td>
</tr>
<tr>
<td>INTENSITY</td>
<td>up to maximum</td>
<td>60–80% max</td>
<td>40–60% max</td>
<td>max</td>
</tr>
<tr>
<td>TIME</td>
<td>Very long total time</td>
<td>Relatively short 30 mins</td>
<td>Long 1+hours</td>
<td>Short</td>
</tr>
<tr>
<td>TYPE</td>
<td>Sport related totally planned</td>
<td>Aerobic/anaerobic planned</td>
<td>Aerobic only (a) planned (b) incidental</td>
<td>Resistance</td>
</tr>
<tr>
<td>CONTINUITY</td>
<td>Intervals</td>
<td>Interval/continuous</td>
<td>Continuous</td>
<td>Intermittent</td>
</tr>
<tr>
<td>SPEED</td>
<td>Generally fastest</td>
<td>Medium</td>
<td>Slow</td>
<td>Very fast</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Slow</td>
<td>Slow–medium</td>
</tr>
</tbody>
</table>
WHAT ELSE CAN EXERCISE PROVIDE FOR ME?

- It improves the ability of your heart to supply oxygen to the body tissues and decreases the risk of a heart attack.
- It keeps your joints supple.
- It builds muscle strength and tone.
- It improves balance, co-ordination and physical skills.
- It helps keep your weight down.
- It promotes a good night’s sleep.

WHAT TYPE OF EXERCISE SHOULD I CHOOSE?

Different types of exercise achieve different effects.

- Aerobic exercise increases the efficiency of your heart and lungs in supplying your tissues with oxygen.
- Stretching exercises keep your body supple.
- Strengthening exercises enable you to do the things you need or wish to do, and protect you against injury.

WHAT STEPS SHOULD I TAKE TO MAKE A START?

- Talk to a doctor if you
  - have health problems
  - are a heavy smoker
  - are more than 10 kg overweight
  - are concerned about joint pain (back, knees, hips)
- Join a reputable exercise class
- Read a book to help you
  - devise a suitable programme
  - choose the right equipment
  - protect yourself against injury.
XERCISING FOR LESS STRESS AND BETTER FITNESS

The stress response is nature's way of preparing the body for action.

Yet physical action is often not useful for dealing with modern day stresses.

Slotting a regular exercise period into your day will release built up tension and satisfy your body's need for activity.

HOW CAN EXERCISE REDUCE STRESS?

- Exercise can help you feel good, calm you down, or generate creative ideas.
- It raises your basic level of fitness and so helps you cope with everyday demands as well as the occasional crisis.
- It acts as a distraction and gives you a break from your worries. Social sports are useful here.
- You may prefer the excitement of competitive sport. Then you can tackle your goals with enthusiasm and enjoy the positive feelings of achievement. Take care that the need to win does not transform your exercise into a stress cause rather than a stress reducer.
Peer Support

The concept of peer support is to encourage the women to build up a relationship with one or two other women so that they may talk openly and honestly about their thoughts and feelings and gain trust and understanding. Many women in gaol will have attended training in the HIV/Health Promotion Unit's Peer Support program in HIV/AIDS, so this concept of sharing information will not be new to them.

Suggested strategies
• Islands is a game to encourage the women to help each other.
• To play this game, place some sheets of butchers paper around the room on the floor.
• Have the participants mill or 'swim' around the room until you shout 'shark'. All the group members must stand on a piece of paper - the 'island'. No part of their feet must touch the floor. When you call 'swim', the participants can move around again.
• Meanwhile, gradually make the 'islands' smaller by removing them or by tearing them.
• The group must try to fit on the 'islands'.
• A small 'island' may remain whereby all participants must help each other to balance on the piece of paper.

Resources
Butchers paper

Conflict Resolution

Conflict will always be present when people live and work closely together. Dealing openly with conflict is a part of becoming more assertive. Negotiation is a skill which can help you deal with conflict to result in a win-win situation for all involved.

Suggested strategies
Ask the women to think of all the ways one can deal with conflict

Key points
• Walking away -- can be both powerful and powerless in the situation
• Using power to enforce what you want -- being aggressive
• Giving in -- being passive
• Getting upset and angry -- self blame
• Blaming the other person -- shifting the responsibility away from self
• Being assertive -- being responsible, owning your feelings, challenging but not threatening, listening to the other person
Conflict Management Skills

Suggested strategies
The first thing we usually do when we are not OK is to blame the other person for the situation and either aggressively argue or passively back off. It is best to deal with these situations by first, owning and dealing with your own feelings and avoid blaming the other person.

- Discuss the 7 steps for dealing with conflict.
- Use an example from within the gaol setting to demonstrate the steps.
- Choose a suitable problem, avoiding obvious clashes, and using the 7 steps ask the women to work in pairs to practice the steps of conflict management.
- At the end of the exercise, promote discussion and ask for feedback on how both parties are feeling (Are both OK or only one OK)

Key points
- Step 1: Check your intention -- are you both willing to negotiate
- Step 2: Sort out what each person wants
- Step 3: Brainstorm all options. Do not look for solutions
- Step 4: Assess the options -- reject the ones that neither agree on; keep the ones that are possibilities
- Step 5: Choose one or more options -- Assess these and choose the ones both are happy with
- Step 6: Take action -- Decide who does what, when and how. Make a time to discuss it again in the near future
- Step 7: Check it out with each other -- how is it going? If no joy, start over at step 1 again.

Resources
OHT, projector
Review and Evaluation

**Session:** Review & Evaluation

**Topic:** Review of Program

**Goals:**
- To identify key factors relating to sexual health
- To review the emotional and physical issues relating to drug use and abuse
- To identify the key components to healthy diet and exercise
- To identify the impact of these issues on the formation of self awareness, body image and self esteem
- To complete written and verbal evaluation of the program
Review - Sexual and Reproductive Health

Suggested strategies
- Ask the group to give a description of sexual health
- Discuss what is involved in staying healthy
- Ask them to discuss what they would do if they found a problem, Eg. A breast lump or a discharge?
- Who do you access? Ask them to list the services for women's health

Key points
- Screening -- pap tests, breast checks, STD tests, blood tests where to go to get them done
- Safe sex -- condom use, dental dams, negotiation skills
- Self care -- self breast exam, self responsibility, pelvic floor exercises
- STD -- what is the definition of an STD, what symptoms may be present, how can they be prevented
- BBCD -- what is the definition of a BBCD, how can they be prevented

Review - Safe Drug Use

Suggested strategies
- Discuss what is involved with safe drug use
- Discuss self help skills
- Ask the group to name D&A community services

Key points
- Safe needle use -- cleaning, needle exchange, not sharing
- Limiting intake -- using minimal amounts, not poly drug use
- Setting goals -- realistic goal setting, making priorities, looking at options
- Assertiveness -- getting what we want without being aggressive
- Self confidence -- changing the self talk, nurturing self
Review - Exercise and Nutrition

Suggested strategies
- Ask the group to describe a healthy diet
- Promote discussion to find out if anyone has tried to improve their diet
- Discuss issues around feeding ones needs through meditation or other means

Key points
- Liver friendly diet — low fat, reduce caffeine
- Wide variety — more fruit and vegies, more water
- Visualisation — as a stress management technique, as something nice to do in the bath

Suggested strategies
- Ask the group to describe the different types of exercise
- Promote discussion to find out if anyone has started an exercise program
- Is anyone using peer support or other means to help them exercise

Key points
- Aerobic
- Muscle building
- Flexibility
- Fat loss

Storytelling
- Storytelling is a way to encourage the women to tell their own story, own it, demonstrate their self responsibility and to be listened to.
- It gives other women the opportunity to learn something, especially if the story is one of success.
- The story may be influential in encouraging other women to do something about their own health

Suggested strategies
- Go around and ask if anyone would like to share a positive story about themselves or their change in behaviour since starting this program
- It may be about having a pap test, dealing with a conflict, being assertive, using the relaxation techniques, etc
Group Closure

The group may well have bonded during the course of the 12 sessions. It is important to recognize this and give respect to the fact that the program has ended. Spend some time on group closure games. You may wish to spend time honouring each person.

Suggested strategies

- Play knots:
  - All stand in a circle
  - Close your eyes and cross your hands in the middle of the circle
  - Feel around and grasp another hand
  - When all hands are held, open your eyes
  - Without letting go, try to unravel the tangle

- Paying compliments:
  - Stand in a circle holding hands
  - One woman stands in the middle
  - In turn, every woman makes a positive short statement or gives one pleasant word to describe the woman in the middle
  - Continue until everyone has had a turn

- Honour each other:
  - Hand out a piece of butchers paper to everyone
  - Ask them to write their names beautifully at the top using coloured pens
  - Attach the sheet to their backs (Use paper clips, or tuck into shirt collar)
  - Each person writes something positive on every sheet
  - Give the women time to read their sheet
  - Encourage them to take it home and read it when they need to