



Australian Society for
Psychosocial Obstetrics
and Gynaecology

36th Annual Scientific Meeting

From Fringe to Forefront

30-31 July 2010

The Royal Women's Hospital
Victoria

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Welcome

We are delighted to welcome you to the Royal Women's Hospital Melbourne for the 36th ASPOG Annual Scientific Meeting.

The new Women's Hospital is a highly appropriate venue for our meeting. The design has created a physical, social and professional environment which exemplifies the values of ASPOG. It celebrates the integration of the social and psychological with the biological dimensions of women's health and health care. Women's needs are at the forefront, from the welcoming entrance precinct, graced by Michael Meszaros's sculpture and Kylie Bird's artwork, the prominent placement of the Women's Health Information Centre, the Aboriginal Women's Health Business Unit and the Pregnancy Advisory Service, through to the best practice Birth Suites and specialist clinics. The Women's has been strong in recognising the traditional owners of the Wurundjeri land on which the hospital is built and in acknowledging past injustices. Members of ASPOG and the Conference Organising Committee are delighted to be holding our meeting in this place and express our warm appreciation to The Women's for making their Conference Centre available to us.

We hope you will find the conference brimming with engaging topics and stimulating discussions, friendly interactions with old and new colleagues and excellent food by *Mary and Steve* – another fine Melbourne institution. We look forward to your company over the next two days.

Organising Committee

Heather Rowe (Convenor)

Chris Bayly

Louise Kornman

Alex Marceglia

Karin Hammarberg

Carol Vance

Ines Rio

Amanda Cooklin

ASPOG

The Australian Society for Psychosocial Obstetrics and Gynaecology is a multidisciplinary association devoted to furthering understanding of the psychosocial aspects of health, particularly in the field of obstetrics, gynaecology and reproductive medicine.

The strength of the Society is its multidisciplinary membership and its informal, supportive meetings that foster interest in communication, counselling and psychosocial aspects of health. The Society welcomes health workers from all disciplines, e.g. medicine, midwifery, nursing, psychology, social work, social sciences, etc.

The Society holds a national congress that moves yearly between states and sometimes offshore. The topics debated reflect the Society's breadth of interests, including psychosocial aspects of puberty, fertility and infertility, contraception, pregnancy, menopause and men's reproductive health.

The **objectives** of ASPOG are

- To promote the scholarly, scientific and clinical study of the psychosomatic aspects of obstetrics and gynaecology including reproductive medicine
- To promote scientific research into psychosocial problems of obstetrics and gynaecology
- To promote scientific programs designed to increase awareness of and understanding of psychosomatic problems affecting women and men during their reproductive years.

Conference Manager

Ms Bianca Scarlett

Scarlett Events

PO Box 198

Welland SA 5008

P: 08 8346 0805

F: 08 8347 1072

E: bianca@scarlettevents.com.au

Artwork

ASPOG wishes to acknowledge the authors of the works reproduced in the registration brochure - Sculpture by Michael Meszaros and Artwork by Kylie A Bird.

Airport Transfers

A taxi fare between Melbourne Airport and the Royal Women's Hospital is approximately \$50. SkyBus (www.skybus.com.au) offers an express bus service from the airport to the city centre. This service operates 24/7, including all public holidays. Buses run from every 10 minutes throughout the day. \$16 per person one way and return \$26.

On arrival at Southern Cross Station in the city, SkyBus provides a complimentary hotel transfer service, subject to availability, during the following hours:
0600-2200 Monday to Friday; 0730-1730 Saturday and Sunday

Certificates of Attendance and CPD points

If you require a certificate of attendance, please ask the registration desk.

RANZCOG

This meeting has been approved as a RANZCOG approved O&G Meeting and eligible Fellows of this College will earn CPD points for attendance as follows:

Full attendance 13 points (Conference Only)

30 July 2010 7 points

31 July 2010 7 points

RACGP

This Meeting has been allocated QA&CPD points and eligible fellow of this College will earn CPD Points for attendance as follows:

30 July 2010 10 points

31 July 2010 12 points

ACRRM

This Meeting has been approved with ACRRM for 12 ALS, PDP points for full attendance.

Points for day attendance as follows:

30 July 2010 7 points

31 July 2010 6 points

Dietary Requirements

If you have dietary requirements and have indicated this on your registration form, they have been passed onto the caterers. Please make yourself known to catering staff to ensure you have the correct meal.

Hotels

Check in/out Time for Hotels:

All hotels have a 2.00 pm check in time and an 11.00 am check out time. If you are arriving from overseas and your flight arrives before 2.00pm, you may not be able to have early access to your room. If you require early access, it may be necessary to book and pay for the accommodation from the night before.

Rydges North Melbourne

<http://www.rydges.com/hotel/0/RVNMEL/Rydges-North-Melbourne.htm>

Cnr Harker Street & Flemington Road

North Melbourne VIC 3051

Ph: 03 9329 1788

North Melbourne Apartments

<http://www.northmelbourneapartments.com/>

115 Flemington Rd

North Melbourne VIC 3032

Ph: 03 9329 3977

Liability

In case of industrial disruption or other external events causing disruption to the ASM, the Organising Committee of the ASPOG 2010 ASM accepts no responsibility for loss of monies incurred by delegates.

Name Badges / Dinner Tickets

Admission to all sessions is by the official conference name badge. Please wear it at all times throughout the conference. Tickets for the Conference Dinner are located in your registration envelope.

Post Office

The nearest Australia Post Office is located at shop 12 Royal Melbourne Hospital 300-336 Grattan Street, Parkville.

Presenters

Please bring your PowerPoint presentation with you on a CD or memory stick to be loaded onto the conference laptop. All PowerPoint presentations will need to be pre-loaded in a refreshment break at least one session before you are due to present. Andrew Standish our Audio Visual Technician will be available in the conference rooms to assist you at this time.

Registration Desk

Ms Bianca Scarlett, Conference Manager
0417 990 111

The Registration Desk will be located in foyer of the Conference Centre at the Royal Women's Hospital. It will be open at the following times:

Friday 30 July 2010	0800 – 1700
Saturday 31 July 2010	0830 – 1700

Social Functions

Conference Dinner

Derek Llewellyn-Jones Oration

This event is an annual highlight of the ASPOG dinner, which will be held at *Brisc* restaurant in North Melbourne, a short walk from the The Women's. We are delighted that this year the oration will be presented by Miss Orla McNally, Director of Oncology, Royal Women's Hospital.

Friday 30 July 2010 7 for 7.30 pm-11.30pm

Venue: Brisc Restaurant
364 Victoria Street, North Melbourne

Dress: Smart casual

Cost: **\$85** per person (not included in full registration)

Farewell Drinks and Presentation of Prizes

Saturday 31 July 2010 4.30 pm – 5.00 pm

Venue: The Royal Women's Hospital

Cost: Included in full and Saturday registration fees.

Travel Insurance

Registration fees do not include insurance of any kind. It is strongly recommended that all delegates take out their own travel and medical insurance prior to coming to the Meeting. The Organising Committee and the Secretariat will not take any responsibility for any participant failing to insure. Please seek further information from your travel agent or airline.

Visitor Information Centre

Visitor Information Centres can help you make the most of your time in Melbourne and Victoria. You'll notice them by the bright blue and yellow 'i' sign that they display. These accredited centres are open 7 days a week and they can provide you with all the information you need for your travels around Victoria.

Federation Square Cnr Flinders & Swanston Streets

2 Swanston Street St

Melbourne VIC 3000

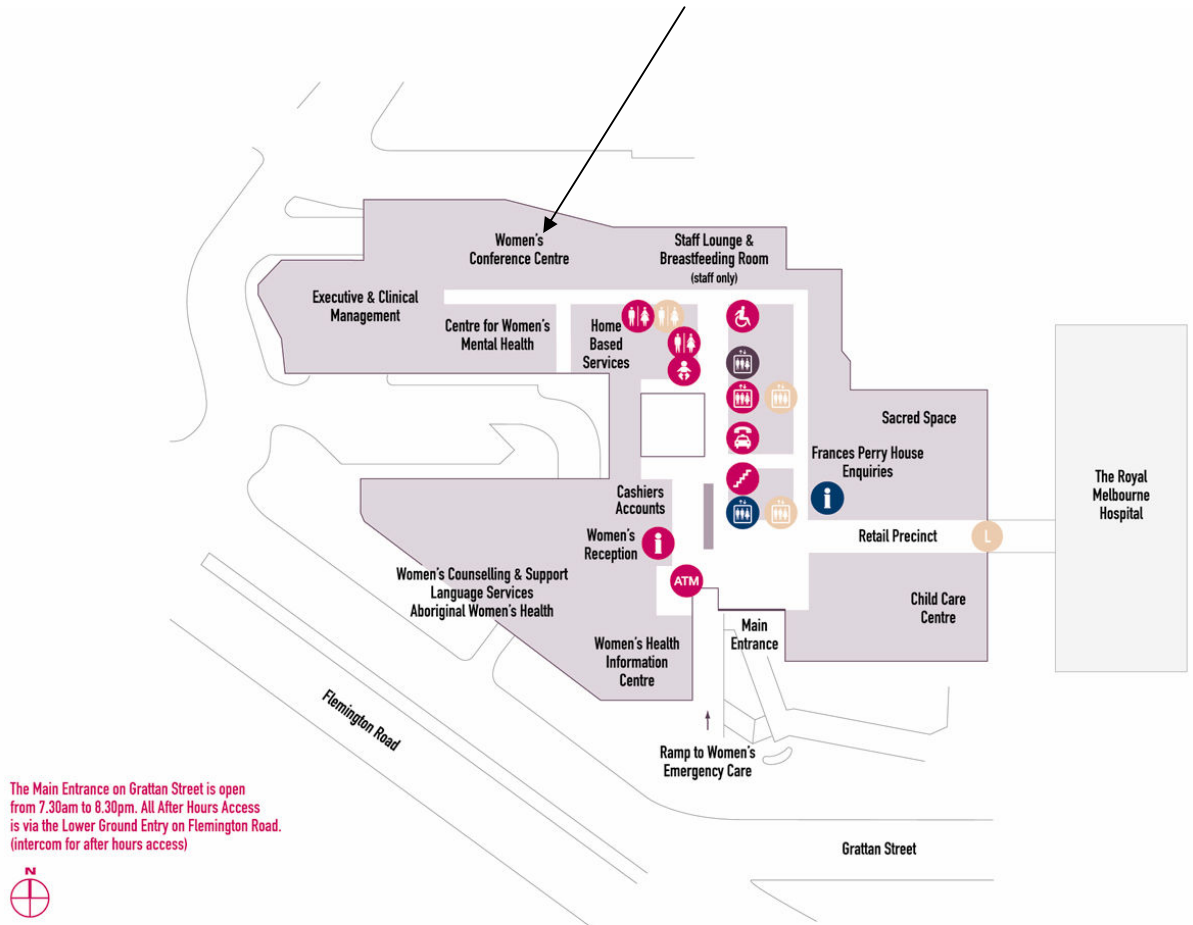
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Fax: 03 9650 7787

Web: <http://www.thatsmelbourne.com.au/touristinformation>

Disclaimer

At the time of printing, all information contained in this handbook is correct; however, the organising committee its sponsors and its agents cannot be held responsible for any changes to the final structure or content of the program, or any other general or specific information published.



Informal Display



Bayer HealthCare Bayer Schering Pharma

The **Women's HealthCare Division** of Bayer Schering Pharma has a long and proud history in providing innovative products for the benefit of Women's Health. A world leader in contraception with a range of oral contraceptives, including **Yaz**, **Yasmin**, **Microgynon** and **Valette**.

The latest oral contraceptive **Qlaira**, the first OC pill with a natural oestradiol effect and the innovative Intrauterine System, **Mirena**.

Bayer Schering Pharma are actively involved in ongoing research and continue to develop new and exciting products and services in these important therapeutic categories to assist Physicians in providing for the health of their patients.

0800	Registration Desk Opens	
0900-0915	Opening and Welcome to Country	
0915-1015	SESSION 1: FROM FRINGE TO FOREFRONT: PSYCHOSOCIAL OBSTETRICS AND GYNAECOLOGY THEN AND NOW	Conference Room A
Chair:	Dr Ann Olsson	
0915-0935	<i>The Way We Were</i> Prof Lorraine Dennerstein Office for Gender & Health Department of Psychiatry The University of Melbourne, VIC	
0935-0955	<i>What's too painful to remember – what has changed in women's health?</i> Ms Mary Draper , Consultant in health and social policy, VIC	
0955-1015	<i>Terra Nullius: Relic or Alive and Well?</i> Dr Mary Belfrage , Medical Director, Victorian Aboriginal Health Service, VIC	
1015-1045	MORNING TEA	
1045-1215	SESSION 2: BECOMING PARENTS IN SPECIAL CIRCUMSTANCES	Conference Room A
Chair:	Dr Karin Hammarberg	
1045-1105	<i>Same-sex Couples Achieving Parenting in a Shifting Socio-legal Environment</i> Dr Ruth McNair , Senior Lecturer, Department of General Practice, University of Melbourne, VIC	
1105-1125	<i>Experiences of Australian Lesbian and Gay Foster Carers</i> Dr Damien Riggs , ARC Postdoctoral Fellow, School of Psychology, University of Adelaide, SA	
1125-1145	<i>Reproductive Options for People Who Are Single, Lesbian or HIV-infected</i> Dr Penny Foster , Fertility Specialist, Melbourne IVF and Chronic Viral Illness Clinic Royal Women's Hospital, VIC	
1145-1205	<i>Can You See What I See? Indigenous Women and Maternity Services</i> Dr Paddy Moore , Obstetrician and Gynaecologist Mercy Hospital for Women, Visiting Gynaecologist, Austin Health and Royal Children's Hospital Melbourne, VIC	
1215-1330	LUNCH	
1245	HOSPITAL TOURS	
1330-1415	SESSION 3: INTEGRATING PSYCHOSOCIAL DIMENSIONS OF CARE	Conference Room A
Chair:	Ms Mary Draper	
1330- 1350	<i>The Road to Aboriginal Women's Wellness</i> Ms Marika Kalargyros , Senior Aboriginal Education and Support Worker, Aboriginal Women's Health Business Unit, The Royal Women's Hospital, VIC	
1350-1410	<i>Not One Without the Other: Clients & Clinicians as Members of an Interdisciplinary Team</i> Ms Sherrie Martin , Senior Clinician, Gynaecology & Student Unit Coordinator, Women's Social Support Services, The Royal Women's Hospital, VIC	

1415-1500	SESSION 4: FREE COMMUNICATIONS: 4A VULVAL HEALTH	Conference Room A
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Chair: Dr Alex Marceglia

1415-1430 *Vulvodynia: A Depressed Vagina?*
St Martin, L

1430-1445 *Difficulties with Current Management of Recurrent Vulvovaginal Candidiasis*
Watson, C, Pirota, M, Myers, S, Garland, S and Fairley, C

1445-1500 *Life Events in Patients with Vulvodynia*
Plante, AF

1415-1500	SESSION 4: FREE COMMUNICATIONS: 4B DIVERSITY OF NEEDS AND RESPONSES	Conference Rooms B/C
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Chair: Dr Ruth McNair

1415-1430 *Needs for Information about Prenatal Genetic Screening in Arabic-speaking women*
Khudu, TF, Fisher, J and Rowe, H

1430-1445 *The Sexual and Reproductive Health of Women on an Opiate Therapy Replacement Program*
Black, K, Stephens, C and Lintzeris, N

1445-1500 *"Treating Everyone Fairly May Not Be Enough." Practitioners Must Challenge Their Assumptions to Improve Health Outcomes for Lesbian and Bisexual Women*
Ivory, KD, Krelle, A, Williams, HM, McNair, R

1500-1530 AFTERNOON TEA

1530-1700	SESSION 5: SEXUALITY AND BODY IMAGE	Conference Room A
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Chair: A/Prof Louise Kornman

1530-1550 *Sexuality: About Self or Other? Body Image and Relationships*
Dr Amanda Gordon, Director, Armchair Psychology Practice,
President, Division Professional Practice International Association Applied Psychology

1550-1610 *Sexual Health and Intimacy after Childbirth: Findings from the Maternal Health Study*
A/Prof Stephanie Brown,
Healthy Mothers Healthy Families, Murdoch Children's Research Institute, VIC

1610-1630 *Treating Vaginismus using a Mind / Body Model as an Educational and Management Tool*
Dr Anita Elias, Head, Sexual and Relationship Clinic, Monash Medical Centre

1630-1650 *Stats & Facts - A Two Way Perspective*
Ms Monique Baldacchino, Oncology Unit, The Royal Women's Hospital, VIC
Ms Elizabeth Williams, Registered Nurse, The Royal Women's Hospital, VIC

1700-1800	ASPOG Annual General Meeting	Conference Room A
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1900
CONFERENCE DINNER
Brisc Restaurant
364 Victoria Street, North Melbourne
<http://www.brisc.com.au/>

Derek Llewellyn-Jones Oration

Multidisciplinary Care: Holism or Reductionism?

Miss Orla McNally

Clinical Director of Gynaecology Oncology and Dysplasia, Royal Women's Hospital

0800	Registration Desk Opens	
0900-0955	SESSION 6: YOUNG WOMEN AND FERTILITY	Conference Room A
Chair:	Dr Jackie Stacy	
0900-0920	<i>Polycystic Ovarian Syndrome, Obesity and Self Esteem</i> Dr Rachael Knight , Fertility Specialist, Melbourne IVF and Royal Women's Hospital, VIC	
0920-0950	<i>Threats to Fertility for Young Women</i> Dr Kate Stern , Fertility Specialist and Gynaecologist, Head of Clinical Research Melbourne IVF; Head, Endocrine and Metabolic Service, Royal Women's Hospital Melbourne IVF, VIC	
0955-1055	SESSION 7: FREE COMMUNICATIONS 7A: STUDIES OF NEW PARENTS AND THEIR EXPERIENCES	Conference Room A
Chair:	Prof John Condon	
0955-1010	<i>Childbirth and the First Encounter with a Newborn after Assisted Conception: Findings from the Parental Age and Transition to Parenthood Australia (PATPA) study</i> Fisher, J , Hammarberg, K, Wynter, K, McMahon, C, Gibson, F, Boivin, J, Saunders, D and Berg, T	
1010-1025	<i>Physiotherapy-based Exercise Together with Allied Health Education: Its Effect on New Mothers' Well-being and Depressive Symptoms</i> Ashby, E, Galea, MP and Sherburn, M	
1025-1040	<i>Mental Health of Women and Men Six Months Postpartum: A Community Study of First-time Parents</i> Wynter, K , Fisher, J and Rowe, H	
1040-1055	<i>Maternal Employment Following Childbirth: The Role of the Mother-infant Relationship</i> Cooklin, AR , Fisher, JRW and Rowe, HJ	
0955-1055	SESSION 7: FREE COMMUNICATIONS 7B: ON CARE AND EXPERIENCE	Conference Rooms B/C
Chair:	Dr Suzanne Abraham	
0955-1010	<i>Caring for Clients with Complex Presentations and Chronic Pelvic Pain</i> St Martin, L	
1010-1025	<i>Breaking New Ground: Creative Arts Therapy in the Field of Obstetrics and Gynecology</i> Ong, T	
1025-1040	<i>Experiencing an Obstetric Rectovaginal Fistula: An Australian Perspective</i> Thompson, J , Haseler, S, Powell, W, WHA Clinical Forum Expert Reference Group	
1040-1055	<i>Withdrawn</i>	
1055-1115	MORNING TEA	

1115-1235	SESSION 8: SEXUAL ABUSE AND ASSAULT	Conference Room A
Chair:	Dr Heather Rowe	
1115-1135	<i>To Screen or Not to Screen?</i> Dr Britt Olsen , General Practitioner, Geelong, VIC	
1135-1155	<i>It's not over, when it's over : The lasting impacts of Indigenous sexual assault and its Implications for health policy and service delivery</i> Dr Kyllie Cripps , Senior Lecturer, Faculty of Law, The University of New South Wales,	
1155-1215	<i>Motherhood and Abuse</i> Prof Louise Newman , Director of the Monash University, Centre for Developmental Psychiatry and Psychology, VIC	
1215-1227	<i>Trauma and the Childbearing Year: A Phase-Two Trial of a Psycho-educational Intervention for Expectant Mothers with Abuse-Related Posttraumatic Stress Disorder</i> Harris, A , Rowe, H, Fisher, J, Seng, J Free Communication	
1235-1330	LUNCH	
1330-1440	SESSION 9: CURRENT CONTROVERSIES 1: SCREENING AND WELL WOMEN	Conference Room A
Chair:	Prof Jane Fisher	
1330-1345	<i>Is There a Future for Chlamydia Screening in Australia?</i> Dr Jane Hocking , Senior Research Fellow, Centre for Women's Health Gender and Society, University of Melbourne, VIC	
1345-1400	<i>Impact of New STIs in Screening</i> Dr Alex Marceglia , Sexual Health Physician, Choices Clinic and Dysplasia Service, Royal Women's Hospital, Sexual Health Physician, General Clinic, Melbourne Sexual Health Centre, Alfred Health, VIC	
1400-1415	<i>A Nationwide Response to Antenatal and Postnatal Depression</i> Highet, N , Purtell, C, Komen, R. <i>beyondblue</i> Free Communication	
1415-1430	<i>Improving Perinatal Mental Health: Why a Focus on Screening Misses the Point</i> Prof Rhonda Small , Director, Mother and Child Health Research, La Trobe University, VIC	
1440-1510	AFTERNOON TEA	

1510-1630	SESSION 10: CURRENT CONTROVERSIES 2: THE FUTURE OF THE CERVIX	Conference Room A
Chair:	Dr Chris Bayly	
	SESSION MODERATOR: Dr David Wrede Consultant Gynaecologist and Lead for Dysplasia, Royal Women's Hospital, VIC	
1510-1525	<i>Australia's Screening Guidelines and the Impact of HPV Vaccination on the Australian Cervical Screening Program</i> A/Prof Marian Saville , Executive Director of the Victorian Cytology Service, VIC	
1525-1540	<i>Fertility-Sparing Surgery for Cervical Cancer</i> Prof Michael Quinn , Professor, Department of Obstetrics and Gynaecology, University of Melbourne, Consultant Oncology/Dysplasia Unit, Royal Women's Hospital, VIC	
1540-1555	<i>Subtotal Hysterectomy and Sexuality</i> Dr Catarina Ang , Head of Unit, Gynaecology Unit 1 (Menstrual Disorders) Royal Women's Hospital, VIC	
1555-1610	<i>Psychological Aspects of Cervical Cancer</i> Dr Christina Bryant , Senior Lecturer in Clinical Psychology, Centre for Women's Mental Health, Royal Women's Hospital and Department of Psychological Sciences, University of Melbourne, Royal Women's Hospital, VIC	
1630-1700	FAREWELL DRINKS AND PRESENTATION OF PRIZES	

The Way We Were

Prof Lorraine Dennerstein

Professorial Fellow, National Ageing Research Institute and Dept of Psychiatry, The University of Melbourne, VIC

In the early 1970s Dr Roger Wurm, a South Australian gynaecologist, organized the first Australian multidisciplinary meeting with a focus on the psychological aspects of obstetrics and gynecology. He had been stimulated to do so by attending meetings of The International Society for Psychosomatic Obstetrics and Gynaecology. The first meeting was attended by obstetricians and gynaecologists, general practitioners, psychiatrists and psychologists. Out of this first South Australian meeting the Australian Society for Psychosomatic Obstetrics and Gynaecology (ASPOG) was born and formalized at the second conference in Melbourne in 1975.

The term psychosomatic was first used to refer to a small group of diseases where psychological factors such as stress were shown to produce organic disease. Over the 20th century the meaning of the term changed. Colloquially the term was understood by many to refer to patients who complained of somatic symptoms where no organic disease could be shown. Sometimes the term was used with pejorative undercurrents. Increasingly, however, by the 1970s, amongst a small coterie of clinicians and researchers new understanding of the term psychosomatic had developed. Psychosomatic was used to refer to the role of psychological and social factors in health conditions. ASPOG subsequently went through a name change to the Australian Society for Psychosocial Obstetrics and Gynaecology. As medical science evolved, the term holistic has virtually replaced the term psychosomatic.

During the first years of the meetings of ASPOG, the society's congresses were the only meetings in Australia where there was sustained scientific multidisciplinary focus on disorders now subsumed under the spectrum of women's health. These included psychosocial aspects of health conditions associated with menstrual cycle, contraception, pregnancy, childbirth and postpartum, infertility and menopause. Society meetings also included the emerging fields of sexual dysfunction and sex therapy. Scientific exchanges and collaborations were auspiced by ASPOG. In 1985 a joint Australian-American ASPOG meeting was held in Hawaii. ASPOG's energy was recognized by ISPOG with the award of the international congress and presidency to Australia in 1986. The Journal of Psychosomatic Obstetrics and Gynaecology was developed in the 1980s with an Australian co-editor.

Both ISPOG and ASPOG have since suffered a decline in membership. In my view this has come about because of the development of international and national scientific societies specializing in single areas of women's health. These have included: the menopause (AMS, IMS and NAMS); pregnancy and postpartum mental health (Marce Society); and sexual dysfunction (ISSM, ESSM, ISSWSH). There has also been the development of societies and congresses focusing on women's health and women's mental health. Specialist societies have become the preferred focus of research scientists and have attracted specialist clinicians. Some of these societies also provide accrediting courses.

Where to now? Is there still a role for ASPOG? That is for you to decide.

What's too painful to remember – what has changed in women's health?

Ms Mary Draper

Consultant in Health and Social Policy, VIC

The Women's Health movement and changes in professional interest have seen a social model of women's health incorporated into understandings of women's health and the provision of health services. The World Health Organization has acknowledged that the economic, social, political and cultural attributes and opportunities associated with being female can impact on women's health status. This paper will discuss progress in incorporating psychosocial aspects of women's lives and gender concerns in provision of health services with particular reference to obstetrics and gynaecology.

Terra nullius: Relic or Alive and Well?

Dr Mary Belfrage

Medical Director, Victorian Aboriginal Health Service, VIC

In this paper I will explore some of the symbolic dimensions of *terra nullius* and how the terms of the original territorial claim on Australia paved the way for relationships between Aboriginal and non-Aboriginal people as a defining aspect of Australian society and culture. Although never morally accepted by many non-Aboriginal people and clearly always an affront to Aboriginal people, *terra nullius* created a legal, moral and emotional landscape that has influenced realms such as identity, policy & resource allocation, and design & delivery of health services.

Same-sex Couples Achieving Parenting in a Shifting Socio-legal Environment

Dr Ruth McNair

Senior Lecturer, Department of General Practice, University of Melbourne, VIC

Social inclusion and acceptance is an important ingredient for the wellbeing of any prospective or current parent. For same-sex couples embarking on this journey, acceptance of their decision to parent together is by no means guaranteed. They can face misunderstanding or even overt opposition from families of origin, friends, colleagues, healthcare providers and complete strangers. However, attitudes to same-sex parenting have shifted enormously over the last decade as evidenced by the media response to activism around improving access to ART and parenting recognition for this group. Largely as a result, waves of legislative reform have occurred around Australia, following international trends to remove discrimination on the basis of sexual orientation.

There is international evidence that inclusive legislation in terms of same-sex marriage and parenting recognition can improve the wellbeing of same-sex couples and their children. This presentation will focus on the psychosocial impacts on same-sex families of negotiating this socio-legal environment, and on factors assisting their resilience. The health care provider's role in enabling inclusion and resilience will also be outlined.

Experiences of Australian Lesbian and Gay Foster Carers

Dr Damien W. Riggs

Flinders University, Adelaide

Whilst a growing number of Australian foster care agencies are actively recruiting lesbians and gay men as potential foster carers, few agencies have guidelines or policies for working with this population. Similarly, whilst there is a growing body of research on the experiences of Australian lesbian and gay parents, little of this research has focused on the experiences of lesbian and gay foster parents. The research reported here sought to address these two shortfalls by exploring the experiences of lesbian and gay foster carers. Drawing on both online surveys and interviews conducted with lesbian and gay foster carers across four Australian states, the analysis found that lesbian and gay foster carers experience ongoing support needs not currently met within foster care systems. Specifically, carers reported requiring considerable skill when negotiating placements due to an awareness of the relatively tenuous position that they hold within foster care systems. Many spoke of an overarching narrative of 'justified suspicion' when it came to engaging with agency workers, and that for some carers the support of other carers in similar positions was vital to managing the considerable stress arising from the effects of homophobia. Yet despite these challenges, lesbian and gay carers spoke in general of the unique and important skills they bring to care provision, and the child focus they bring to their parenting. These findings suggest that whilst guidelines are essential for providing a policy framework for working with lesbian and gay foster carers that protects their wellbeing, agencies need to go beyond the production of simple check lists for working with lesbian and gay carers so as to 1) challenge heteronormativity, 2) move beyond a liberal inclusive model, and 3) recognise the broader social contexts in which both carers and agency workers operate, which function to constrain the lives of lesbian and gay carers and the children in their care.

Reproductive Options for People Who Are Single, Lesbian or HIV-infected

Dr Penny Foster

Fertility Specialist, Melbourne IVF and Chronic Viral Illness Clinic Royal Women's Hospital, VIC

Single women and women in lesbian relationships now have increased access to treatment with clinic-recruited (anonymous) donor sperm, as well as continuing access to existing recipient-recruited (known) donor sperm programmes.

Treatment may involve self-insemination, medical intra-uterine insemination (IUI), or IVF/ICSI.

A diagnosis of 'Medical Infertility' is required for Medicare funding of IUI or IVF/ICSI.

HIV- positive men and women and their partners wishing to conceive may access assisted reproductive treatment through the Chronic Viral Illness Clinic at the Royal Women's Hospital, which offers a risk-minimisation programme in suitable couples/people to reduce the risk of transmission of HIV to the partner/offspring.

"Can You See What I See" The Challenge of Negotiating Appropriate Maternity Services for Indigenous Women

Dr Paddy Moore

Obstetrician and Gynaecologist Mercy Hospital for Women, Visiting Gynaecologist Austin Health and Royal Children's Hospital Melbourne, VIC

How do we provide appropriate care for Aboriginal and Torres Straight Island women attending mainstream services?

The experiences of clients and colleagues in 1 multidisciplinary clinic are shared to illustrate the challenges faced and insights gained.

Paddy will be joined by indigenous artist Safina Fergie who will introduce her art work "Can you see what I see" commissioned to stimulate and educate non indigenous health workers .

The Road to Aboriginal Women's Wellness

Ms Marika Kalargyros,

Senior Aboriginal Education and Support Worker, Aboriginal Women's Health Business Unit, The Royal Women's Hospital, VIC

The long history that the Women's carries with it is one that is embedded within hospital culture and has contributed to issues that Aboriginal people face when accessing mainstream health services. Historically hospitals have been seen by Aboriginal people as places of death and despair, and where Aboriginal babies were removed from families under past government policy. Access to 1st class healthcare in the 'lucky' country has not been equitable for Aboriginal people. As a result the health of Aboriginal people has suffered. Understanding issues of the past and present together with contemporary Indigenous culture is a great starting point when considering what will help to forge a more positive experience for Aboriginal patients. Applying this to a mainstream institute such as the Women's Hospital poses a challenge that by no means ends anytime soon. The Women's has invested resources over the last 12 years in order to address issues of access and equity and forge a strong commitment towards reconciliation and closing the gap.

Not One Without the Other: Clients & Clinicians as Members of an Interdisciplinary Team

Ms Sherrie Martin

Senior Clinician, Gynaecology & Student Unit Coordinator, Women's Social Support Services, The Royal Women's Hospital, VIC

The social worker's role in a healthcare setting is integral in creating an environment that is accepting, non-judgmental and safe. As members of an interdisciplinary team, social work training, expertise and use of self makes us uniquely qualified to engage with women, breaking down barriers to increase access to much needed healthcare services.

Working within the social model of health framework and performing complex psychosocial assessments and interventions, social workers in Women's Social Support Services create safe environments for women who access intimate women's health, gynaecological, obstetric, neonatal, and oncology services. Accessing these services is often made more difficult against the backdrop of women's personal biographies. Their biographies can include racism, poverty, and trauma as refugees of political conflict, as well as cultural practices which can have adverse health affects, sexual abuse, domestic, family, community and other forms of violence.

This paper aims to situate both clinicians and the women we serve in a specialized relationship which calls upon the rich diversity of both client and clinician as members of an interdisciplinary team, to perform an integrated effort with the goal of achieving positive health outcomes for women, their families, and communities.

Vulvodynia: A Depressed Vagina?

Leena St Martin

*Clinical Psychologist, Gynaecology Outpatients Department, Greenlane Clinical Centre
Auckland District Health Board, Auckland, New Zealand*

Vulvodynia is a chronic pain syndrome of the vulvar area not due to any infectious, dermatological, metabolic, autoimmune or neoplastic process. Causes can be multifactorial and the involvement of a multidisciplinary team is usually indicated.

In this paper I consider the psychological and emotional aspects of vulvodynia by describing my work as a clinical psychologist with women attending a gynaecology outpatient clinic.

“The submitted abstract does not report on research using human participants”

Difficulties with Current Management of Recurrent Vulvovaginal Candidiasis

Watson, C (1), Pirotta, M (2), Myers, S (3), Garland, S (4), Fairley, C (5)

1, *Royal Women's Hospital; University of Melbourne, Melbourne,*

2, 5. *University of Melbourne, Melbourne,*

3. *Southern Cross University, Lismore,*

4. *Royal Women's Hospital, Melbourne*

Vulvovaginal candidiasis (thrush, or VVC) is a condition that affects many women, with around 75% experiencing the condition in their lifetime. A further 5-10% will experience recurrent thrush, which is defined as 4 or more episodes in a 12 month period.

Recurrent VVC is not easily managed, and long term treatment is currently recommended. This treatment using antimycotics is expensive, costing up to \$900 for a six month treatment regimen. Some women experience side effects, and around half experience recurrences within six months of ceasing treatment. Recurrent VVC is often largely under-reported, as women often use over the counter medications and may not seek medical advice. The impact of this condition is often underestimated by clinicians.

The physical symptoms of recurrent VVC can be distressing and embarrassing, and women are often frustrated by conflicting advice received. Much of the current literature in the area ignores the psychological impact of the condition. Most look at the clinical manifestations, diagnosis, and treatment, and the psychological effect that results is often presented as a post-script, if at all. While many studies acknowledge the resulting anxiety, others suggest that when the diagnosis is unconfirmed, women exaggerate their symptoms in order to gain attention. The impact of the condition is often described in terms of health dollar costs and many papers neglect to explore its multi-faceted nature and how it affects women, their partners and their families.

Acknowledging the growing popularity of using complementary and alternative medicine in this condition and how these therapies are under-represented in the medical literature, the author will present her current project and explore how this study will add to the body of knowledge in this area, providing women and clinicians with more information. Using methods including a randomised controlled trial and participant questionnaire, physical as well as emotional issues in the area of recurrent VVC will be explored.

This abstract reports on research using human participants with approval from an Institutional Human Research Ethics Committee.

Life Events in Patients with Vulvodynia

A-F Plante

Royal Women's Hospital, Melbourne, VIC

Background: Vulval pain, in the absence of identified pathology, may have a psychological basis. This may have its roots in early life events.

Methods: An audit with a structured questionnaire was applied to all patients with vulvodynia as their primary symptom presenting to a physiotherapist specialising in pelvic floor disorders. Control patients consisted of women from the same private practice being treated for urinary tract disorders or post-childbirth routine physiotherapy, and who had no vulval pain on direct questioning. Questions included information on the patient's symptoms as well as early life events.

Results: 78 consecutive women presenting with vulvodynia (mean age 34 years, mean duration of symptoms 48 months), and 78 controls (mean age 39), were studied. A similar proportion of both groups were married. Adverse current or previous relationships (39% v 9%, $p=.0007$), parental divorce (26% v 9%, $p=.0007$), and work difficulties (19% v 9% $p=.0215$) were more common in patients than controls. Aspects of being a victim: life time incidence of physical assault (31% v 19%, $p=.0272$), intra-family physical violence and neglect (12% v 6%, $p=.0046$), and exposure to an exhibitionist (19% v 12%, $p=.0847$), were all more common in vulvodynia patients than controls. A history of sexual abuse was not more common in vulvodynia patients compared to controls (13% v 10%, $p=0.49$ NS). Lack of libido was common in vulvodynia patients (94% v 29%, $p=.000$).

Conclusions: Violence and conflict are common factors in patients with vulvodynia. These factors are likely to mediate the genesis of pain through stress-related mechanisms. Sexual interest is diminished in these patients. Sexual abuse is not a factor in most of these patients. These findings have implications for treatment.

Notes:

Needs for Information about Prenatal Genetic Screening in Arabic-speaking Women

Tshepo Fiona Khudu, Associate Professor Jane Fisher, Dr. Heather Rowe
Centre for Women's Health, Gender and Society, University of Melbourne, Melbourne.

Background and Aims: Providing ethical and culturally appropriate prenatal genetic screening (PGS) services for culturally and linguistically diverse (CALD) communities has proven difficult in western countries that have become increasingly multicultural. Little is known specifically about Arabic-speaking women's views and needs regarding PGS in Australia, which are addressed in this study.

Methods: Focus group discussions with 15 Arabic-speaking women, who had given birth in Australia since 2005 and attended playgroups in Melbourne, were used. Data were analysed by discourse analysis.

Results: The findings challenge stereotypes. Arabic-speaking women are not a homogenous group. They are diverse in countries of origin, religion, culture and language. Decision-making about PGS is collaborative, with little evidence of paternalism from male relatives. Health care was experienced as unsatisfactory in some ways. PGS was offered as part of routine care, with little information and explanation, and questionable elicitation of informed consent in some settings. There were disparities in quality of services between metropolitan hospitals and community clinics. Health professionals provided unbalanced information about Down Syndrome (DS) at times, focussing disproportionately on negative consequences. There were insufficient Arabic language information resources and interpreting services were perceived as somewhat inadequate. Disclosure of soft markers during ultrasound was confusing and distressing for some women.

Recommendations: Cultural competence in PGS service can be achieved by avoiding stereotypes. Arabic-speaking women share some common cultural and religious values, but are diverse. The provision of high quality PGS and equity in those services is likely to be improved by facilitating informed choices, allowing sufficient time to explain PGS and giving women the opportunity to express their understanding. The professional training of doctors in community clinics is important in enabling equity of PGS services.

The submitted abstract reports on research using human participants with approval from The University of Melbourne Human Research Ethics Committee, and permission sought from the Victorian Co-operative on Children's Services for Ethnic groups for access to the playgroups.

Notes:

The Sexual and Reproductive Health of Women on an Opiate Therapy Replacement Program

Kirsten Black (1)*, Christine Stephens (2) Nicholas Lintzeris (3)

(1) *Department of Obstetrics and Gynaecology, The University of Sydney*

(2) *Sydney South West Area Health Service, Sydney*

(3) *South Eastern Sydney and Illawarra Area Health Service*

Background: Women account for approximately 30–40% of clients attending drug health services, but at both a national and international level there is dearth of research regarding their unique health requirements. This study aimed to identify the sexual and reproductive health needs of women attending drug health services for treatment of their substance use.

Methods; Women enrolled in public opioid treatment programs (OTP) within the Sydney West Area Health Service (SSWAHS) were asked to self-complete questionnaires about their past and present sexual health history and health service usage. The study was undertaken with a grant from NSW Health and was approved by the SSWAHS Ethics Committee.

Results: 204 women completed the questionnaire. Over half of women had attended a health service in the last 12 months for a women's health issue (58.7%; 118). When asked where they would ideally like to access services for their women's health issues, the participants expressed diverse preferences. Some nominated their GP and others wanted their OTP to provide a women's health service. 163 women (79.9%) reported they had had sex with a man in the last year. Of those, 30 reported having sex for money (18.4%), 19 (11.6%) for drugs and close to half whilst intoxicated (72; 44.1%). Women had poor uptake of contraception and very low utilisation of reliable contraception methods. They had high pregnancy rates, with almost 30% of women reporting 6 or more pregnancies and higher than national rates of adverse pregnancy outcomes (miscarriage, termination, and stillbirth).

Conclusion: Findings from this study indicate that women in drug service have unaddressed reproductive health needs and that screening for women's health issues should be routinely performed for all women in OTP programs. Referral pathways should ideally involve a variety of services, including generalist (primary care) and specialist (sexual health, family planning and gynaecology) health services.

Notes:

“Treating Everyone Fairly May Not be Enough.” Practitioners Must Challenge Their Assumptions to Improve Health Outcomes for Lesbian and Bisexual Women

Ivory, KD* (1), Krelle, A (2), Williams, HM (3), McNair, R (4)

(1) Senior Medical Officer, Family Planning Victoria, Melbourne

(2) Manager, Manager Practice & Learning, Centre for Adolescent Health, Melbourne

(3) Senior Lecturer, School of Population Health, University of Melbourne, Melbourne

(4) Senior Lecturer, Department of General Practice, University of Melbourne, Melbourne

The importance of practitioner cultural competency in healthcare is reflected in undergraduate curricula and workforce training. However, cultural competency training about people from sexual minorities, especially lesbian and bisexual women, is minimal despite significant data indicating negative health outcomes in this population as a result of discrimination and exclusion.

Physician failure to communicate effectively with patients is associated with lower patient satisfaction and poorer health outcomes, including delays in seeking further care, and non-disclosure of important health information,

Current medical education encourages neutrality among doctors and tends to overemphasise understanding the “other” (minority group) without examining the embedded assumption of the “normality” of the dominant group. However, medicine does have a culture and the objective practice of medicine is not socially and politically neutral.

This paper presents the results of a recently completed evaluation of cultural competency training for health practitioners on working with sexual minorities. Both the literature, and the data from our study, show practitioners must face their own biases to improve client encounters and outcomes. While most parameters showed positive change after the training, data collected two months later highlighted some of the difficulties practitioners face translating training into practice and the power of institutionalized heterosexism. These issues deserve further attention to achieve real change in client health outcomes.

Our data show practitioners can improve their cultural competency towards clients from sexual minorities. This paper will highlight why practitioners need to move beyond neutral in order to improve outcomes for lesbian and bisexual women’s sexual and reproductive health, and demonstrate ways in which that understanding may be achieved and supported in the workplace to further improve access to health services for this high-risk group

This project has ethical approval from the University of Melbourne, School of Population Health Human Ethics Advisory Group

Notes:

Sexuality: About Self or Other? Body Image and Relationships

Dr Amanda Gordon

Director, Armchair Psychology Practice, President, Division Professional Practice International Association Applied Psychology

There is no doubt that many factors contribute to a woman's sexuality, including her physical health and status. Although in primitive societies sexual instinct and social mores guided sexual behavior, it could be argued that in the western world in the twenty first century many other things come into play. For example, girls learn to make judgments about themselves and their own bodies at a very young age, and their sense of themselves as sexual beings is based on those judgments. Further, sex has become such a commodity that it can be hard to relate to the idea of sexuality as being of oneself. Young girls are being sexualized by the media while very young, so that they have little connection with the ideas that are being conveyed about sex and sexual behavior. Sexuality is thus a complex issue, determined by factors beyond the consciousness of individuals, yet affecting their behavior and their relationships significantly.

"If sexiness is equivalent to a particular body shape and type, and if I don't have that body, am I sexy?"

"How do I convince a potential partner that I am sexy when obviously my body isn't?"

"If I eat in certain ways, or purge my body, or exercise incessantly, or have surgical enhancements, my body will be different and I will be/feel sexy"

Such uncertainties influence women's ability to make relationships that are true, and impact upon communication that could enhance sexual satisfaction and joy. Such self-doubt also undermines many relationships that could be the source of such joy and growth.

Sexual Health and Intimacy after Childbirth: Findings from the Maternal Health Study

A/Prof Stephanie Brown

Healthy Mothers Healthy Families, Murdoch Children's Research Institute, VIC

Background: While much has been written about emotional aspects of pregnancy and childbirth, there is very little information available about ways in which pregnancy and birth affects sex and intimacy between couples. As a result many couples are under-prepared for the extent of change during and after pregnancy.

Study design: In the Maternal Health Study, data has been collected from 1507 first time mothers from early pregnancy to when their first child is four and a half years old. A sub-group of women agreed to take part in an in depth interview focusing on sexual health and intimacy.

Results: In late pregnancy, around 60% of women reported loss of interest in sex and 22% had not had any sexual contact in the last month. By six weeks postpartum, 40% of women had attempted to have vaginal sex, increasing to 81% by 12 weeks postpartum. The majority of women found it painful the first time they tried to have vaginal sex. At three months postpartum, tiredness was the most common issue affecting women's sex life (88%), followed by lack of time (72%) and pain or tenderness (47%). At three, six and 12 months postpartum, around 70% of women reported that they were having sex less frequently than before their pregnancy. Many women would have liked more information and support to deal with the impact of pregnancy, childbirth and the transition to motherhood on their sexual and intimate relationships.

Conclusion: It is rare for women to feel 'back to normal' by six weeks postpartum. The common perception that things should be 'back to normal' by this time puts pressure on women to resume sex by this time, and leaves many women wondering if they are abnormal for not seeing sex as a priority in the early months of parenting a newborn infant.

Treating Vaginismus using a Mind / Body Model as an Educational and Management Tool

Dr Anita Elias

Monash Medical Centre, Melbourne, The Women's Hospital, Melbourne

By the time a patient reaches a specific clinic which deals with sexual difficulties, they have often seen a number of practitioners, and been given conflicting advice. Patients are often confused about the nature or origin of their sexual symptoms, asking "Is it real or in my head?" "Is it physical or psychological?" This is especially true for vaginismus, where physical and psychological factors may both play an important role and are interlinked.

A diagrammatic flow chart was developed as an educational and management tool, and has been used by medical practitioners and psychotherapists, to explain to their patients, the importance of the Mind / Body connection, as it relates to sexual difficulties. It helps patients understand the effect of their thoughts and emotions on their physical sexual responses. It is adapted to each individual or couple in a way that is relevant to their presenting symptoms, context, past history and the dynamics operating in their relationship.

Using this model has the advantages of:

Conveying that the clinician has understood them.

Explaining the Mind / Body connection, in relation to their symptoms.

Identifying the repetitive "vicious" cycles that contribute to and exacerbate their difficulties.

Highlighting the factors, which need to be addressed in order to treat their presenting sexual difficulties.

This presentation will explain the use of this model with varying clinical case presentations, and will provide clinicians with a practical clinical tool.

Stats & Facts - A Two Way Perspective

Ms Monique Baldacchino

Oncology Unit, The Royal Women's Hospital, VIC

Ms Elizabeth Williams

Registered Nurse, The Royal Women's Hospital, VIC

The impact of a diagnosis and treatment for a breast or gynaecological cancer has a major affect on a woman's appreciation of her sexuality and body image. A project is being undertaken by two Registered Nurses who have had training in, and a passion for, addressing the mismatch between current practice and the actual needs of these women in regards to sexuality, body image and intimacy. Surveys conducted with both patients and clinicians included personal comments which strongly point to the need for a multi-dimensional approach to this subject. Also included is the personal perspective of 'the Nurse' who became 'the Patient'.

Polycystic Ovarian Syndrome, Obesity and Self Esteem

Dr Rachael Knight

Fertility Specialist, Melbourne IVF and Royal Women's Hospital, VIC

Polycystic ovarian syndrome affects 7% of the female population. Research suggests this maybe rising given the epidemic of obesity in our community. Many young women are faced with the impact of polycystic ovarian syndrome and obesity upon their medical, reproductive and psychological wellbeing. PCOS and obesity quality of life data will be presented including results from our own unit and the Royal Women's Hospital.

Threats to Fertility for Young Women

Kate Stern* (1), Franca Agresta (2), Tanya Stewart (2), Lyndon Hale (1)

*(1)Royal Women's Hospital, and Melbourne IVF, Melbourne**(2)Melbourne IVF, Melbourne*

Intrinsic fertility is maximal for young women between the ages of 25 and 30 years. After the age of 35 years, there is a progressive decline, which becomes exponential after the age of 40 years. As young women, we generally take our fertility (or potential fertility) for granted. For a variety of reasons, many women may not attempt conception till the early or mid thirties, and for some the opportunity does not present until the early forties, when there is significant compromise of ovarian function and egg quality.

Fertility is incredibly fragile, and susceptible to many threats. Lack of suitable partnering, socioeconomic considerations and career aspirations may predispose to a delay in onset of attempts to have a baby. Considerable environmental risks exist, such as smoking, alcohol and other drugs, as well as certain environmental toxins. Sexually transmitted infections, often unrecognized, may also predispose to infertility. Obesity and its metabolic associations prevail in our society and are on the increase, significantly impairing fertility, compromising the safety of pregnancy, and increasing the risk of serious cardiovascular and metabolic sequelae.

The prevalence of cancers affecting young women (approximately 1/550 women under the age of 40 years in Australia), as well as other non-malignant but serious diseases, can also compromise fertility potential. Occasionally this is because of the need for sterilizing surgery, but more often fertility is threatened by the absolute requirement for gonadotoxic chemotherapy or radiation treatment.

The concept of fertility preservation includes acknowledgement of the risks to fertility from all of the above. Therefore there is considerable focus nowadays, supported by the professional bodies involved in women's health, to raise public awareness of the dangers to fertility, and to take steps to minimize the harm. This includes a major focus on reducing the prevalence of obesity, including public education programs and support at both the primary and tertiary health care levels.

Medical fertility preservation programs provide options for preservation and protection of fertility for young women having cancer treatments. These young women can usually expect to be both cured of their disease, and be given the opportunity to have their own children.

We must continue to work towards reduction of the environmental, metabolic, societal and medical risks to fertility, and to maximize the opportunity for young women to have a robust reproductive future.

Childbirth and the First Encounter with a Newborn After Assisted Conception: Findings From the Parental Age and Transition to Parenthood Australia (PATPA) Study

Jane Fisher¹, Karin Hammarberg¹, Karen Wynter¹, Catherine McMahon², Frances Gibson², Jacky Boivin³, Douglas Saunders⁴, Turi Berg¹

¹Centre for Women's Health, Gender and Society, Melbourne School of Population Health, The University of Melbourne; ²Australia Institute of Early Childhood & Psychology Department, Macquarie University, Sydney, Australia; ³Psychology Department, Cardiff University, UK, ⁴IVFAustralia, Sydney, Australia

Aim: The aim of the PATPA study was to investigate the separate and combined effects of maternal age and mode of conception on early adjustment to parenthood. It is a controlled prospective study examining the bio-psychosocial determinants of postnatal mental health.

Method: Participants were 592 first-time mothers, aged between 20 and 51 years, and their infants; 297 (50%) had conceived through ART (ARTC). At four months postpartum mothers completed a structured interview and self report questionnaire which included information about childbirth, the Edinburgh Postnatal Depression Scale (EPDS) and the First Contact Index (FCI) which assesses three dimensions of mothers' first encounter with their newborns: interval between birth and first holding, duration of first holding, and emotional appraisal.

Results: Significantly more ARTC mothers (49%) had Caesarean births than SC mothers (38%), $p=0.012$. Mean FCI scores indicate that women who had had Caesarean births reported significantly poorer quantity and quality of first contact with their newborn than women who had vaginal births ($p<0.001$). Regardless of mode of delivery, ARTC women reported significantly poorer quantity and quality of first contact with their newborn than SC women ($p=0.004$). Higher quality first contact (FCI scores) was associated with significantly lower levels of depressive symptoms (EPDS scores), $p=0.004$.

Conclusion: It is important for clinicians to be aware that ART conception may be associated with lower quality first contact between a mother and her newborn, which in turn is associated with symptoms of postnatal depression and anxiety.

This study was conducted with the approval of the Royal Women's Hospital Research and Ethics Committees, the University of Melbourne's Human Research Ethics Committee; the Macquarie University Human Research Ethics Committee, the St George's Hospital Ethics Committee and the Royal North Shore Hospital Ethics Committee.

Physiotherapy-based Exercise Together with Allied Health Education: Its Effect on New Mothers' Well-being and Depressive Symptoms.

Ashby E^{1,2}, Galea MP², Sherburn M^{2,3}

1 Angliss Hospital, Ferntree Gully

2 Rehabilitation Sciences Research Centre, Physiotherapy, The University of Melbourne, Parkville

3 Royal Women's Hospital, Parkville

The aim of this clinical trial was to determine the effect of the *Mother and Baby Program*, an eight week physiotherapy exercise program with allied health education, on the psychological well-being and depressive symptoms of new mothers. The outcome measures of psychological well-being, depressive symptoms and physical activity levels were collected at baseline, at the conclusion of the eight week program, then again four weeks after the program. The exercise group ($n = 62$) had significantly higher well-being scores ($p < 0.001$) and lower depressive symptoms ($p < 0.001$) post-program when compared to the control group ($n = 70$). The proportion of women in the exercise group who were at risk of Post-natal Depression at baseline had reduced by 50% post-program. Results revealed that the well-being and depression scales used were well-correlated ($p = 0.003$) indicating that a high well-being score reflected low symptoms of post-natal depression. Analyses also revealed that the intervention did not significantly increase participant's physical activity levels. However, membership of the *Mother and Baby Program* was a strong predictor of well-being scores and depression symptoms. The significant results of this trial, the first of its kind, demonstrate the effectiveness of the *Mother and Baby Program*, a specialised exercise program provided by a women's health physiotherapist with allied health education, on new mothers' psychological well-being and risk of depression. This multi-disciplinary intervention can be provided at relatively little cost.

The submitted abstract reports on research using human participants with approval from an Institutional Human Research Ethics Committee.

Mental Health of Women and Men Six Months Postpartum: A Community Study of First-time Parents

Karen Wynter, Jane Fisher & Heather Rowe

Centre for Women's Health, Gender and Society, Melbourne School of Population Health, University of Melbourne

Background and Aim: Postpartum mental health studies have focused predominantly on women and on depression. Much less is known about men's postpartum mental health, and about other common mental health problems like anxiety and adjustment disorders. This study aimed to establish the prevalence of depression, anxiety and adjustment disorders in primiparous women and men in the first six months postpartum, and to identify factors which characterise co-occurring morbidity in both parents.

Method: English-speaking couples were recruited in seven local government areas in Victoria, Australia. Women and men completed separate telephone interviews four weeks and six months postpartum. At four weeks, participants completed the Vulnerability Personality Scale (VPS) and Edinburgh Postnatal Depression Scale (EPDS), and socio-demographic information was collected. At six months, the Composite International Diagnostic Interview (CIDI) was completed; the main outcome was any diagnosis of depression, anxiety or adjustment disorder in the first six months postpartum.

Results: Complete data were available for 323 couples. In 181 couples (56.0%) neither women nor men had any diagnosis of depression, anxiety or adjustment disorder. In 121 couples (37.5%) one parent (79 women and 42 men) had a diagnosis. In 21 couples (6.5%) both parents had a diagnosis. Controlling for other relevant factors, co-occurring morbidity in both parents was significantly associated with men having a vulnerable personality and lower education level and women having had a higher EPDS score at 4 weeks postpartum.

The most common diagnosis in both women and men was adjustment disorder with anxious mood, which accounted for 69% of diagnoses in women and 75% in men. Depressive disorders were far less common than anxiety disorders.

Implications: Families in which both parents are functioning poorly may be identified by assessing specific risk factors. Public health initiatives focusing on postpartum depression may miss more prevalent but relevant anxiety disorders.

Ethical Compliance: Approval to conduct the study was provided by the Department of Human Services Victoria Human Research Ethics Committee and the University of Melbourne's Human Research Ethics Committee.

Notes:

Maternal Employment Following Childbirth: The Role of the Mother-infant Relationship

Amanda R Cooklin (1,2), Jane RW Fisher(1), Heather J Rowe(1)

1. *Centre for Women's Health, Gender and Society, University of Melbourne*

2. *Parenting Research Centre, Melbourne*

Background: Forty per cent of Australian women resume employment in the first postpartum year. It is accepted that maternal and employment characteristics, including older maternal age, higher education, socio-economic advantage, and access to parental leave are associated with a return to the paid workforce. However, few studies have included the developing mother-infant relationship as salient to maternal employment decisions. The aim of this prospective study was to investigate the contribution of the mother-infant relationship, defined as maternal-infant emotional attachment, maternal separation anxiety, and breastfeeding, to maternal employment status at ten months following first childbirth.

Method: Approval to conduct the study was obtained from the Research and Ethics Committees, Royal Women's Hospital, Melbourne. A consecutive sample (n=165) of employed, pregnant women, over 18 years of age and with sufficient English to complete questionnaires were recruited from one public and one private maternity hospital. Data were collected by structured interview and self-report questionnaire in the third trimester of pregnancy, and at three and ten months postpartum. Socio-demographic, employment, and breastfeeding information were collected. Participants completed standardised assessments of Maternal Separation Anxiety (Hock et al., 1989) and mother-to infant emotional attachment (Postnatal Attachment Questionnaire, Condon et al., 1998).

Results: Continuing to breastfeed at ten months (OR = 0.22, p= 0.004) and reporting higher maternal separation anxiety (OR = 0.23, p=0.01) were independently associated with a reduced odds of employment participation at ten months postpartum when socio-demographic and employment factors were adjusted for in analyses.

Conclusion: The developing mother-infant relationship is highly salient to women's postpartum employment participation. Public and workplace policy implications include the need to enhance the length of paid maternity leave to protect breastfeeding duration and the development of optimal maternal concern about separation from her infant.

Notes:

Caring for Clients with Complex Presentations and Chronic Pelvic PainLeena St Martin*Clinical Psychologist, Gynaecology Outpatients Department, Greenlane Clinical Centre
Auckland District Health Board, Auckland, New Zealand*

In this paper I describe a theoretical and practical model which was developed to enhance the experiences of both patients with chronic pelvic pain conditions, such as endometriosis, and the staff caring for their needs within the hospital inpatient setting. This approach evolved in response to the challenges raised by a small subgroup of women who often presented in crisis with severe pain and psychosocial stressors and who did not seem to benefit from the standard approach used by staff at the time. The aim has been to facilitate faster access to acute gynaecological and pain services when these are required, to shorten length of stay in hospital, and to encourage better use of outpatient coping mechanisms.

The submitted abstract does not report on research using human participants

Breaking New Ground: Creative Arts Therapy in the Field of Obstetrics and GynecologyOng, T*Creative Arts Therapist, Melbourne, VIC*

In 2007, on completion of Master of Creative Arts Therapy Degree at R.M.I.T. University, Melbourne, and influenced by my research findings, I began to explore the idea of using the creative arts therapies in the field of obstetrics and gynecology, in particular, with women with endometriosis. At this time, I was aware of a gap in support for this group of women due the recent demise of the Endometriosis Association of Victoria. In turn, this discovery indicated that the only other forms of face-to-face support available to women with endometriosis were traditional individualistic counseling-based methods of approach.

With recent research in the endometriosis field indicating that women with endometriosis value the opportunity to network with one another, and my knowledge of the use of creative arts therapy group work for clients with chronic illnesses such as cancer - I was aware of a paucity of research material in the creative and expressive arts therapy literature relating to the use of these therapies with women with endometriosis - I began to see the potential to develop a new model of approach to support: group work using an arts-based approach.

In 2009, I developed - and implemented - a series of arts-based workshops for women with endometriosis. Over the last year, this group work has also been seeded with a number of other client groups in the field of obstetrics and gynecology: women with polycystic ovarian syndrome (PCOS), ovarian cancer, and women undergoing IVF treatment. In this presentation, using (with permission) some examples of client artwork, I will give an insight into the development of this work, and some of the outcomes of the groups.

The submitted abstract does not report on research using human participants.

Experiencing an Obstetric Rectovaginal Fistula: an Australian Perspective

Jane Thompson¹, Sally Haseler¹, Wendy Powell^{2*}, WHA Clinical Forum Expert Reference Group

1. *Women's Hospitals Australasia, Canberra*

2. *Recto Vaginal Fistula Support Network, Melbourne*

As part of its Clinical Forum Program, in 2009, Women's Hospitals Australasia (WHA) examined issues surrounding the care of women experiencing obstetric pelvic floor trauma. The aim was to share knowledge and examine best practice in prevention, assessment and management of obstetric pelvic floor trauma and resultant bladder, bowel and pelvic floor dysfunction. We identified an underexplored area: women's experience of a rectovaginal fistula in the Australian context. Fortunately, this injury is very uncommon among women giving birth in Australia. However, it can occur, particularly as a consequence of poor healing of a primary repair of a third or fourth degree perineal tear. For the woman affected, the consequences are personally devastating, debilitating and socially isolating.

In this video presentation, Wendy Powell, talks frankly of her personal experience of a rectovaginal fistula sustained following the birth of her first baby. She required twelve operations (including two types of stoma) over a period of twenty months, before her fistula was fully repaired. The impact on both her and her family was enormous. It took many months of physiotherapy, learning to live with the consequences of this injury and dealing with the psychological impact.

Several things impelled her to turn her traumatic experience into something positive: The lack of information in the initial stage; her feelings of isolation; and, coming to terms with a negative experience of childbirth. She established the Rectovaginal Fistula Support Network (RVFSN), an association to support women who sustain a fistula through childbirth. The association puts women who have had or are living with a fistula in touch with each other. They offer educational information about fistulae along with any related matters, and encourage women to seek the best possible care from a qualified medical advisor.

The submitted abstract does not report on research using human participants. The video is shown with permission of the author.

Notes:

To Screen or Not to Screen?

Dr Britt Olsen

General Practitioner, Geelong, VIC

The awareness of Childhood Sexual Abuse has increased over the past couple of decades. The body of research and documentation is growing. This tells us that the health of adult survivors can be effected in various ways. We also know that past abuse often is not disclosed.

To what extent has this evidence impacted on clinical practice? Should clinicians screen for abuse?

It's not over, when it's over : The lasting impacts of Indigenous sexual assault and its Implications for health policy and service delivery

Dr Kyllie Cripps

Senior Lecturer, Faculty of Law, The University of New South Wales, NSW

Family violence and sexual assault in Australian Indigenous communities is not a new phenomenon, it has been the subject of a number of reports of the past decade. These reports have called on the support of government to assist Indigenous community members to stop the violence. These reports have also highlighted the disproportionate incidence of sexual assault and family violence within Indigenous communities and the many complexities associated with such experiences. Over the past two years we have seen an increase in the intensity of demands for the violence to stop as shocking examples of child sexual abuse perpetrated against Indigenous children have been exposed to the public through the media. Indigenous and non-Indigenous leaders have declared the problem of sexual abuse as an 'issue of urgent national significance' demanding appropriate action and intervention. The responses, including the Northern Territory Emergency Intervention (NTER) in 2007, have largely focused on law and order measures designed to secure safety and to hold perpetrators accountable. Yet, the importance of also considering the broader health and social implications of sexual assault for Indigenous women and children is essential. This presentation will explore these issues in the Indigenous context in which sexual assault takes place. It will also consider the implications of this context for health policy and service delivery.

Motherhood and Abuse

Prof Louise Newman

Director of the Monash University, Centre for Developmental Psychiatry and Psychology, VIC

Experiences of early abuse and maltreatment can have far-reaching effects on a woman's self-representation and experiences of pregnancy and the perinatal period. Sexual abuse, neglect and attachment related trauma in childhood can result in difficulties in regulating emotional states and impulses and in forming trusting relationships. The experience of pregnancy and of forming a relationship with an infant can be directly impacted by early trauma. Women may have anxieties relating to their capacity to nurture and tolerate the dependency of the infant. Some will find pregnancy and delivery intrusive and retraumatising. Support for abused women should focus on developing capacity to develop a concept of self-as-parent and attachment figure.

Trauma and the Childbearing Year: A Phase-Two Trial of a Psycho-educational Intervention for Expectant Mothers with Abuse-Related Posttraumatic Stress DisorderHarris A. (1), Rowe H. (2), Fisher J. (3), Seng J. (4)

(1, 2, 3) Centre for Women's Health, Gender and Society, University of Melbourne, Melbourne

(4) School of Nursing and Department of Women's Studies, University of Michigan, Ann Arbor, Michigan

Background and Aim: Women with a history of sexual assault may develop posttraumatic stress symptoms which are re-triggered during pregnancy, birth and early motherhood. There are limited psychosocial interventions to support the specific needs of this vulnerable population. The Survivor Mom's Companion© (SMC) is a psycho-educational, self-study program consisting of ten modules, each followed by a 30 minute consultation with a tutor. The aim of this study is to conduct a Phase 2 trial to assess the safety, acceptability and feasibility of the SMC in antenatal settings in Melbourne, Australia and Michigan, USA.

Methods: Melbourne participants were recruited from the Royal Women's Hospital and were women who were at least 18 years old, less than 27 weeks pregnant, had a history of sexual assault or childhood abuse, and were not engaged in psychotherapy. Participants completed the SMC intervention and participated in 3 structured research interviews and an open-ended evaluation interview by telephone. Tutor-reported measures of participant distress (Subjective Units of Distress-SUDs) were collected after each tutor session, and a standardised self-report measure of PTSD symptoms (MPSS-SR) was completed after modules 2, 4, 6 and 8. The changes in these scores over time were calculated.

Results: Thirty-six women were recruited. Complete SUDs and MPSS data were available for 11 and 15 women respectively. The SUD scores were low and varied over the course of the intervention; however there was a significant decrease in MPSS scores. Responses in the evaluation interview were positive.

Conclusion: This novel psycho-educational intervention for pregnant women appears to be safe and acceptable. The findings from this preliminary trial will inform the protocol for a future randomised control trial of the SMC.

The submitted abstract reports on research using human participants with approval from an Institutional Human Research Ethics Committee.

Is There a Future for Chlamydia Screening in Australia?

Dr Jane S Hocking

Centre for Women's Health, Gender and Society, Melbourne School of Population Health, University of Melbourne, VIC

Chlamydia trachomatis is the most commonly diagnosed bacterial sexually transmitted infection in Australia; diagnosis rates have risen from 73.9 per 100,000 in 1999 to 286.6 per 100,000 in 2009 (62,682 cases in 2008). The greatest burden of chlamydia infection in Australia is among young adults with prevalence estimates of 3 to 5%. Chlamydia can cause pelvic inflammatory disease (PID) which can lead to tubal damage and subsequent infertility. As over 80% of infections are asymptomatic, screening is the main way to detect cases. However, the findings of a recent systematic review concluded that there is considerable uncertainty about whether annual screening for chlamydia is effective, and whether the benefits of screening outweigh the harms. This conclusion is supported by data from countries with widespread screening such as Sweden and Denmark, where chlamydia detection rates decreased in the early 1990s, but have increased since. The risk of PID following chlamydia seems to be much lower than originally estimated, with a recent study finding PID rates of less than 10% following untreated infection. There is also debate about whether screening reduces the body's ability to mount short-term immunity to infection, thus placing an individual at increased risk of re-infection. This is a concern considering the risk of PID increases with repeat infection and Australian studies have found re-infection rate rates of 27% per year. Further, it is also important to consider the potential psychosocial consequences for a young woman diagnosed with chlamydia and the possible negative impact on her relationships.

In response to increasing chlamydia rates and to concern about the effectiveness of screening, the Australian Department of Health and Ageing has funded a chlamydia screening randomised controlled trial to evaluate whether annual chlamydia screening can reduce the burden of chlamydia and whether it is acceptable to young adults. This presentation will review the harms and benefits of chlamydia screening and discuss the future of screening in Australia.

Impact of new STIs in screening

Dr Alex Marceglia

Royal Women's Hospital & Melbourne Sexual Health Centre, Melbourne, VIC

Mycoplasma genitalium was first described as a cause of NGU in men in 1980. Difficulties with culture held back research with the role of *M genitalium* in disease in women often being controversial. The advent of NAAT testing for *M genitalium* has led to a rapid expansion in knowledge of the role of *M genitalium* in disease in the genital tract however awareness of this organism remains poor, with *M genitalium* often being confused with *Mycoplasma hominis*, part of the normal flora of the female genital tract.

M genitalium is a sexually transmissible pathogen that is causally associated with urethritis and cervicitis. There is increasing evidence linking *M genitalium* to upper genital tract disease such as endometritis, salpingitis, pelvic inflammatory disease and tubal factor infertility. As with other STIs, and bacterial vaginosis, there is an association between *M genitalium* and HIV infection. Recent population prevalence studies reveal a rate of *M genitalium* of about 1-3% in the general population < 30 years of age, with higher rates in specific populations.

Treatment of *M genitalium* is complicated as the first line treatment, a single dose of azithromycin, is only 80%- 85% effective, requiring a test of cure. Alternative therapies are limited and not available in many settings. Increasing resistance looks to be a future problem.

The lack of a commercially available assay continues to hamper progress in research and screening for this organism.

A Nationwide Response to Antenatal and Postnatal Depression

Highet, N, Purtell, C, Komen, R
beyondblue

A recent national survey conducted by beyondblue revealed high levels of confusion about the link between depression and motherhood. More than half of those surveyed considered depression to be a normal part of pregnancy.

Early beyondblue research into antenatal and postnatal depression prompted the beyondblue National Action Plan for Perinatal Mental Health and the development of government funded National Perinatal Depression Initiative (NPD).

This paper will report on the progress of NPD including the collaboration between all governments on routine and universal psychosocial assessment of women in the perinatal period. The progress on the recently released draft Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period will be outlined. Results of a recent national survey on community awareness and attitudes surrounding depression and anxiety in the perinatal period will be discussed. Newly developed training materials and resources for health professionals, women and fathers /partners to promote family and infant mental health will be presented.

This paper highlights how research led to national action and a change in culture, intervention and treatment for all women, their families and carers in the perinatal period.

The submitted abstract does not report on research using human participants.

Improving Perinatal Mental Health: Why a Focus on Screening Misses the Point

Prof Rhonda Small

Mother & Child Health Research, La Trobe University, Melbourne, VIC

The current Australian Government's National Postnatal Depression Initiative controversially plans to introduce routine and universal depression screening for *all* women having babies, once during pregnancy and once after birth.

One might well ask, 'How has it come to this?'

This presentation aims to take a critical look at what we know about maternal depression and about screening as a response to improving maternal mental health in the perinatal period. Some of the challenging questions to be faced in the current context will be considered. What do women think about screening? Are the potential 'screeners' – midwives, GPs, maternal and child health nurses – supportive and supported? How do we know when to screen? Why depression screening? What about screening for other 'psychosocial' issues – anxiety, intimate partner violence, drug and alcohol use? Or does screening miss the point? What is 'best practice' when evidence for screening effectiveness is lacking?

Australia's Screening Guidelines and the Impact of HPV Vaccination on the Australian Cervical Screening Program

A/Professor Marion Saville

Victorian Cytology Service Incorporated - Melbourne

In November 2006 the Australian Government announced that it would fund vaccination for all Australian school girls in their first year of high school, commencing in 2007. In addition, it will fund a catch up program for all girls attending high school and all young women under the age of 26, through their general practitioners, for the next 2 years.

The HPV vaccination program as announced can be anticipated to have significant impacts on cervical cancer prevention strategies in Australia. A range of needs for information about the vaccination have been identified. It is anticipated that there will be a reduction in the number of screen detected abnormalities and this has a number of implications for cervical cancer screening. In addition, in the long term, a 70% reduction in the number of cervical cancers is anticipated. This makes the current Australian screening program, which is already extremely intensive, much less cost effective. The changes brought about by the introduction of the vaccine will mean that review of the program is essential. It will be important to determine the optimal approaches to screening in a context where primary prevention through vaccination is available. A proposed algorithm for screening in this new environment will be presented.

Presentation Synopsis:

This presentation will briefly outline the present screening guidelines in Australia including screening policy and the policy on the management of women with screen detected abnormalities. The HPV vaccination policy will be presented briefly and the currently proposed process for renewal of the Australian Screening Program will also be presented.

Fertility-Sparing Surgery for Cervical Cancer

Prof Michael Quinn

Department of Obstetrics and Gynaecology, University of Melbourne, Consultant Oncology/Dysplasia Unit, Royal Women's Hospital, VIC

Cervical cancer remains the most common women's cancer in the developing world with almost 500,000 new cases annually. More than 350,000 women will die from the disease usually in dreadful circumstances and without palliative care. The current vaccines still have to have an impact on these awful statistics. Traditionally, management of early stage disease has involved radical surgery with substantial resultant morbidity, including bladder problems, lymphoedema and infertility. New approaches include nerve sparing radical hysterectomy which reduces bladder sequelae, sentinel node biopsy which obviates the need for full node dissection and radical trachelectomy which allows the potential for future childbearing. Further refinements using MRI and PET/CT will allow even more conservative approaches in the future.

Subtotal Hysterectomy and Sexuality

Dr Catarina Ang

Head of Unit, Gynaecology Unit 1 (Menstrual Disorders), Royal Women's Hospital, VIC

Subtotal hysterectomy is a mode of performing hysterectomy that has been in and out of favour over the last century. The latest evidence is yet to support any advantages of sexual function. Surgically, it has been shown to decrease intraoperative blood loss, and reduce operating time significantly.

Psychological Aspects of Cervical Cancer

Dr Christina Bryant

Senior Lecturer in Clinical Psychology, Centre for Women's Mental Health, Royal Women's Hospital and Department of Psychological Sciences, University of Melbourne, Royal Women's Hospital, VIC

In contrast to the considerable amount of research devoted to breast cancer, gynaecological cancers, including cancer of the cervix, have received scant attention. This presentation will review the available data and discuss some of the issues that arise for women in adjusting to diagnosis and treatment, and in seeking appropriate support. These include the lower levels of awareness regarding gynaecological cancers, and the shortage of studies that have researched this population. Those studies that have investigated minority cancers, such as cervical cancers, have highlighted the problems of sense of isolation and poor self esteem in such populations. The presentation will consider the clinical implications of these findings.

Dr Caterina Ang

Clinical interests in endometriosis with multidisciplinary approach to pelvic/perineal pain. Accredited Level 6/6 (RANZCOG/AGES) laparoscopic surgeon, focussed on minimally invasive approach to management. Performs total laparoscopic hysterectomy, resection of severe endometriosis, including rectal/rectovaginal endometriosis, residual ovary syndrome, laparoscopic myomectomy and laparoscopic adhesiolysis. Clinical Research Fellow in Oxford and appointed to both John Radcliffe Hospital and University of Oxford. Awarded fellowship at renowned CHU Clermont-Ferrand (Polyclinique de l'Hotel-Dieu) and Centre Internationale de Chirurgie Endoscopique (CICE) in Clermont-Ferrand, France. Completed Diploma of Epidemiology with prestigious London School of Hygiene and Tropical Medicine. Head of Gynaecology 1 Unit, Royal Women's Hospital, Melbourne.

Ms Monique Baldacchino

Monique Baldacchino is a Clinical Nurse Specialist and Breast Care Nurse who has ten years experience working on the Oncology Unit at The Women's. She is here to discuss an ongoing Sex, Sexuality & body image Quality Assurance project that she is working on with her colleague Liz Williams.

Dr Mary Belfrage

Dr Mary Belfrage is the Medical Director of the Victorian Aboriginal Health Service. She has worked in Aboriginal Health intermittently over the past 20 years in both urban and remote settings, and in a range of other primary health care settings as a GP. Mary has also been involved in various pilot and research projects in fields of social and public health. She has an interest in safety and quality issues in health care delivery, particularly how that translates into the patient experience of receiving care.

Dr Kirsten Black

Dr Kirsten Black trained in obstetrics and gynaecology and then specialised in reproductive and sexual health in the UK. She is a senior lecturer at the University of Sydney where she is responsible for co-ordinating undergraduate and post graduate training. Her areas of clinical and research interest are office gynaecology, early pregnancy and contraception.

A/Professor Stephanie Brown

A/Professor Stephanie Brown leads the Healthy Mothers Healthy Families Research Group and Mother Infant Stream at the Murdoch Childrens Research Institute, and holds honorary appointments as Principle Research Fellow in the Department of General Practice and School of Population Health at the University of Melbourne. Her research interests include women's health after childbirth, maternal depression, and intimate partner violence. She is the Principle Investigator for an NHMRC funded multi-centre prospective pregnancy cohort study investigating the health of 1507 first time mothers from early pregnancy until their first child is four years old. The study provides a comprehensive picture of the complex interplay between physical health problems, sexual health, depression and changes in intimate partner relationships. The findings have drawn attention to a hitherto unrecognised association between intimate partner violence and common maternal physical health problems including urinary and faecal incontinence.

Dr Christina Bryant

Dr Bryant is a clinical psychologist with extensive clinical experience in working with people with physical health problems. She has a particular interest in the relationships between physical and mental health. She has a PhD from Melbourne University, and is a Senior Lecturer in the Department of Psychological Sciences at the University of Melbourne, where she is involved in research, and in teaching on the clinical psychology training programme. At the Royal Women's Hospital Dr Bryant was involved in the establishment of an innovative multi-disciplinary clinic for women with chronic pelvic pain, and provides clinical psychology services to the Menopause Clinic.

Dr Amanda Cooklin

Amanda is a social science researcher with over 8 years of research experience. Since completing her Master of Women's Health at the University of Melbourne, Amanda has been employed as a researcher on a number of projects investigating the social determinants of women's mental health, in particular during pregnancy and following childbirth. Her research interests include women's employment, maternity leave, workplace sexual discrimination during pregnancy, mental health, and breastfeeding.

Before joining the PRC, Amanda completed her PhD at the University of Melbourne, investigating the relationship between women's employment in pregnancy and following birth and their mental health and wellbeing.

Amanda now works in the Parent Fatigue and Wellbeing team as a Research Fellow, and is also a member of the PRC team that is analysing and disseminating results from the current Longitudinal Study of Australian Children.

Dr Kyllie Cripps

Kyllie Cripps is a Pallawah woman and a Senior Lecturer in the Indigenous Law Centre, Faculty of Law, at the University of New South Wales. She was awarded her PhD in 2005 for her thesis entitled 'Enough Family Fighting: Indigenous Community Responses to Addressing Family Violence in Australia & the United States'.

She is currently, one of only a handful of researchers in the country whose sole research is on Indigenous family violence, sexual assault and child abuse. She is regularly invited to provide advice to state and federal governments and also provides professional training for members of the academy and to professional bodies. She is also committed to building the capacity of the Indigenous workforce in this area and regularly provides advice and support to Indigenous organisations working in the sector. Her research strengths also cut across the areas of policy development and program delivery; Indigenous research processes and practices; Indigenous health and Indigenous education.

Prof Lorraine Dennerstein

Professor Dennerstein is a professorial fellow at The University of Melbourne, Australia. She established and directed the first academic centre for teaching and research in women's health and also the first inpatient mother-baby psychiatric unit in an obstetrics hospital. Her contribution to women's health was recognised by the award of the Order of Australia in 1994. She has been a consultant to the Commonwealth Secretariat (London), the World Health Organisation, the Global Commission on Women's Health (WHO) and the International Bioethics Committee of UNESCO. For over 30 years she has researched the relationship of ovarian steroids to women's sexual functioning. Studies included effects on women's mood and sexual functioning of: changes in endogenous hormones with menstrual cycle and menopause; hysterectomy and bilateral oophorectomy; oral contraceptive pill and hormone therapy. Her population based study of women through the menopausal transition has been able to document prospectively the relative importance of hormonal to psychosocial factors in women's sexual functioning.

Research experience includes surveys, bioavailability studies, double blind randomized clinical trials, evaluation of therapies, the development and validation of questionnaires for assessing female sexual functioning and epidemiological studies. Publications include 24 books authored/edited and over 430 journal articles/chapters (250 in peer reviewed journals). She has been president of national and international medical societies and organised national and international scientific conferences. She is a Past President of ASPOG, ISPOG and of the International Society for the Study of Women's Sexual Health and is currently Review Editor of the Journal of Sexual Medicine. In July 2005 she was awarded a Gold Medal for Lifetime Achievement in Sexuality Research by the World Association of Sexology.

Ms Mary Draper

Mary Draper has worked in and around women's health for 25 years, most recently as Director of Clinical Governance at the Royal Women's Hospital, Melbourne. Previously as a manager within the Quality Branch of the Department of Human Services in Victoria, her responsibilities included clinical effectiveness, the Maternity Services Strategy, and consumer participation. ...At RMIT, she undertook research on consumer perspectives on health care as well as teaching policy process.

From 1983 – 1987, Mary was Director of the Women's Policy Co-ordination Unit, Department of the Premier and Cabinet, Victoria, advising the Premier on women's policy issues, including women's health policy. She was a founding member of the Committee of Management of the Centre against Sexual Assault at the Women's and chaired the Ethics Committee.

Dr Anita Elias

Dr Anita Elias has a background as a General Practitioner, and has trained in Psychotherapy, Couple therapy and Family therapy. She has been practicing in Psychosexual Medicine for 14 years and is now working as head of the the Sexual and Relationship Clinic (SARC) at Monash Medical Centre, in the Psychosexual Service at The Women's Hospital, and in private practice at the Malvern Psychotherapy Centre. She is also involved in teaching Monash Medical students, Medical and other Health practitioners and Psychotherapists.

A/Prof Jane Fisher

Associate Professor Jane Fisher first joined the staff of the Key Centre for Women's Health in Society at The University of Melbourne as a Postdoctoral Research Fellow in 1994, and was promoted to Associate Professor in 2006. She teaches in the Melbourne School of Population Health's postgraduate and short course programs and supervises research higher degree students.

Jane Fisher's broad research interest is in the links between reproductive health and mental health, including the short term psychological impact of: fertility difficulties and assisted reproductive technologies, pregnancy loss and operative interventions in childbirth and their longer term impact on postpartum maternal adjustment and early parenting difficulties.

As part of the Centre's WHO Collaborating Centre in Women's Health activities she is involved in building evidence about perinatal mental health in resource-constrained countries and the contribution of mental health to safe motherhood. She collaborates with local colleagues in the North and the South of Vietnam on research into the mental health problems of mothers and fathers and the impact on infant health in development in their country.

Dr Penelope Foster

Dr Penelope Foster trained in Melbourne and the UK in obstetrics and gynaecology and then infertility and IVF. Since 1989 she has been on the consultant staff of the Royal Women's Hospital, where she currently holds specialist appointments at Reproductive Services in Infertility and runs the Chronic Viral Illness Clinic. She is a founding director and the Acting Designated Officer for Melbourne IVF. She has a special interest in chronic viral illness relating to assisted reproduction treatment and chairs the Chronic Viral illness Committee. She also has clinical responsibility for the embryo biopsy programme (preimplantation genetic diagnosis) and the Melbourne IVF donor gamete programme.

Dr Amanda Gordon

Director Armchair Psychology Practice President Division Professional Practice, International Association Applied Psychology, NSW

Amanda Gordon is a Clinical Psychologist in Private Practice in Sydney. Well known for media and broadcasting. Past President of the Australian Psychological Society, she is currently President, Division of Professional Practice of the International Association of Applied Psychology. As President of the APS She was very involved in the issue of sexualisation of young girls through the media, and spoke to the Senate Committee Enquiry, representing psychological evidence.

Ms Anna Harris

Anna Harris is an undergraduate medical student at the University of Melbourne. Currently in her fourth year of her studies, she has just completed the Advanced Medical Science (AMS) year in order to obtain a Bachelor of Medical Science. Her AMS research was completed at the Centre for Women's Health, Gender and Society, in the Melbourne School of Population Health. Together with her supervisor Dr. Heather Rowe, Anna was involved in a collaboration with Associate Professor Julia Seng and Mickey Sperlich at the University of Michigan and the Women's Social Support Services at The Women's. Anna hopes that the understandings she has gained in the areas of sexual trauma and mental health will inform her future clinical practise and increase her awareness of psycho-social influences on physical health.

Dr Nicole Highet

Dr Nicole Highet is the Deputy CEO of *beyondblue; the national depression initiative* and deputy Chairman of the perinatal Guidelines Evaluation Advisory Council which has informed the development of the current draft perinatal guidelines.

In her capacity at *beyondblue*, Nicole has also overseen the *beyondblue* Perinatal Depression Research Initiative (2001-2004), which identified prevalence rates of ante and postnatal depression in Australia, the development of the National Action Plan and is now the *beyondblue* Senior Advisor to the National Perinatal Depression Initiative.

Nicole is also responsible for *beyondblue*'s community awareness activities and will oversee the research, development, implementation and evaluation of community awareness activities surrounding perinatal disorders.

Dr Jane Hocking

Jane Hocking is an epidemiologist whose research interests include the epidemiology and control of sexually transmitted infections. Jane works at the Centre for Women's Health, Gender and Society at the University of Melbourne. Her research has led to an increased understanding of the epidemiology and control of genital *Chlamydia trachomatis* infection in Australia. She is currently running a number of projects, including a national chlamydia testing randomised controlled trial, that will inform future chlamydia control policy in Australia and shape a possible future national chlamydia screening program.

Dr Kimberley Ivory

Dr Kimberley Ivory is Senior Medical Officer at Family Planning Victoria. She is interested in the role of practitioners on the social determinants of health, especially with regard to young people and sexual health. This research was completed as a part of the Master of Public Health (Sexual Health) at Melbourne University.

Ms Marika Kalargyros

Senior Aboriginal Women's Support and Education Worker, The Women's Hospital
Marika Kalargyros is a proud Aboriginal woman from the Yorta Yorta Nation and has worked at the Women's going on 11 years. Marika comes from a family active in Aboriginal affairs which has forged her passion for Aboriginal community and in particularly Aboriginal women's health.

Ms Tshupo Fiona Khudu

A fourth year medical student at the University of Melbourne, from Botswana, Africa. During my Advanced Medical science year I was involved in research at the Center for Women's Health, Gender and Society under supervision from Associate Professor Jane Fisher and Heather Rowe. My time with the Center introduced me to the complexities involved in providing equity in health services to culturally and linguistically diverse communities, and the knowledge I've gained I hope will enrich my medical career.

Dr Rachael Knight

Dr Rachael Knight trained in Tasmania and Melbourne where she qualified as an obstetrician and gynaecologist, later obtaining a Doctorate of Medicine from Melbourne University for clinical research. She undertook further training in Reproductive Endocrinology and Infertility in Australia and the UK. Dr Knight has a consultant appointment at The Royal Women's Hospital, where she is Head of the Polycystic Ovarian Syndrome Clinic and involved in the Chronic Viral Illness clinic run through the RWH in conjunction with Melbourne IVF. She has a private practice based in East Melbourne and is involved in active research.

Dr Alex Marceglia

Dr Alexandra Marceglia, Sexual Health Physician, has been employed in both the primary and tertiary health sector providing specialist sexual health medicine for over 20 years. During this time Dr Marceglia has developed her clinical expertise in a number of key and evolving areas of clinical practice including care of HIV infected women, vulva disorders and the increasingly important role of vaccination in sexual health medicine.

Dr Marceglia's current role at The Royal Women's Hospital and the Melbourne Sexual Health Centre enable her to be at the forefront of clinical expertise in sexual health medicine and to be an active participant in ongoing research and clinical practice improvement in delivery of sexual health services.

Ms Sherrie Martin

Sherrie is a social worker who has worked in large healthcare settings in the United States and Australia for over 20 years. She began her professional career as a medical transcriptionist for a range of medical disciplines and in credentialing of doctors for practicing privileges. After graduation and licensure as a clinical social worker, she worked as a Family Therapist in the Child and Family Team at Kaiser Permanente. She has lived in Australia for six years this June, and has worked in a range of positions at Anglicare Family Support, at the Casey Hospital weekend Emergency Department and at Berwick. She is now the Senior Clinician, Gynaecology and the Student Unit Coordinator at The Women's Social Support Service, positions she has held for 4 years.

Dr Ruth McNair

Ruth is a general practitioner in an inner-urban general practice and a Senior Lecturer at the Department of General Practice, University of Melbourne. She is the Chairperson of the Victorian Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, and is Treasurer of the Rainbow Families Council. She is involved in lesbian parenting at a number of levels, including providing fertility advice for same-sex couples as a GP, and conducting parenting research. She was a member of the Advisory Committee to the Victorian Law Reform Commission enquiry into Assisted Reproductive Technologies and Adoption.

Miss Orla McNally

Orla came to the Women's in 2009 from the Taunton and Somerset NHS Trust in England, where as lead consultant for gynaecological cancer, she developed a Gynaecological Cancer Centre providing full oncology services. She is passionate about multidisciplinary team working and is actively collaborating with the Royal Melbourne and PeterMcCallum hospitals towards the Parkville Comprehensive Cancer Centre.

Dr Paddy Moore

Dr Moore has trained and worked in New Zealand, Britain and Australia. She has a special interest in young women's sexual and reproductive health. In 2000 she established and continues to work in an antenatal clinic for women with special needs. This is a multidisciplinary clinic with approximately 50% of clients being indigenous.

Prof Louise Newman

Louise Newman is the Professor of Developmental Psychiatry and Director of the Monash University Centre for Developmental Psychiatry & Psychology. Prior to this appointment she was the Chair of Perinatal and Infant Psychiatry at the University of Newcastle and the previous Director of the New South Wales Institute of Psychiatry. She is a practising infant psychiatrist with expertise in the area of disorders of early parenting and attachment difficulties in infants. She has undertaken research into the issues confronting parents with histories of early trauma and neglect. Her current research is focussing on the evaluation of infant-parent interventions in high-risk populations, the concept of parental reflective functioning in mothers with borderline disorders and the neurobiology of parenting disturbance

Professor Newman is involved in the education of psychiatrists and a range of mental health professionals in the areas of attachment theory and infant-parent interventions.

She is the Convenor of the Alliance of Health Professions for Asylum Seekers and an advocate for the rights of asylum seekers and refugees.

She is the current President of the Royal Australian & New Zealand College of Psychiatrists.

Dr Britt Olsen

Dr Britt Olsen was born in Sweden and Migrated to Australia in 1975. She studied Medicine at Monash and graduated in 1983 (MBBS) then completed FRACGP in 1997. She then went onto do Post graduate studies at the Key Centre, Melbourne University and obtained a Graduate Diploma in 1995 and in 1999 a Masters in Medicine.

The masters was a literature review on health concerns in adult survivors of childhood sexual abuse from a general practice perspective. She has worked mainly in traditional family practice and also women's health clinics, occupational health, aboriginal health and some forensic medicine. She has worked for some years under the supervision of Dr Gita Mammen at SOCA- a clinic under the auspice of St Vincent's Hospital for mental health needs of adult survivors of CSA.

Ms Tricia Ong

Tricia Ong is a qualified (master degree) creative arts therapist who works with women with chronic illnesses in the field of obstetrics and gynecology. She specializes in support for women with endometriosis, but has also worked with women with ovarian cancer, polycystic ovarian syndrome (PCOS) and women undergoing IVF treatment.

She is a professional member of the Australian Creative Arts Therapies Association (ACATA).

Her inspiration for her work is her endometriosis experience.

To complement her professional work, Tricia has observed gynecological surgery with a specialist laparoscopic surgeon and clinical consultations with a specialist endometriosis gynecologist. She does work for Endometriosis.org - the global forum for news and information about endometriosis – and has also published on endometriosis.

In 2010, Tricia seeded a (grant-funded) project for women with endometriosis, and is currently in the process of developing a new project for this group of women. She also has research interests.

Tricia is based in Melbourne.

Ms Anne-Florence Plante

Anne-Florence is a senior Clinician Physiotherapist and trained in Psychiatry and Women's Health Elective in France. She is fully registered and specialised in pelvic pain in Australia since 2008. She has been working at The Royal Women's hospital since February 2008.

Anne-Florence did 3 post grad in Forensic Medicine in France which gives her interest in somatic disorders associated with PTSD:

Ann-Florence has does lecturing internationally and nationally in Australia since arriving 3 years ago. She was working together with vulva disease unit in Cochin-Tarnier Hospital in Paris with Dr Micheline Moyal and Christine Vahdat.

She is currently working at The Women's in the vulva clinic with Dr Ross Pagano and Dr Anne Howard. Recent publications were with interest towards Vulvodynia and Sexual disorders.

Anne-Florence is currently working and has been recruited for that reason in the new Chronic Pelvic Pain Clinic which started march 2009 together with the Gyne 2 team, Pain Specialist Dr Angela Chia Senior Psychologist Christina Bryant.

Professor Michael Quinn

Michael is Chair of the Australian & New Zealand Gynaecologic Oncology Trials Group, Chair Elect and Executive Member of the Gynecological Cancer Inter-Group and a Member of the Advisory Group, National Centre for Gynaecological Cancer. He has an extensive publication record and is currently on the editorial boards of *Gynecologic Oncology* and *International Journal of Gynaecological Oncology*.

Dr Damien Riggs

Damien W. Riggs is a lecturer in the department of social work and social policy at Flinders University and a family and relationships counsellor at Relationships Australia. He is the author of *Becoming parent: Lesbians, gay men, and family* (Post Pressed, 2007), *What about the children! Masculinities, sexualities and hegemony* (Cambridge Scholars Press, 2010), and is the editor of the *Gay and Lesbian Issues and Psychology Review*.

A/Prof Marian Saville

A/Prof Saville was appointed Director of VCS in July 2000. She is a New Zealand medical graduate who trained in cytopathology and histopathology in the United States. She is a Fellow of the International Academy of Cytology and serves on the Membership Committee of the Academy.

A/Prof Saville's major interest is in cervical screening policy and planning and she has completed a Graduate Diploma in Clinical Epidemiology at the University of Sydney in 1998.

A/Prof Saville has served on a number of advisory committees most recently the Advisory Panels for the Medical Services Advisory Committee (MSAC); Reference 39 "Human papillomavirus triage test for women with possible or definite low-grade squamous intra-epithelial abnormalities of the cervix", and MSAC application 1122 "The ThinPrep® System for Cervical Cancer Screening".

A/Prof Saville has also been involved in the HPV Working Party to the Australian Technical Advisory Group on Immunisation (ATAGI); The Policy and New Technologies subcommittee of the Australian Screening Advisory Committee (ASAC) and she was a member of the National Health and Medical Research Committee (NHMRC) reviewing the Guidelines for the Management of Asymptomatic Women with Screen Detected Abnormalities, chairing the terminology working group.

She is currently the President of the Australian Society of Cytology.

Dr Margaret Sherburn

Dr Margaret Sherburn is an experienced physiotherapy clinician and academic whose main areas of research interest are the conservative management of pelvic floor dysfunction in older women with prolapse or incontinence, and the role of exercise for pre and postnatal women. She has been the recipient of two NH&MRC grants for large multicentre studies into the effects of physiotherapy for pelvic organ prolapse - the POPPY study - and for an investigation into the effect of intensive pelvic floor muscle training for stress incontinence in elderly women. Margaret has led pre and postnatal exercise classes for over 30 years, during which time she has co-written a pregnancy exercise book, 'Changing Shape'.

She is the national chairperson of Continence and Women's Health Physiotherapy Australia, an Australian Physiotherapy Association National Group, a Fellow of the College of Physiotherapy and serves on the Program Advisory Committee of the College. She is a member of the Ethics Committee of the International Continence Society, and is on the editorial board of the Australian and New Zealand Continence Journal.

Prof Rhonda Small

Professor Small has been involved in research into maternal depression for the last twenty years, from descriptive epidemiological studies of prevalence and associated factors, to in-depth interviews with women about their experiences of depression, to several randomised trials to improve maternal wellbeing. She has also led significant research on the wellbeing of immigrant and refugee women giving birth in Australia and participated actively in the debates about universal screening for postnatal depression. Rhonda has recently been appointed Director of Mother & Child Health Research at La Trobe University, the public health research centre where she has worked since 1991.

Dr Kate Stern

Kate Stern is the Head of the Endocrine and Metabolic Service at the Royal Women's Hospital and Head of Research at Melbourne IVF. She is a fertility specialist, gynaecologist and reproductive endocrinologist.

Kate is the medical coordinator of the Fertility Preservation Service at MIVF and RWH and this area is her major research interest.

Ms Leena St Martin

Leena St Martin is a clinical psychologist from Auckland, New Zealand. She has specialised in women's health for the past ten years via her work at Gynaecology Outpatients, National Women's Hospital as well as at Fertility Associates Auckland and in private practice. Leena has a passion for women's health both academically and clinically and has presented and published on topics ranging from female-to-male gender transition to the management of chronic pelvic pain and vulvodynia

Leena also has a leadership role for psychologists at Auckland District Health Board and combines this with her clinical work.

Dr Jane Thompson

Jane has a science background with a PhD. She is currently Senior Research Officer, Women's Hospitals Australasia

Her research interests are in maternal health after childbirth. She has been involved in research projects on mothers' experiences of neonatal intensive care, epidemiology of postnatal depression and of women's postpartum health. She also has experience in clinical practice improvement, primarily in obstetrics. She is an active member of the Perinatal Society of Australia and New Zealand (PSANZ).

Ms Cathy Watson

Cathy Watson is a Women's Health Nurse Practitioner working part time at the Royal Women's Hospital. While she was doing her masters degree she examined the evidence (or in some cases, lack of evidence) underpinning the management of recurrent vulvovaginal candidiasis (or vaginal thrush).

Despite having three unruly boys, she obviously doesn't have enough to do, and is undertaking a PhD in the Dept of General Practice at Melbourne University. Her thesis investigates the possibility of a compound of garlic and its use in prevention of recurrent thrush. She is also interested in the impact recurrent thrush has on sufferers and her presentation today addresses this issue.

Ms Liz Williams

Liz Williams is a Registered Nurse who has 25 years experience working in the Oncology Unit at The Women's. She holds an Advanced Nursing Degree in Community Health in which she majored in Sexuality and Education. She also works in Health Promotion in a Secondary School. She is here to discuss an ongoing Sex, Sexuality & body image Quality Assurance project that she is working on with her colleague Monique Baldacchino.

Mr C. David H. Wrede

David graduated in medicine from Cambridge University and St. Thomas' Hospital, with post-graduate training in Surgery and O&G in London (mostly at St. Mary's) and Oxford, including a period of molecular biological research on HPV and Cervical Cancer at the Ludwig Institute. IN 1995 he became Senior Registrar in the West Midlands, which included a post at the Birmingham Women's Hospital under the tuturship of Mr. Joe Jordan. This was followed by Consultant appointments in O&G with an interest in Oncology & Colposcopy in Fife Scotland (1999 - 2004) & Somerset England (2004 - 2009) and subsequently to the Royal Womens' Hospital as Staff Specialist & Lead for Dysplasia last year.

Interests include Medical Education reform and Healthservice funding via medical politics.

Dr Karen Wynter

Karen completed her studies in Mathematics and Psychology at the University of Stellenbosch (South Africa), and then focused on quantitative research in psychological aspects of education at the University of Cambridge. She worked as General Manager for SPSS South Africa before she migrated to Melbourne in 2005. She has been at the Centre for Women's Health, Gender and Society at the University of Melbourne, focusing on reproductive mental health, since 2007.

Name	Organisation	State
Dr Suzanne Abraham	University of Sydney	NSW
Dr Quenby Louise Alinskie		VIC
Dr Catarina Ang	Royal Women's Hospital	VIC
Mr Pat Armiento	Bayer Australia Limited	VIC
Ms Daniela Arturi	CSL Biotherapies	VIC
Dr Jane Baird	Central Northern Adelaide Health Service	SA
Ms Monique Baldacchino	The Royal Women's Hospital	VIC
Dr Bruce Batagol	Psychiatrist	VIC
Dr Chris Bayly	Royal Women's Hospital	VIC
Dr Mary Belfrage	Victorian Aboriginal Health Service	VIC
Ms Sabina Berman	Bayer Australia Limited	VIC
Dr Kirsten Black	University of Sydney	NSW
A/Prof Stephanie Brown	Murdoch Children's Research Institute	VIC
Dr Christina Bryant	Royal Women's Hospital	VIC
Ms Karin Butler	Royal Women's Hospital	VIC
Dr Margaret Butler	Women's and Children's Hospital	SA
Dr Angela Chia	Royal Women's Hospital	VIC
Prof John Condon	Repatriation Hospital	SA
Dr Amanda Cooklin	University of Melbourne	VIC
Dr Kyllie Cripps	The University of New South Wales	NSW
Prof Lorraine Dennerstein	The University of Melbourne	VIC
Dr Deepali Dhillon		VIC
Ms Susan Dillon	QLD Health	QLD
Ms Mary Draper		VIC
Dr Anita Elias	Royal Women's Hospital	VIC
Dr Jane Elliott	North Adelaide Family Practice	SA
A/Prof Jane Fisher	University of Melbourne	VIC
Ms Lucy Forward	University of SA	SA
Dr Penelope Foster	Melbourne IVF and Chronic Viral Illness Clinic Royal Women's Hospital	VIC
Ms Patricia Galante	Monash Medical Centre	VIC
Dr Amanda Gordon	Practice President Division Professional Practice	NSW
Dr Fiona Haines	Healthy Women	QLD
Dr Karin Hammarberg	University of Melbourne	VIC
Mrs Anna Harris	University of Melbourne	VIC
Dr Nicole Highet	Beyondblue	VIC
Dr Jane Hocking	University of Melbourne	VIC
Dr Kimberley Ivory	Family Planning Victoria	VIC
Ms Marika Kalargyros	The Royal Women's Hospital	VIC
Ms Tshepo Fiona Khudu	Melbourne School of Population Health	VIC
Dr Rachael Knight	Melbourne IVF and the Royal Women's Hospital	VIC
A/Prof Louise Kornman	Royal Women's Hospital	VIC
Mrs Lesley Kueter-Luks	Royal Women's Hospital	VIC
Dr Katerina Lagios	Marie Stopes International	NSW
Dr Lia Laios	Royal Women's Hospital	VIC
Dr Alexandra Marceglia	Royal Women's Hospital	VIC
Ms Sherrie Martin	Royal Women's Hospital	VIC
A/Prof Amanda McBride		NSW
Dr Ruth McNair	University of Melbourne	VIC
Miss Orla McNally	Royal Women's Hospital	VIC
Dr Paddy Moore	Austin Health and Royal Children's Hospital	VIC
Ms Cynthia Murray	University of Melbourne	VIC
Prof Louise Newman	Monash University	VIC
Ms Anna Nguyen	Bayer Australia Limited	VIC
Ms Jenny Niven	Lyell McEwin Hospital	SA
Dr Britt Olsen	General Practitioner	VIC
Dr Ann Olsson	Royal Adelaide Hospital	SA

Ms Tricia Ong	Private Practitioner - Creative Arts Therapist	VIC
Ms Sandra O'Toole	The Queen Elizabeth Hospital	SA
Dr Debbie Owies	Southern Health / Royal Women's Hospital	VIC
Ms Anne-Florence Plante	Royal Women's Hospital	VIC
Dr Mary Prendergast		SA
Dr Michael Quinn	University of Melbourne	VIC
Dr Mahmoud Rahimi	Gosford Hospital	NSW
Dr Damien Riggs	University of Adelaide	SA
Mrs Bronnie Roberts	Ann Olsson & Repromed	SA
Dr Anna Rogers	Obstetrician & Frances Perry House	VIC
Mr George Ross	Bayer Australia Limited	VIC
Dr Heather Rowe	University of Melbourne	VIC
Ms Sarah Rudd	Well Women / Fit to Deliver Physiotherapy Clinic	VIC
Dr Marian Saville	Victorian Cytology Service	VIC
Dr Margaret Sherburn	Royal Women's Hospital	VIC
Dr Thambimuthu Sivabalan	Mount Isa Hospital	QLD
Prof Rhonda Small	La Trobe University	VIC
Dr Jacqui Smith	Perinatal Emergency Referral Service	VIC
Ms Leena St Martin	Auckland District Health Board	New Zealand
Dr Jackie Stacy		NSW
Dr Kate Stern		VIC
Ms Gretel Stewart-Holmes	Bayer Australia Limited	VIC
Dr Jane Thompson	Women's Hospitals Australasia	ACT
Mrs Cathy Watson	University of Melbourne	VIC
Dr Yvonne White		NSW
Mr Greg Whiteside	CSL Biotherapies	VIC
Dr Bronwyn Williams		SA
Dr Vicki Windholz	Monash Medical Centre	VIC
Mr David Wrede	Royal Women's Hospital	VIC
Dr Karen Wynter	University of Melbourne	VIC
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