QUEENSLAND WOMEN'S HEALTH NETWORK NEWS

APRIL 2008 *'Aims to strengthen links between women by providing access to information and support'*

www.qwhn.asn.au

WOMEN&DISABILITY—THE HIDDEN & THE SILENT

Women With Disability Australia (WWDA)

***Madge Sceriha** introduces the peak organisation for women with disabilities.*

It is very timely that this edition of our Queensland Women's Health Network Newsletter is focusing on Women With Disability because it offers me a really valuable window of opportunity to promote the work of Women With Disability Australia (WWDA), the peak organisation for women with all types of disabilities in Australia. In particular I want to recommend to you a recent publication, *WWDA Violence Against Women With Disabilities RESOURCE MANUAL*. This resource is presented as a series of four booklets which provide: a global overview, individual stories, information about the issues and a guide for women's refuges to develop disability discrimination act action plans.

WWDA in a Nutshell

WWDA is the only organisation of its kind in Australia and one of only a few internationally. It is run by women with disability for women with disability and, being inclusive, does not discriminate against any disability. Its objectives are to promote the inclusion of women with disabilities in all aspects of social, economic, political and cultural life, to advocate on issues of concern to them, to engage in systemic advocacy, to provide policy advice, to undertake research, and to provide support, information and education. WWDA is well respected for the work it does and is constrained only by the limited resources to which it has access from doing more. As with other vibrant, feminist peaks which have felt the effects of drastic cutbacks in funding over the eleven years of conservative government control of fiscal purse strings, the most consistent resource available to ensure the survival of this vital network of women has been the courage, determination, creativity, resilience and dedication of members and staff.

WWDA addresses disability within a social model which identifies the socio-structural, attitudinal, cultural and institutional barriers and restrictions which marginalise and disempower vulnerable people. The social model of disability represents a major paradigm shift from individualising and pathologising medical model thinking, which prevailed until the latter part of last century. Now firmly established, this social model has provided the conceptual framework on which disability politics and rights activism has continued to build. The work of WWDA is an example of how this has brought the gendered nature of disability into sharp focus, especially its manifestation in the incidence and prevalence of violence against women with disability.

WWDA's Latest Publication

Among other sobering facts, WWDA's *Resource Manual* points out that compared to non-disabled women, women with disabilities:

- experience violence at higher rates and more frequently
- are at a significantly higher risk of violence and abuse

(continued over page)

IN THIS EDITION: **WOMEN & DISABILITY—**THE HIDDEN & THE SILENT

FUNDING FOR THE QWHN INC. IS PROVIDED BY QUEENSLAND HEALTH

The Theme for our
Next Newsletter is:

WOMEN & PRISON

Does your organisation have expertise in this area?

Or are you a woman with knowledge / experience on this topic?

Share your insights with over 400 organizations, professionals, and other women in Queensland and beyond...

We welcome your articles, news items, or other submissions.

If you have an idea, or would like more information please get in touch with us today!

Deadline: 23 May

CONTACT DETAILS *on* Page 8

QWHNEWS

To start the year on a positive note, I'd like to say a belated 'thank you' to all those organisations who provided us with brochures and other information for distribution at our Regional Women's Health Forum in Cherbourg (south-west Queensland) last year. A special thank you to Anne Haag, from Continence Foundation of Australia, who was exceptionally helpful by providing QWHN with 'showbags' of brochures and resources specifically designed for Aboriginal and Torres Strait Islander communities. We utilized and combined these with other resources to present to participants at the Forum. If you'd like to know more about the Foundation, check out Anne's article on the next page.

Our next edition will examine the various issues involved in the intersection between women and prison. If you'd like to contribute an article on this or another topic, please feel free to contact me for more information.

Maree Hawken
Coordinator

WWDA

(continued from front page)

- tend to be subjected to violence for significantly longer periods of time
- experience violence that is more diverse in nature
- experience violence at the hands of a greater number of perpetrators, and
- have considerably fewer pathways to safety.

In light of this it is probably not surprising that included in the problems brought to WWDA's attention by Queensland members in recent times has been the issue of lack of access to women's refuges. This is not an easy problem to overcome and has haunted women's services since ever refuge doors were opened to women escaping violence in the home. The booklet *More Than Just a Ramp* shows a way forward which I urge all who are concerned about this continuing crisis to read. It includes a realistic example of one refuge which took steps toward that goal, and presents strategies which may inspire action, or at least keep the ideas high on the agenda of what is possible. And then there are the very honest, moving and confronting stories and poems contained in another of the booklets in this resource, *A Life Like Mine*. To read them is to get to know more about some of the issues women with disability live with. *Forgotten Sisters*, the global review booklet is a very concise but comprehensive account of what is described as *"...a global epidemic of crisis proportions that is largely ignored in efforts to address violence against women."* An Annotated Bibliography of known published and unpublished resources about the issues is a valuable addition to the content of the booklet. *It's Not OK - It's Violence*, the fourth booklet in the series, presents important information for women with disabilities and, for service providers, suggesting some easy ways to be more inclusive and responsive.

End Notes

Several other issues were raised recently with WWDA by its Queensland members, all of them important, such as housing affordability, over-representation of women with disabilities in prisons, and motherhood and parenting challenges including removal of babies and children from the care of mothers with mild intellectual disabilities. There are no easy ways to deal with any of these issues but WWDA helps keep them on the agenda by raising awareness through its networks and representation in influencing policy decisions. Check out WWDA Update Report August/ September 2007 to sample the extent of its role as a national disability organisation, a national women's organisation and a national human rights organisation.

I would be happy for anyone interested to know more about how to get involved with WWDA to contact me: msceriha @bigpond.net.au or you can go to WWDA directly.

Contact details appear below either to purchase the *Resource Manual* which I recommend to you, or to become a member which I also recommend. Full or associate membership is available.

Women With Disabilities Australia
PO Box 605 Rosny Park
Tasmania 7018
www.wwda.org.au – provides links to publications and membership information
wwda@wwda.org.au

INCONTINENCE

Anne Haag discusses this 'hidden' but sometimes disabling condition.

In any culture, a problem to do with bladder or bowel control (leakage of urine and faeces), carries a lot of "psychological baggage" – shame, embarrassment, even guilt. Yet statements like "It's because you've had babies", or "It's because you're getting old" or "It's because I'm a woman" are simply not good reasons to overlook a problem of bladder or bowel control (incontinence). This health condition is never normal, at any age. It can be treated and often cured if it is properly assessed and an individual management program developed for the person.

The most common barrier stopping people improving their "leakage" problem is not wanting to talk about it. We seem to be able to freely talk about blood, sweat or tears, but urine - simply another bodily fluid - is whispered about or totally ignored! Many people pretend they don't have a problem at all. Some say they "only have a small problem". Yet there are many doctors, nurses and continence physiotherapists in our communities who make this area of health their special area of interest.

Incontinence can have a big effect on many lives. It causes people to give up work or enjoyable social activities, family outings, movies or travel – and it can have a bad effect on close personal relationships too. It can shrink back lives so that people confine themselves to home - and they can become unmotivated and sad.

Faecal incontinence (leakage from the bowel) can be even more embarrassing and isolating. It can sometimes seem like "diahorrea", but the problem could actually be constipation (blocking the bowel) that is the basic cause. This is where liquid material finds its way around an "impaction" (solid mass of faeces) and leaks out. With urinary incontinence, sometimes the problem is not drinking enough water. This causes the urine to become more concentrated and therefore more irritating to the inside of the bladder, making it "unstable". Going to the toilet often, or a sudden need to rush there, or constipation and haemorrhoids (piles) are also problems that can be associated with incontinence.

> "... it can shrink back lives so that people confine themselves to home ..."

The important message about an incontinence problem is to overcome the barriers in our head and talk about it! It can be difficult at first, but it's important to discuss it with someone who can help stop problems getting worse. At any age - and no matter how small the problem - a health professional's advice can help people get back in control.

The National Continence Helpline (1800 33 00 66) is a free service (and a free call from anywhere in Australia). The Helpline's continence nurse advisors give free advice, tips on how to improve control problems, treatment options, good bladder and bowel habits, and they can also mail out leaflets on many continence-related topics. The Helpline's nurse advisors not only have medical knowledge about this area of health, but they are also very sensitive to the emotional and social issues around incontinence. There is an excellent ATSI range of incontinence materials available from the Helpline. As well as calls from the community, the Helpline advises health professionals about strategies to help improve their clients' incontinence, as well as products available and where to get them – and the ATSI range of resources can also be ordered in quantity.

For further information contact:

Anne Haag
Continence Foundation of Australia
Tel: (03) 9347 2522
Email: anne@continence.org.au

THE AUSTRALIAN ORGAN DONOR REGISTER

Transplantation gives recipients renewed or enhanced quality of life.

Every Australian has the opportunity to register their consent to donate organs and tissues for transplantation on the Australian Organ Donor Register.

Registration brochures are available through:

- every Medicare office
- by telephoning the toll free number **1800 777 203**
- on the website: http://www.medicareaustralia.gov.au/yourhealth/our_services/aaodr.htm

For information contact: Debbie Austen, Organ and Tissue Coordinator for **QUEENSLANDERS DONATE**, Rockhampton Hospital Intensive Care Unit.
Ph: 4920 6728 or 4920 6313 or email Debbie_Austen@health.qld.gov.au

MOVING BEYOND THE SOUND BARRIERS

*Be part of the solution to issues affecting Deaf women with this advice from **Carmel Murphy**.*

Seeking medical advice and treatment can be a frightening, stressful and embarrassing experience for anyone, and for many Deaf Australians the experience is magnified by a communication and cultural barrier.

One in six Australians[1] have some degree of hearing loss. More than 6,500 Australians over the age of 16 use Sign Language[2]. This article contains a brief introduction to some of the issues affecting deaf women and how you can help remove the barriers.

Deaf vs Hearing Impaired

Whether someone identifies as 'Deaf' or 'hearing impaired' is a matter of personal choice and preference. However, in broad terms, a person who uses sign language as their preferred mode of communication and who identifies as a member of the deaf community will often refer to themselves as 'Deaf'. A person who uses lipreading and speech as their preferred means of communicating (may or may not use sign language) will often call themselves 'hearing impaired, or hard-of-hearing'.

QUICK FACTS

- Not all deaf or hearing impaired people can lipread — it is an incredibly difficult skill to master and not an innate skill of deaf people
- Not all deaf people can use written English to communicate — literacy levels among deaf people can differ markedly depending on past educational access
- Most deaf people are not mute — but many choose not to use their voices
- 'Deaf and Dumb' is not an acceptable term anymore

Sign Language

Auslan (Australian Sign Language) is the language of the Australian Deaf Community. Auslan is a visual language and is not a signed system of the English language. It is a full and complete language, with it's own grammatical structure and was recognised by the Australian government in 1987. As with any spoken language, Auslan can be used to express abstract and complex concepts, and is used in politics, religion, philosophy - any context that a spoken language is used.

Culture

Deaf people who regard themselves as 'culturally deaf' are generally proud members of their community, who identify as a cultural and linguistic minority, not necessarily as a disability group. Deaf communities throughout Australia have a vast array of networks including social and sporting clubs and events, political groups, religious groups and so forth.

Interpreters

Interpreters act as a cultural and linguistic conduit between hearing and deaf people and ensure smooth and accurate transfer of information.

Deaf people have a right to access the same medical services and information as hearing people. A deaf patient will feel far more comfortable asking questions, giving a medical history and understanding medical explanations and instructions if the conversation is conducted in their first language. By booking an interpreter you can be sure that detailed information is given and received and there is much less risk of miscommunication. As anyone who works in this field will be aware, the consequences of misunderstanding medical information could be fatal.

Accredited Interpreters should always be used, and signing family members or friends should **never** be asked to act as interpreter.[3]

NAATI Accredited Auslan interpreters have received extensive training and have the same accreditation, registration requirements and ethics that accredited spoken language interpreters have. They are bound by a strict Code of Ethics which includes confidentiality and impartiality. The interpreter will not offer their own opinions and should not be asked for their input into the discussion.

Working with Interpreters

For Deaf people, face to face interpreting is needed to ensure participation. Telephone interpreting service is not an option when working with Deaf clients.

The interpreter will usually sit next to the professional, opposite the deaf patient; this is so the deaf patient can see the interpreter and the professional at the same time. Let the Deaf person tell you where they feel comfortable to place the interpreter with seating arrangements, lighting etc - sometimes furniture needs to be moved, or a curtain drawn.

The interpreter will speak everything that is being signed and sign everything that is being spoken. Speak in your normal voice, at your normal pace - if you are going too fast, the interpreter will let you know. Speak directly to the deaf patient, as if the interpreter was not there e.g.,

COMMUNICATING WITH HEARING IMPAIRED/ HARD OF HEARING PATIENTS

If the patient does not require an interpreter, some things you can do to assist the communication between you and a hearing impaired patient include:

- Face the patient when speaking to them, so they can read your facial expression and lips easily
- Try to keep hands away from your face and lips
- Get the patient's attention before starting to speak
- Minimise background noise (radios, air-conditioning)
- Speak normally — don't shout or over-exaggerate your lip movements
- Be patient if misunderstanding occurs — try rephrasing rather than repeating over and over
- Write important points down e.g. medication doses

"can you tell me what your symptoms are?" not to the interpreter, "can you ask her what her symptoms are?"

Preferred interpreters

Many deaf people have a preferred interpreter, especially for medical or sensitive situations. This might be someone that the deaf person knows well and trusts or who has a signing style that is comfortable for the deaf patient. For ongoing and recurring appointments, e.g., cancer treatment, the deaf patient may prefer to have the same interpreter booked for each appointment if possible, as this provides continuity of information and perhaps will ensure the deaf patient feels safe in getting medical treatment, having built up a trust relationship with the interpreter.

If the medical appointment is of a sensitive nature, a female deaf patient may feel more comfortable with a female interpreter. It is appropriate to ask the patient or the booking agency if a female interpreter would be more suitable.

General Awareness

It has been found that Deaf people leave school with a reading age much lower than their hearing peers. This is a result of the education system and not the intelligence of the deaf individual. Many support services throughout their schooling years, such as interpreters or note takers, have been restricted or non-existent, which has resulted in limited access to information and learning. In addition to this, it can be difficult for Deaf people to engage in 'incidental learning' that is, learning by hearing and participating in other people's conversations, listening to radio, TV and other media.

For the reasons outlined above, Deaf women may have less general awareness of their health and bodies, or they may not have the same generic understanding of medical conditions and procedures as the wider, hearing community. Deaf women may require more explanation of procedures and medications - be prepared to check understanding by asking open ended questions.

Power Imbalance

Many patients feel a power imbalance with medical professionals, especially if the professional is male and the patient is female. This can be further compounded for deaf women as many feel an imbalance between Deaf and hearing people.

Some deaf women have been disempowered throughout their lives and as a result, may find it difficult to express dissatisfaction, or clear up misunderstandings, or they may feel too intimidated to seek clarification of their diagnosis or treatment.

Deaf Services Queensland is a not-for-profit organisation providing referral and information services for Deaf, hard of hearing and hearing people. If you would like further information about deafness, sign language or interpreters please contact our office or visit our website on www.deafservicesqld.org.au.

Deaf Services Queensland also provides Deafness Awareness Training sessions to professionals and offer Community Auslan Courses and Auslan in the Workplace training. Please see our website for further details.

For enquiries contact:

Carmel Murphy
Service Development Manager
DEAF SERVICES QUEENSLAND
Tel: (07) 3892 8500
Mob: 0433 146 124
Fax: (07) 3392 8511
TTY: (07) 3892 8501
473 Annerley Road
(PO Box 173) Annerley Qld 4103

---

[1] *Listen Hear, The Economic Impact and Cost of Hearing Loss in Australia Study*, Access Economics, Feb 2006 pg 5.

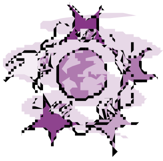
[2] Supply and Demand for Auslan Interpreters Report. Orama Research on behalf of the Australian Government. Jan 2004.

[3] Accredited NAATI interpreters are those who have sat examination under the National Accreditation Authority for Translators and Interpreters. This is a Commonwealth program.

WHAT'S ON…

Important events, conferences and workshops around the state & beyond

29-30 APRIL	**CRIAH ABORIGINAL HEALTH RESEARCH CONFERENCE 2008 — Sydney, NSW.** The Coalition for Research to Improve Aboriginal Health (CRIAH) Conference brings together Aboriginal communities, researchers and policy makers to consider how research can assist in improving the health of Aboriginal people. For more information visit: www.saxinstitute.org.au or call (02) 9514 5950
22-23 MAY	**5th NATIONAL HOMELESSNESS CONFERENCE — Adelaide, SA.** Presented by Homelessness Australia. For information call Beverly on (02) 6247 7744
4-6 JUNE	**THE TRUTH ABOUT VIOLENCE AGAINST WOMEN CONFERENCE — Sydney, NSW.** Presented by Women's Health NSW. For full details visit: www.conference.herwill.net
23-25 JULY	**QLD SUICIDE & SELF-HARM PREVENTION CONFERENCE 2008 — CAIRNS, QLD.** Intervention, Post-Vention/Bereavement and Self-Harm. A conference focusing on Indigenous, Multicultural, New & Emerging Groups. For information: (07) 4051 0727, www.suicidepreventionconference2008.com or email: admin@kochfoundation.org.au



WOMEN'S HEALTH ON THE NET

PEOPLE WITH DISABILITY AUSTRALIA

www.pwd.org.au

People With Disability Australia is a peak organisation with a focus on rights and advocacy, which was founded in 1981, the International Year of Disabled Persons. PWD provides information, advocacy, education and training, and also auspices the National Disability Abuse and Neglect Hotline and the Complaints Resolution and Referral Service. The site provides access to publications on news and developments at state, national and international levels. Useful links include: Aboriginal Disability Network (NSW) and the Disabilities Studies and Research Institute.

NSW NETWORK OF WOMEN WITH DISABILITY

www.femability.org.au

This website begins by asking the important question: *'Why do we need a network for women with disability?'* and answers it by stating that often organisations for *women*, or organisations for people with *disability*, either aren't aware of, or don't discuss, the issues that affect *women with disability*. It goes on to list some of these key issues, including the higher rates of poverty and violence that women with disability experience. The site provides some resources, publishing and interactive components, so women can share their insights, opinions and outlooks.

IDEAS

www.ideas.org.au

IDEAS (Information on Disability and Education Awareness Services) is an organisation for people with disability, including age-related disability, their families and other supporters. The website provides access to the latest disability news, links to databases, information, products and services that support independence for people with disability. IDEAS also provide a Disability Info Line to enable people with disability to access information on topics such as: Disability & diseases; accessible holidays options; transport; employment; daily living aids; respite care; entitlements and subsidies; leisure and sports programs.

BREAKING DOWN OSTEOPOROSIS

Do you know how to avoid the disabling effects of osteoporotic fracture? ***Osteoporosis Queensland***

Approximately 2.2 million Australians are affected by osteoporosis, in fact 1 in 2 women and 1 in 3 men over the age of 60 years will suffer an osteoporotic fracture[1].

Vertebral fractures, which cause significant pain and disability are the most common osteoporotic fracture. Women who have sustained a vertebral fracture are 4 times more likely to sustain a new fracture within the next year — the so called cascade effect. They are at increased risk of hip fracture with all of its associated costs, and increased risk of premature death. Someone is admitted to hospital with an osteoporotic fracture every 5-6 minutes[1].

Identifying risk factors for osteoporosis and making lifestyle changes to minimise their effect may reduce the risk of developing osteoporosis and osteoporotic fractures. Risk factors fall into 2 main categories — modifiable and fixed.

MODIFIABLE RISK FACTORS

Alcohol

Studies show that more than two units of alcohol per day can increase the risk for osteoporotic and hip fractures. Some of this increased risk is due to decreased bone mineral density, which may be a result of an effect of alcohol on the bone forming cells. But some of the risk is also attributable to other factors, which may include general deteriorating health and the increased likelihood of falling, especially in the elderly.

Smoking

Smoking also increases a person's fracture risk. Although the risk from smoking increases with age, the effects of cigarette smoke appear early. Smoking in young people may reduce their peak bone mass — established in the early to mid 20s — and thereby increase the risk of osteoporosis in later life.

Low Body Mass Index

The body mass index, or BMI, is a measure of how lean someone is and can be used as a guide to measure his or her osteoporosis risk. BMI below 19 is considered underweight and a risk factor for osteoporosis. Because bone is a living tissue and responds to the load that is placed upon it, heavier people tend to have higher bone mineral density and hence better bone strength.

Poor Nutrition

Calcium is an essential part of bone mineral but it is also essential for muscles, nerves and other cells in the body. When insufficient calcium is absorbed from the diet, calcium stored in bone is used to supply the nerves and muscles. This accelerates osteoporosis.

Vitamin D is also essential, since it assists calcium absorption.

Eating Disorders

Osteoporosis can also be compounded by eating disorders such as anorexia and bulimia. These conditions can dramatically reduce calcium intake and accelerate mineral loss from bone. Oestrogen deficiency in women afflicted by these disorders hastens bone loss in a similar way to that in post-menopausal women.

Insufficient Exercise

Just like muscles, bones respond when they are "stressed," in other words, when they are forced to bear more weight than they are used to. This can be achieved by "weight bearing" or impact exercises such as walking, running, lifting weights, jumping, or dancing. Studies show school children who exercise have higher bone mineral density than those with more sedentary lifestyles. A regular, well structured exercise regimen has been demonstrated to help protect against osteoporosis. Exercises that improve posture and balance will help protect from falls and reduce the likelihood of having a first, or further bone fractures.

FIXED RISK FACTORS

There are also fixed risk factors that increase a person's risk for osteoporosis and bone fractures. Fixed risk factors are those that one is born with or cannot alter. Even though these factors cannot be changed, they must not be ignored. It is important to be aware of these fixed risks so steps can be taken to reduce losses of bone mineral.

Age

One of the primary fixed risks is age. The vast majority of hip fractures (90%), for example, occur in people aged 50 and older. This is partly because of reduced bone mineral density — as people pass into middle age, the bone remodelling balance tips in favour of bone mineral loss, increasing the risk of fracture. Poor balance and weaker muscles in the elderly also contributes to falls.

Gender

Women, particularly post-menopausal women, are more susceptible to osteoporosis than men. Careful monitoring of bone mineral density in post-menopausal women, combined with exercise, proper diet, and control of other risk factors can help fight osteoporosis.

Family History

Genetics also plays a large part in osteoporosis. Scientists are

(continued from previous page)

uncovering subtle variations in the human genetic code that make some people more susceptible to bone loss than others.

Previous Fracture

Recently, worldwide studies revealed that people with a prior fracture are at increased risk of any type of fracture compared to people who have never broken a bone.

Race/Ethnicity

Osteoporosis is more common in Caucasian and Asian populations.

Menopause or Hysterectomy

Hysterectomy, if accompanied by removal of the ovaries, may also increase the risk of osteoporosis because of oestrogen loss. Post-menopausal women, and those who have had their ovaries removed, must be particularly vigilant about their bone health. Post-menopausal women should consult their doctor about lifestyle changes and treatments that can help prevent osteoporosis.

SECONDARY RISK FACTORS

Secondary risk factors can have an impact on bone health. These risk factors include other diseases that directly/indirectly affect bone or conditions that can affect balance, which can contribute to an increased risk of falling and therefore having a fracture. Examples include: asthma; rheumatoid arthritis; hypogonadal states; endocrine disorders (eg diabetes, cushing's syndrome, hyperparathyroidism).

Some medications may have side effects that directly weaken bone eg: corticosteroids, high-dose thyroid hormone treatment, certain steroids, certain gastro-intestinal medications. Patients should consult with their doctor about their medications in relation to their bone health.

Osteoporosis Queensland employs osteoporosis educators to provide support and education. To speak to either **Kellie** or **Lynne** or if you wish to receive a free osteoporosis information pack please contact **Osteoporosis Queensland** on **1800 242 141**.

Based on a report prepared by Prof Cyrus Cooper, University of Southhampton, UK on behalf of the International Osteoporosis Foundation. Reprinted with permission from Osteoporosis Australia..

[1] *The Burden of Brittle Bones Epidemiology, Costs & Burden of Osteoporosis in Australia 2007.* Prepared by The Department of Medicine, University of Melbourne, Western Hospital, Footscray, Victoria. For Osteoporosis Australia.

QWHN CONTACT DETAILS

Phone (07) 4789 0665
Fax (07) 4789 0647
Postal Address: PO Box 1855
Thuringowa BC QLD 4817

Email: qwhn@bigpond.com.au

Committee Members

Townsville:	Betty McLellan (07) 4728 5600
Brisbane:	To Be Filled
Mount Isa:	Shirley Slann (07) 4743 0946
R'hampton:	Sandra O'Brien (07) 4935 2003
Cherbourg:	Lillian Gray (07) 4168 1016

HAVE YOUR SAY…

We are interested in obtaining feedback on the quality of the newsletter and issues and topics you would like to see in future editions.

If you have something to say please contact Maree on (07) 4789 0665 or email us at qwhn@bigpond.com.au

MEMBERSHIP

To join or renew your membership with QWHN, simply fill in this form and send to QWHN at PO Box 1855, THURINGOWA BC, QLD 4817

Membership of the Network is open to women's organisations & individual women who are in agreement with the Network's purpose and objectives.

Name: *NEW MEMBER?* ☐YES ☐NO
Address:
Phone: Fax:
Email/Web:
Profession/ Organisation:
MEMBERSHIP FEES: Individual (unwaged or student) — **$5.50** Individual (waged) — **$11.00** Organisation — **$33.00**

Please find enclosed a cheque/money order for $……………… for one financial year's membership (1 July 2008–30 June 2009)

Do you consent to your name, as part of the membership list, being distributed for networking purposes? ☐YES ☐NO

I/We hereby agree to abide by the Purpose, Objectives and Policies of the QWHN.

Signature…………………………………………………………………… ***Date***…………………………………

TAX INVOICE
ABN 11700374032