

47TH ANNUAL SCIENTIFIC MEETING

EXPLORING THE TAPESTRY OF PSYCHOSOCIAL OBSTETRICS & GYNAECOLOGY

24-26 FEBRUARY 2023 • ADELAIDE AUSTRALIA



HANDBOOK & ABSTRACTS

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**VENUE INFORMATION
HOTEL GRAND CHANCELLOR
ADELAIDE**

65 Hindley Street, Adelaide, SA 5000, Australia

Level – Mezzanine



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WELCOME

Welcome to our conference - ASPOG 2023, where we will have the chance to hear from many different disciplinary perspectives about a range of important issues in psychosocial obstetrics and gynaecology. The conference committee has worked hard to secure an exceptional line-up of speakers.

I really love the way the ASPOG conference always opens my eyes to issues which maybe outside of my field of expertise but are always stimulating and prove to be relevant to my own work in some way. We are also thrilled to have received more abstracts than we expected, which suggests that many of you are keen to get back to in-person conferences and you find ASPOG as fun and interesting as we do.

This will also be the chance to meet old colleagues and to make new ones!

I look forward to seeing you.

Meredith Temple-Smith

President, ASPOG

ORGANISING COMMITTEE

Convener: Prof Meredith Temple-Smith,

Deputy Head and Director of Research training in the Department of General Practice at the University of Melbourne.

Prof Jane Ussher, *Women's Health Psychology, Western Sydney University, NSW*

A/Prof Michelle Peate, *Royal Women's Hospital, University of Melbourne, VIC*

A/Prof Janette Perz, *Director of the Centre for Health Research, Western Sydney University, NSW*

Dr Jennifer Marino, *Epidemiologist, University of Melbourne, Royal Women's Hospital, VIC*

Dr Jade Bilardi, *Monash University, University of Melbourne, VIC*

Dr Alex Hawkey, *THRI, Western Sydney University, NSW*

Dr Marita Long, *General Practice, Family Planning Tasmania, TAS*

Dr Amy Moten, *Coordinator: Medication Education at SHINESA, General Practice SA.*

Dr Helena Obermair, *Junior Medical Officer, Liverpool Hospital, NSW*

Dr Rhea Psereckis, *General Practitioner, Tasmania*

A/Prof Gemma Sharp, *NHMRC Early Career Fellow and Clinical Psychologist at the Monash Alfred Psychiatry Research Centre (MAPrc), Monash University*

Prof Caroline Smith, *Dean of the Graduate Research School (Policy and Innovation) and a researcher with NICM Health Research Institute, Western Sydney University, and leads the Healthy Women research theme*

Dr Mariana Sousa, *University of Technology Sydney, Chancellor's Postdoctoral Research Fellow at IMPACCT Trials Coordination Centre*

Dr Wendy Vanselow, *Head of Psychosexual Medicine at RWH*

Dr Laura Whitburn, *Lecturer of Anatomy and Deputy Head of Discipline at La Trobe University*

ASPOG

The Australian Society for Psychosocial Obstetrics and Gynaecology is a multidisciplinary association devoted to promoting the 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 relevant disciplines, such as medicine, midwifery, nursing, psychology, social work and the social sciences..

The Society holds a national congress that moves yearly between states. The topics reflect the Society's breadth of interests, including the wider psychosocial aspects affecting women and men's general, sexual and reproductive health.

The **objectives** of ASPOG are

- To promote the scholarly, scientific, clinical teaching and practice of the psychosocial 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 psychosocial problems affecting women and men during their reproductive years and beyond.

ANNUAL GENERAL MEETING

ASPOG invites all members to attend the Annual General Meeting. The meeting will be held at 1240 on Saturday 25th February 2023.

SOCIAL PROGRAM

Welcome Reception

Friday, 24th February – 1830 to 1930.

Venue: Hotel Grand Chancellor – 65 Hindley Street, Adelaide, 5000, South Australia, Australia.

Included in full registration fee, \$65 extra tickets.

LLEWELYN-JONES ORATION

Friday 24th February at 1715pm.

Sexual and Reproductive Health and Rights: Taking Nothing for Granted

Professor Deborah Bateson

Professor of Practice, The Daffodil Centre, Faculty of Medicine and Health, The University of Sydney.

CPD

Certificates of Attendance will be emailed upon completion.

REGISTRATION DESK

The Registration Desk will be located on Mezzanine level, Hotel Grand Chancellor.

Friday 24th February – 1230–1700

Saturday 25th February – 0830–1700

Sunday 26th February – 0830–1300

Presenters

Please bring your PowerPoint presentation with you on a 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.

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.

GENERAL INFORMATION

Airport Transfers

The taxi stand is outside the airport. The fare to and from the airport is approx. \$25.

Uber designated Ride Share pick up area is located outside of the terminal on the arrivals level, across the forecourt and to the left of the car park building. The fare to and from the airport is approx. \$20.

Parking

The hotel operates its own carpark underneath the building at \$25 per day. The car park has a lift to the Hotel lobby and subsequent floors. Please be aware that a height restriction applies of 2.03 meters.

Convenience Store

SA Convenience Store 80 Hindley St, Adelaide SA 5000

Name Badges

Admission to all sessions is by the official meeting name badge. Please wear it at all times throughout the conference.

Weather

Average temperature is 29°C during the day, and overnight 18°C. advisable to bring a jacket.

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 their staff to ensure you have the correct meal.

Insurance - Personal

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 Conference. 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.

Liability

In case of industrial disruption or other external events causing disruption to the Conference, the Organising Committee of the ASPOG 2023 ASM accepts no responsibility for loss of monies incurred by delegates.

Privacy

Personal information, as defined under the national privacy legislation, The Privacy Amendment (Private Sector) Act 2001, will be treated in accordance with the National Privacy Principles and only shared with related or third parties in accordance with those principles.

Visitor Information

Please visit the [link](#) to find out what's on in Adelaide.

ASPOG 47th ANNUAL SCIENTIFIC MEETING, 2023 - Program

Friday 24th February

1230-1700	Registration	
1400-1410	Welcome	ASPOG President, Prof Meredith Temple-Smith
	Acknowledgement of Country	
	Opening of ASPOG 2023	Hindley 1&2

1410-1530 Session 1 – Sexual and Reproductive Health (Chairs: Michelle Peate, Lucy Caughey) Hindley 1&2

1410-1430	Out with cancer	Jane Ussher
1430-1450	Syphilis /outbreak	Carole Khaw
1450-1510	IVF Add ons	Sarah Lensen
1510-1530	Sex, Reproduction, Data and Risk: Unintended consequences?	Tania Leiman

1530-1550 AFTERNOON TEA - Mezzanine

1550-1710 Session 2 – Care in the Antenatal Period (Chairs: Jane Ussher, Mohajeri Mahta) Hindley 1&2

1550-1610	Hypnosis and communication in pregnancy and childbirth	Allan Cyna
1610-1630	What's love got to do with it: Relationality as ethical care in maternity practice	Liz Newnham
1630-1650	Supporting women in labour: Do words matter?	Laura Whitburn
1650-1710	Translating evidence into practice: Implementing culturally-safe midwifery-led continuity for First Nations women in three maternity services in Victoria, Australia	Helen McLachlan

1715-1815 Llewelyn-Jones Oration (Chair: Meredith Temple-Smith) Hindley 1&2

Sexual and Reproductive Health and Rights: Taking Nothing for Granted

Speaker: **Deborah Bateson**, Professor of Practice at the Daffodil Centre, The University of Sydney

1830-1930 WELCOME RECEPTION, HOTEL GRAND CHANCELLOR Mezzanine

Saturday 25th February

0900-1030 Session 3 - Pregnancy (Chairs: Janette Perz, Vrinda Jain) Hindley 1&2

0900-0920	Men's experiences of grief and support after pregnancy loss	Kate Obst
0920-0940	Miscarriage Australia	Amy Webb
0940-1000	Improving perinatal experiences of African women	Anna Ziersch

1000-1010

Poster pitches:

[01] Exploring Women's Planning for Childbirth: Identifying Coping Strategies as Intrinsic or Extrinsic – *Janine Shifman, presented by Laura Whitburn*

[02] The prevalence of perinatal anxiety in low- and middle-income countries: a systematic review and meta-analysis – *Alexandra Roddy Mitchell*

[03] Australian Intended Parents' Decision-Making and Characteristics and Outcomes of Surrogacy Arrangements Completed in Australia and Overseas - *Ezra Kneebone*

1010-1030 HISTORY OF ASPOG – Jackie Stacy and Ann Olsen (Chair: Meredith Temple-Smith)

1030-1100 MORNING TEA - Mezzanine

Saturday 25th February

1100-1240	Session 4 – Beyond discourses of individual responsibility for health (Chairs: Jennifer Marino, Louis Taffs)		<i>Hindley 1&2</i>
1100-1240	Panel Presentations and Discussion <i>Vivienne Moore, Kristi Urry, Belinda Lunnay, Megan Warin</i>		
1240-1300	ASPOG AGM		
1300-1400	LUNCH - Mezzanine		
1340-1450	Session 5 – Clinical & Poster Presentations (Chair: Michelle Peate, Maddy Lim)		<i>Hindley 1&2</i>
1400-1415	Challenges in the management of postnatal depression in a vulnerable immigrant mother - <i>Mahta Mohajeri</i>		
1415-1430	A gynaecological case report on a tortured teratoma – <i>Kay Shi</i>		
1430-1445	Requesting a bilateral tubal ligation at 26 - maternal psychosocial implications – <i>Emma Watson</i>		
1445-1450	Poster Pitches: [04] Down the rabbit hole! Pregnancy-related neuropsychiatric disorders: a case report - <i>Vrinda Jain</i>		
1450-1520	AFTERNOON TEA - Mezzanine		
1520-1700	Session 6 – Concurrent Free Papers		
	CONCURRENT SESSION 6A - Hindley 1&2 (Chair: Alex Hawkey, Samantha Ryan)	CONCURRENT SESSION 6B - Hindley 3 (Chairs: Marita Long, Nipuni Susanto)	
1520-1535	Community Awareness and Use of Anti-Mullerian Hormone (AMH) Testing in Australia: A Population Survey of Women – <i>Rachel Thompson</i>	The Psychology of Typology–Patient Typologies used by ART/IVF Health Care Professionals and Implications for Practice – <i>Elizabeth Sutton</i>	
1535-1550	Exploring the Psychosocial and Behavioural Impact of Anti-Müllerian Hormone (AMH) Testing on Women – <i>Anastasia Vakkas</i>	“Natural” birth expectations in nulliparous women: How birth dissonance is born – <i>Elizabeth Sutton</i>	
1550-1605	Women’s Work: A scoping review of how reproductive responsibilities are shared between heterosexual partners – <i>Cassandra Caddy</i>	Genital Body Image in Young Adolescent Girls: A Pilot Study – <i>Anne Fernando</i>	
1605-1620	Eggsurance? A Randomised Control Trial of a Decision-Aid for Women Considering Elective Egg-Freezing – <i>Sherine Sandhu</i>	Genital Body Image Education Research in Adolescent Cisgender Females: Exploring Issues of Parental Consent – <i>Gemma Sharp</i>	
1620-1635	Elective Egg Freezers’ Disposition Decisions: “Some things in life don’t turn out, and it’s painful.” - <i>Lucy Caughey</i>	The Sexual and Reproductive Health of Adolescent Women with Cerebral Palsy in Rural Bangladesh – <i>Rosalie Power</i>	
1635-1650	The silent world of IVF – <i>Louis Taffs</i>	Establishing the Preventive Sexual and Reproductive Health Care needs of Karen Women from Refugee Backgrounds in Victoria – <i>Natasha Davidson</i>	
1650-1705	Developing a web-based tool for predicting individualised risk of infertility in young breast cancer patients: an international multi-cohort study – <i>Michelle Peate</i>	An evolutionary concept analysis of reproductive coercion: The evidence for a novel measure – <i>Desiree LaGrappe</i>	
1800	CASUAL DINNER, BAMBINI CUCINA – TICKETS PURCHASED THROUGH REGISTRATION <i>6 Peel Street, Adelaide – short walk from venue</i>		

Sunday 26th February

0900-1055 Session 7 – Concurrent Free Papers

	CONCURRENT SESSION 7A - Hindley 1&2 (Chair: Amy Moten)	CONCURRENT SESSION 7B - Hindley 3 (Chair: Gemma Sharp)
0900-0915	Mapping the abject: Women's embodied experiences of premenstrual body dissatisfaction through body-mapping – <i>Samantha Ryan</i>	What are the barriers to implementing psychosocial assessment in the private sector? - <i>Tanya Connell</i>
0915-0930	Heavy menstrual bleeding and pelvic pain in adolescents: a systematic review of self-management strategies, quality of life and unmet needs – <i>Shiva Roudbaneh</i>	I guess I see it as an odd thing for someone my age to be concerned about” – why haven't young people discussed sexual and reproductive healthcare needs with a GP? - <i>Jacqueline Coombe</i>
0930-0945	Endometriosis Diagnosis Pathways in South Australia: A qualitative study – <i>Gabrielle Shea</i>	Understanding the information needs of people making decisions about using a contraceptive implant or intrauterine device: findings from a scoping review and online survey – <i>Jaqueline Coombe</i>
0945-1000	The most bothersome symptom: a new measure for endometriosis – <i>Alice Mitchell</i>	An examination of a free safer sex program at the University of Melbourne: what worked and what did not – <i>Madeleine Lim</i>
1000-1015	How might we screen for psychosocial factors in individuals with pelvic pain? An electronic-Delphi study – <i>Jane Chalmers</i>	Construction and Experiences of Hormonal and Non-Hormonal Contraception – <i>Susan Manners</i>
1015-1030	Protecting the virtues of (good) womanhood: How culture and religion shape Middle Eastern women's experiences of period pain – <i>Alex Hawkey</i>	Primary Health Care Providers' views on providing Menopause-related Care to Migrant Women from Low- and Middle-Income Nations: what are the Barriers and what are the Facilitators? - <i>Karin Stanzel</i>
1030-1036	Poster pitches: [07] Staff Perceptions of Facilities and Support for Early Menarche in Australian Primary Schools: A Qualitative Interview Study – <i>Olivia Bellas</i> [10] The relationship between the intensity of domestic violence and the level of adherence to home quarantine among pregnant women in the context of COVID-19: a cross-sectional study in Bojnourd, Iran – <i>Shiva Roudbaneh</i>	Poster pitches: [11] The Frequency, Severity and Interference of Vasomotor Symptoms in Cancer Survivorship: A Systematic Literature Review – <i>Nipuni Susanto</i>
1036-1120	MORNING TEA - <i>Mezzanine</i>	

1120-1240 Session 8 – Complex Pelvic Pain (Chairs: Laura Whitburn, Cassandra Caddy) Hindley 1&2

1120-1240 Presentations and Panel discussion
Carmel Reynolds, Shan Morrison, Amanda Gierasch

1240-1310 PRIZES, SUMMATION & CLOSE

ABSTRACTS – FRIDAY

SESSION 1 – SEXUAL AND REPRODUCTIVE HEALTH

Out with Cancer

Jane M. Ussher (Professor of Women's Health Psychology, Translational Health Research Institute, Western Sydney University)

Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) communities are increasingly recognised as a vulnerable population in cancer care. They experience disproportionate cancer burden and unique psychosocial challenges. This paper will present the findings of the The Out with Cancer Study, a co-design mixed-methods project involving surveys, interviews, and photo-elicitation exercises with LGBTQI patients/survivors and caregivers, across a range of LGBTQI identities and ages. 430 patients/survivors and 132 carers completed surveys, and 105 patients/survivors and 31 carers completed interviews.

Over 40% of LGBTQI patients/survivors and carers reported high distress, a rate 3-6 times higher than non-LGBTQI patient/survivor studies. Significantly higher distress and lower quality of life (QOL) were identified in younger, transgender, intersex, bisexual and queer participants. Distress and QOL were associated with minority stress (discrimination, discomfort in being LGBTQI, outness), impact on gender and LGBTQI identities, lack of social support, physical concerns and sexual concerns. Qualitative data provided further insights into participants' experiences of heterosexism in healthcare, and how they navigated changes in sexual and reproductive embodiment. This includes resistance to the pinkification breast cancer and rejection of cis-heteronormative constructions of sexual embodiment. For trans participants, cancer treatment served to reinforce or disrupt gender affirmation.

Findings and translational outcomes of the Out with Cancer study will be informative in improving inclusivity and appropriateness of cancer care and support for LGBTQI people impacted by cancer.

Syphilis/Outbreak

Carole Khaw (South Australia)

Syphilis, an old disease, also known as the "great imitator" is re-emerging. Over the past decade, outbreaks of this infection here in a developed country like Australia, have occurred in men who have sex with men, in the indigenous population and now, in the non-indigenous heterosexual population. Unfortunately, there have been several cases of syphilis in pregnancy and of congenital syphilis in Australia. This has reflected poorly in our healthcare system and should not have happened. The occurrence of congenital syphilis especially in our indigenous population has been considered by many, to be a national disgrace.

This short presentation will focus on brief aspects of the history of syphilis, the epidemiology and re-emergence of this infection here in South Australia and clinical aspects of syphilis in pregnancy as well as congenital syphilis..

IVF Add Ons

Sarah Lensen (NHMRC Research Fellow, University of Melbourne, VIC)

IVF add-ons are procedures, techniques or medicines which may be considered nonessential to IVF and are usually used with the claim or the hope they will improve the probability of conception and live birth. Examples include endometrial scratching, EmbroGlue and preimplantation genetic testing of embryos for aneuploidy. Most IVF add-ons are not supported by robust evidence that they increase the probability of pregnancy or live birth, or are safe to use. Despite this, IVF add-ons are widespread. They are used by over 70% of IVF patients in Australia and the UK.

In this presentation, Dr Lensen will discuss her team's research which has evaluated IVF add-ons in clinical trials and systematic reviews, assessed the accuracy and quality of information about add-ons on IVF clinic websites and estimated the prevalence of IVF add-on use in Australia and overseas. With a view to better understanding why these unproven treatment options are used, her research has also undertaken surveys and qualitative interviews to explore the perspectives of IVF patients, clinicians and embryologists, and she plans to use this information as a foundation to build an evidence-based decision support tool to assist people in deciding whether or not to use IVF add-ons during their treatment.

Sex, Reproduction, Data and Risk: Unintended consequences?

Tania Leiman (Flinders University, SA)

For years women have been tracking their periods using handwritten notations on the calendar pinned to the wall in their bathroom, bedroom or in their hard copy diaries.

However, recently there has been an explosion in apps tracking menstruation and ovulation: 'the fertility app space has never been, well, more fertile' <<https://www.parents.com/getting-pregnant/ovulation/fertile-days/the-10-best-period-and-ovulation-tracker-apps/>>

But what are the implications of this sort of 'techno-social engineering' – on our lives, on our relationship, on autonomy, privacy and freedom from surveillance.

How might the data impact healthcare, employment, education, insurance and other areas?

This presentation will use a legal lens to explore new connected technologies that track some of our most intimate actions.

Many wearables and other devices already gather significant amounts of data about our behaviour health, our travel routes, heartrate, blood pressure, eye gaze, reaction times, and levels of arousal.

So who accesses this data, and what is it being used for?

This data may have significant ramifications – not only for individuals, but also for families, employers, insurers, legal and regulatory authorities.

It raises complex questions about how competing values such as safety, sustainability, efficiency, productivity, cost and privacy should be balanced, especially in the context of women's health.

SESSION 2 – CARE IN THE ANTENATAL PERIOD

Hypnosis and communication in pregnancy and childbirth

Allan Cyna (Women's and Children's Hospital, University of Adelaide, SA)

Pregnant women have been shown to have increased hypnotisability when compared to when non-pregnant. The use of metaphor and avoiding words likely to have a nocebo effect, such as 'sting', 'hurt', 'itch,' and 'worry' during pregnancy and childbirth can help women optimize a sense of control and a therapeutic outcome. Learnable frameworks for effective hypnotic, clinical communication can assist in the delivery of antenatal care. These structures include: the GREAT (Greeting; Rapport; Expectations; Addressing Concerns; Tacit agreement) LAURS (Listening; Acceptance; Utilisation; Reframing and Suggestion) acronyms of hypnotic communication. This concept helps ensure that the patient's words are heard, listened to for meaning, and that the patient knows that they have been heard and understood. Talking about finishing rather than starting a potentially painful procedure will allow patients to avoid generating anticipatory anxiety. For example, prior to vaginal examination in labour, one could say, "Would it be OK to finish examining you to assess the position of your baby and labour progress". Similarly on IV insertion one could say, "just finishing positioning the drip" allows the patient to be goal focused.

What's love got to do with it: Relationality as ethical care in maternity practice

Liz Newham (University of Newcastle, NSW)

Experiences of dehumanisation, obstetric violence and birth trauma are reported by birthing people across the globe. In addition, maternity care practitioners are also in crisis, with high levels of moral distress and attrition. There is a need to reimagine maternity care systems that are at present based on outdated fragmented and industrialised models. In this presentation, I first explore representations of autonomy, including experiences of its transgression, as they relate to current bioethical frameworks guiding maternity care practice. I then discuss how ideas of 'relationship' and 'emotionality' in midwifery theory can be used to both explain and mitigate these issues. Finally, drawing on care ethics, I propose that one of the ways to achieve a reimagined, humanised maternity care system is to redefine ethical practice in maternity care, with a focus on an embodied ethics that centres relational attentiveness.

Supporting women with pain in labour: Do words matter?

Laura Whitburn (La Trobe University, VIC)

The experiences of women during childbirth are greatly influenced by their social environment, as well as other factors. Women have reported changes in their perception of pain, their confidence to cope, and their decisions regarding pharmacological pain interventions, based on the words and cues they receive from those present during labour.

This talk will delve into the neurobiological mechanisms behind this phenomenon, exploring the concept of the nocebo effect, where negative experiences can be elicited through words. It will also examine the hormonal physiology of labour and its impact on women's conscious state, to help us understand why communication is so crucial when supporting women during this transformative time.

With rising rates of birth trauma, fear of childbirth, and medical interventions in developed countries, there is a growing need to improve our approach to supporting women. Therapeutic communication with women during labour has the potential to be a simple yet highly effective way to enhance their birth experience.

Translating evidence into practice: Implementing culturally-safe midwifery-led continuity for First Nations women in three maternity services in Victoria, Australia

Helen McLachlan (La Trobe University, Melbourne)

Strategies to improve outcomes for Australian First Nations mothers and babies are urgently needed. Caseload midwifery is associated with better clinical and psychosocial outcomes; however few Aboriginal women have access to this model.

La Trobe University, in partnership with the Victorian Aboriginal Community Controlled Health Organisation and four Victorian maternity services undertook a research translation project to explore implementation of a culturally safe caseload model for women having a First Nations baby.

During 2017/2018, three services implemented the new model. Prior to commencement, only 34 **women** having a First Nations baby had ever received caseload at the services. During 2017- 2020, 87% of 1040 women were offered the model; uptake was high (90%) and 92% received the model. The fourth service in regional Victoria was unable to implement the model due to ongoing staffing crises in their service.

Three Victorian health services successfully implemented a culturally safe caseload model for most women having a First Nations baby at their service. Key reasons for success were co-design, engagement and collaboration with First Nations people using 'Birthing on Country' principles.

LLEWELYN-JONES ORATION

Sexual and Reproductive Health and Rights: Taking Nothing for Granted

Deborah Bateson (Professor of Practice, The Daffodil Centre, Faculty of Medicine and Health, The University of Sydney, NSW)

Sexual and Reproductive Health and Rights (SRHR) are central to gender equity and women's health and wellbeing, and play a vital role in shaping future economic development and environmental sustainability. Having spent almost three decades studying and working in the areas of contraception, abortion care, sexual health and cervical cancer prevention, I will take you on a journey through some of the extraordinary advances I have been privileged to witness both locally and globally, as well as the hurdles thrown in the way of universal SRHR. There have been huge leaps in knowledge and innovation - new methods of contraception people want to use, the rise of medical abortion and 'no touch no test' person-centred approaches, and new tools to prevent untimely and often stigmatised deaths from cervical cancer. Yet significant threats persist, including weak political commitment (or worse, as evidenced by the overturning of Roe v Wade), inadequate resourcing and disinvestment in SRH, coercive policies and practices and persisting stigma around matters of sex and sexuality. Nothing can be taken for granted. We must continue to address the inequities and hold those with power to account, both locally and globally.

ABSTRACTS – SATURDAY

SESSION 3 – PREGNANCY

Men's experiences of grief and support after pregnancy loss

Kate Obst (University of Adelaide, SA)

This program of research explored men's experiences of grief and support following pregnancy loss (including miscarriage, medical termination of pregnancy, and stillbirth) and neonatal death in Australia. Employing mixed methods, the program of research comprised three studies including: (1) a systematic review, (2) a nationwide survey of men's experiences, and (3) in-depth interviews. Overall, findings indicated that understanding men's grief requires a socio-ecological conceptualisation. Following pregnancy loss and neonatal death, men can experience significant grief and specific challenges to grief expression, requiring acknowledgement, validation and tailored support from healthcare professionals, family, friends, communities and workplaces. Specific challenges to grief expression include balancing a desire to both support and be supported, and being overlooked as fathers by current health support services, systems and policies. Future support and policy strategies should consider the full range of grief styles and expansion of existing perinatal care infrastructure, drawing upon existing family-centred frameworks that are father-inclusive.

Miscarriage Australia

Amy Webb (Monash University, University of Melbourne, VIC)

Miscarriage Australia is a collaborative group of researchers and clinicians who undertake research to improve support for those affected by miscarriage. Their past research has shown social and healthcare support is often lacking at the time of miscarriage. As a result, people turn online for the information and support they want and need however, struggle to find evidence-based information, informed by reputable experts and healthcare providers, all in the one place, on an Australian based website. Healthcare providers too report difficulty finding miscarriage information and resources and are often unaware of the support services available to help those affected.

This presentation reports on the team's development of the Miscarriage Australia website to fill this gap in online support. Using a four-stage human centred design approach, the team worked with consumers, clinicians and expert website designers and developers to design the Miscarriage Australia website. Human centred design is considered best practice for design and software development to appropriately develop systems, products and services - including online content - which meet diverse end user's needs. The Miscarriage Australia website was launched in October 2022 and provides miscarriage information, resources and support for those affected by miscarriage and healthcare providers caring for those affected by miscarriage.

Improving maternal experiences of African women

A/Prof Anna Ziersch (Flinders University, SA)

Clemence Due, Lillian Mwanri, Moira Walsh, Constance Jones, Cathy Troup, Josephine Sheriff and Susan Cooper.

This presentation will discuss the findings of a research project and related government funded community project that sought to consider how to improve maternal health experiences of African women. The initial research drew on interviews with 19 African women from refugee backgrounds and 20 service providers and highlighted the importance of continuity of care, cultural safety of care, and agency in decision making, as well as documenting the ongoing impacts of maternal care experiences. A subsequent community project led by the African Women's Federation of South Australia (AWFOSA) (the 'African Women's Maternal Health Care project') built directly on this research. As part of this project, further consultation was conducted with African women (from both migrant and refugee backgrounds) and key hospital staff to identify and prioritise areas for action. Key current priorities include developing a cultural care plan, training and resourcing 'community champions' and promoting culturally appropriate food in hospitals. This process and potential implications for practice will be discussed.

POSTER PITCHES

[01] Exploring Women's Planning for Childbirth: Identifying Coping Strategies as Intrinsic or Extrinsic

Shifman, J.,^{1,2} Jones, L.E.,^{1,3} Davey, M-A,⁴ East, C.^{1,5} & Whitburn, L.Y.¹

¹ *La Trobe University, Bundoora, Australia*

² *St Vincent's Hospital, Fitzroy, Australia*

³ *Singapore Institute of Technology, Singapore*

⁴ *Monash University, Clayton, Australia*

⁵ *Mercy Hospital for Women, Heidelberg, Australia*

Background: It is common for women to be familiar with strategies to help them cope with the challenges of labour. These strategies are usually discussed in the literature as either pharmacological or non-pharmacological. As labour is a very individual experience, each woman should be enabled to choose strategies that they feel will work best for them. By exploring women's intentions and choice of strategies, this study aimed to better understand which strategies women plan to use to best cope with labour.

Methods: Fifty-six primiparous women were recruited from one tertiary hospital in Melbourne, Australia between February and May, 2021. Data were collected via questionnaires in late pregnancy using open-ended questions. Thematic analysis was used to analyse responses.

Results: Most women had pre-planned strategies that were targeted towards managing pain and also the mental challenges of labour. We found that these strategies could be grouped into two broad categories: intrinsic and extrinsic. Intrinsic strategies were those that women could self-generate, with those appearing most frequently in the data including breathing techniques (59%), movement (50%), and meditation (25%). Extrinsic strategies were those that required either equipment or others to administer, including using the shower/bath (48%), reassurance from support people (41%), TENS machine (37.5%), touch (34%), and planned epidural (9%).

Discussion: Grouping strategies into intrinsic and extrinsic categories has shown that women value having a range of tools that both enable self-trust and also welcome support from others, and moves beyond the 'pharmacological and non-pharmacological' categorisation of strategies. These findings provide a foundation for more targeted research into how women navigate, individualise and implement these intrinsic and extrinsic strategies.

Ethical compliance: This study received ethics approval from Mercy Health Human Research Ethics Committee and La Trobe University (ethics number 2019-034).

[02] The prevalence of perinatal anxiety in low- and middle-income countries: a systematic review and meta-analysis

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Anxiety is one of the most common morbidities of the perinatal period (from conception to 12-months postpartum) in high-income countries and is associated with a range of negative outcomes for women and babies. Its prevalence in low- and middle-income countries however is unclear. This study aimed to determine the prevalence of perinatal anxiety in low- and middle-income countries.

We searched MEDLINE, Embase, PsycINFO, CINAHL, Web of Science and the Cochrane Library (from database inception until April 15, 2021) for studies reporting the prevalence of anxiety during pregnancy, or up to 12 months postpartum in countries defined by the World Bank as low, lower-middle, and upper-middle income. Two reviewers independently assessed study eligibility, extracted data, and assessed studies for bias. Prevalence estimates were calculated using a random-effects meta-analysis model.

Our search identified 8,106 studies, of which 97 studies met the inclusion criteria and reported outcomes of 106,532 women from 23 countries. The pooled prevalence of perinatal anxiety was 25.8% (95% confidence interval [CI], 23.3 – 28.3). Lower-middle income countries had the highest prevalence of perinatal anxiety, at 31.1% (95% CI, 23.1 – 39.2). Prevalence estimates were similar between low-income countries and upper-middle income countries at 21.6% (95% CI, 8.7 – 34.4) and 23.0% (95% CI, 20.5 – 25.5) respectively. Perinatal anxiety was more common during pregnancy than postnatally: prevalence during pregnancy was 27.5% (95% CI, 24.6 – 30.5) while postnatally it fell to 20.4% (95% CI, 15.1 – 25.7).

Anxiety is common in low- and middle-income countries, affecting 20-30% of women during pregnancy and in the 12 months following. Despite this significant burden, research on prevention and treatment of perinatal anxiety in low- and middle-income countries is still lacking. Recognising perinatal mental health, including anxiety as a public health priority is essential in improving outcomes for women and babies.

Ethical compliance: As this study is a systematic review and utilises publicly accessible research studies as evidence, ethical approval was not required.

[03] Australian Intended Parent's Decision-making and Characteristics and Outcomes of Surrogacy Arrangements Completed in Australia and Overseas

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Background: Majority of Australians hoping to have a child through surrogacy turn to overseas destinations to find a surrogate. Little is known about the factors that influence intended parents' decisions about where to pursue surrogacy, and whether the outcomes for children differ between arrangements completed in Australia or overseas.

Aim: To describe how Australian intended parents decide where to pursue surrogacy, and to compare the characteristics and outcomes of arrangements completed within and outside of Australia.

Method: This study collected data through an anonymous online survey between August and November 2021. People in Australia who had completed, were completing, or planned to complete surrogacy were eligible to participate.

Results: The survey was completed by 319 respondents. The findings reveal that nine in ten intended parents prefer to complete surrogacy in Australia as opposed to overseas. Perceived benefits of Australian surrogacy include the ability for intended parents to be involved with the pregnancy and to have ongoing contact with the surrogate. However, due to difficulties in finding a surrogate, and a lack of professional assistance and legal security in Australia, four in five intended parents complete surrogacy overseas.

Overseas arrangements often involve anonymously donated oocytes and the transfer of more than one embryo. Additionally, rates of multiple birth and neonatal intensive care stays are higher in arrangements completed overseas than in Australia.

Conclusion: This study raises concerns about the psychological and physical wellbeing of Australian children born through surrogacy overseas. Reducing the barriers in Australia would allow more intended parents to complete surrogacy domestically – as is their preference. This would in turn, reduce the risks to those born through surrogacy.

The study was approved by the Monash University Human Research Ethics Committee (MUHREC 28359).

SESSION 4 – BEYOND DISCOURSES OF INDIVIDUAL RESPONSIBILITY FOR HEALTH

Panel presentations and discussion

Beyond discourses of individual responsibility for health

Prof Vivienne Moore¹, Prof Megan Warin¹, Dr Kristi Urry¹, Dr Belinda Lunnay²

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High body weight, alcohol use and smoking have consequences for women's health and thus receive clinical attention, especially when women are pregnant. The framing of these issues as 'lifestyle choices' for which individuals need to take responsibility continues to be dominant. This is despite decades of social science and other research implicating the social conditions in which people live and work - from constrained resources and precarity, to demanding jobs with low control - and the ways these are influenced by gender, class and ethnicity. These same conditions can contribute to poor mental health, highly relevant. The dominant framing means that in many clinical encounters (as in many public health efforts), the repertoire of responses to these issues is narrow, the mainstay being advice to change behaviour. We are critical of the premises of lifestyle advice and assumptions made about people and their lives. Moreover, this can be harmful and counterproductive for women, who are socialised to internalise gendered standards that are often out of reach, such as maintaining 'perfect' bodies, the 'right' way to mother, and always putting others' needs first. While acknowledging that clinicians are constrained by the systems in which they work, individual lifestyle responses reproduce clinical complicity in victim blaming and the perpetuation of a discourse that oversimplifies the issues. How can this be resisted in clinical encounters and in research designed for clinical translation? We consider alternative framings of these issues that might be taken up and resonate with women's lives.

SESSION 5 – CLINICAL & POSTER PRESENTATIONS

Challenges in the management of postnatal depression in a vulnerable immigrant mother

Mahta Mohajeri (Western Sydney University, NSW)

Postnatal depression is rising in Australia. Common symptoms include loss of self-esteem and mood, lack of appetite and enjoyment in daily activities. It is very crucial to address this due to severe impact on individual's health and wellbeing as well the newborn.

Social support and access to help is key to assisting this population overcome PND. However, for immigrant families this is extremely difficult due to complex psychosocial issues as well the cultural and language barriers that limit their access to further support. As a result, postnatal depression prevalence is the highest, with 42% of migrant communities experiencing this condition compared to 14% in the non-immigrant population.

A 35-year-old Afghani woman presented to the GP with severe low mood and loss of appetite after giving birth a month ago. This is complicated by her background of post-traumatic stress disorder (PTSD) as well as chronic back pain. Based on the symptoms and the timeline she was diagnosed with post-natal depression. The patient was then offered counselling as well as given the option to take antidepressants. However, due to cultural reasons she rejected both options.

Additional history revealed that she has no family in Australia and her husband is unable to help due to long work hours. They are struggling financially which has further increased the stress. They have another two children under the age of 5 whom she is the main carer of. Patient was encouraged to follow up with her GP and was introduced to community support groups which helped her.

This case highlights the need for culturally appropriate treatment of postnatal depression in immigrant communities. Implementing public health groups that are diverse and easy to access for all communities can help to break the language and cultural barrier. To help empower marginalised communities and provide them appropriate care.

A gynaecological case report on a tortured teratoma

Kay Chengen Shi¹

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Ms KN, a young, Middle Eastern woman in her mid-20s presented to the Emergency Department (ED) with a 1-month history of pain in her left iliac fossa which had evolved to generalised abdominal pain 2 days prior to her presentation. She spoke limited English, with her primary language being Arabic. On investigation, a 7.8L complex ovarian cyst with torsion was found. She underwent a laparotomy with left salpingo-oophorectomy and a right cystectomy. She had an uncomplicated recovery and was discharged promptly after. Ovarian torsion, the partial or complete twisting of the ovary around the vascular pedicle, represents a gynaecological emergency, with early diagnosis imperative to preserve the function of the ovaries and fallopian tubes (1-3). The presence of a 7.8L cyst begs the question, how was it not picked up prior to this admission, and if it was, why was nothing done about it? South Western Sydney represents one of the most linguistically

diverse populations in Sydney, many of which belonging to the non-English speaking population, and this fact offers possible insight into the prior question. Given the immediacy of treatment required, surgery was promptly initiated, nevertheless, a salpingo-oophorectomy and cystectomy represent major procedures, with possible impact on future fertility and fecundability. Given the aforementioned context, it does aptly raise the question, how much was Ms KN able to comprehend, did she understand the possible future ramifications, and whether she had any further concerns regarding such a procedure?

Requesting a bilateral tubal ligation at 26 – maternal psychosocial implications

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Bilateral tubal ligation is an uncommon procedure in young females, particularly when no medical contraindication to a future pregnancy exists. The decision to pursue a tubal ligation can arise from significant psychological torment surrounding reproductive choices. Reluctance of clinicians to perform this procedure, particularly due to concerns of women later regretting their decision, can result in patients feeling unheard and undermined by the healthcare system.

A semi-structured interview was conducted with a 26 year old woman who had requested a bilateral tubal ligation at the time of caesarean section, where her fourth and fifth children were born. The woman had a complex psychosocial background, which significantly contributed to this decision.

Major themes identified in the interview included a sense of ownership over the patient's fertility after the procedure, and relief of not having to go through another pregnancy. Negative experiences included feeling significant persuasion towards other contraceptive options, and as if her opinion was disregarded at times. She described being told 'you will regret this', causing her to feel diminished in her womanhood, and role as a mother. However, she felt that she received adequate information about the procedure, and was well supported by the hospital staff overall.

Bilateral tubal ligation is a procedure with numerous ethical considerations, particularly in young women. Desire for the procedure, and fear of the mental and physical consequences of a pregnancy, can have profound psychosocial impacts on some women. Informative, unbiased information regarding all methods of contraception, and clear, respectful communication are needed to understand and support women in their reproductive choices.

Informed written and verbal consent was provided by the patient for this case presentation.

POSTER PITCHES

[04] Down the rabbit hole! Pregnancy-related neuropsychiatric disorders: a case report

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We present a complex case of neuropsychiatric disorders with a pregnancy-related onset on a background of significant psychosocial stressors.

Case Report

A 21-year-old female, gravida 1 para 1, developed various neuropsychiatric conditions following an unplanned but medically uncomplicated teenage pregnancy, on a background of a complex psychosocial history. This includes her adverse childhood experience of parental separation, bullying and domestic violence starting from her secondary education. At a young age, she was diagnosed with anxiety and depression, and she began smoking tobacco and cannabis.

Although her pregnancy was medically uncomplicated, her physical and mental health deteriorated in the postpartum period. This was exacerbated by her child's diagnosis of hypospadias at birth and subsequent blame by the father of the baby. The patient was progressively diagnosed with a multitude of neuropsychiatric conditions including functional neurological disorder (FND), somatization disorder, generalized anxiety disorder (GAD), eating disorder, adjustment disorder and cluster B personality disorder. Across two years of multiple mental health presentations to the Emergency Department, a multidisciplinary approach was taken, largely involving symptom relief, antidepressants, psychoeducation, and cognitive behavioural therapy (CBT). The patient was discharged home with community mental health follow-up.

The pathophysiology of neuropsychiatric disorders, especially those that are pregnancy related, is poorly understood. However, it is believed to be heavily influenced by a combination of biological, psychological and social factors. The aforementioned psychosocial history, coupled with an unplanned teenage pregnancy, placed the patient in an extremely vulnerable state. In such settings, a multidisciplinary model of healthcare, that is responsive to changing clinical and psychosocial needs, is essential to providing holistic patient-centered care.

SESSION 6 – CONCURRENT FREE PAPERS

CONCURRENT SESSION 6A

Community Awareness and Use of Anti-Mullerian Hormone (AMH) Testing in Australia: A Population Survey of Women

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Objective: There is growing concern that the anti-Mullerian hormone (AMH) test is being used inappropriately to predict fertility but no public data on current patterns of uptake in Australia. We therefore conducted the first investigation of AMH test use in Australia.

Methods: A national cross-sectional online and telephone survey of the Life in Australia™ probability-based population panel was administered in January 2022. All active female panel members aged 18-55 years were invited to answer questions about the AMH test, including if and how they had heard about the test, whether they had had the test, the main reason for having the test, and how they accessed the test.

Results: Of the 2423 women invited, 1773 (73%) responded. Of these, 13% had heard about AMH testing and 7% had had an AMH test. Testing rates were highest among women currently aged 35-39 years (14%) and were associated with education. Almost all women had accessed the test through their general practitioner or fertility specialist. The main reason for having the AMH test was: 'it was part of infertility investigations ...' (51%), 'I was considering getting pregnant soon and wanted to understand my chances of conceiving' (19%), 'to find out if a medical condition had affected my fertility ...' (11%), 'I was curious about my fertility' (9%), 'I was considering freezing my eggs' (5%), and 'I was considering delaying pregnancy and wanted to know if this was a good idea or not' (2%).

Conclusions: Concerningly, of women who had had the AMH test, one third had done so for reasons not supported by evidence. Potential implications of inappropriate testing include unnecessary distress, risk of unnecessary procedures, and false reassurance about current or future fertility. Public and professional education on the limited utility of AMH testing outside of fertility treatment settings is urgently needed.

Ethics: This study was approved by the University of Sydney Human Research Ethics Committee (2021/893).

Exploring the Psychosocial and Behavioural Impact of Anti-Mullerian Hormone (AMH) Testing on Women

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Anti-Müllerian Hormone (AMH) is increasingly promoted as a measure of fertility potential. AMH tests are often marketed as an empowering technology and a surrogate marker for measuring the reproductive lifespan; however, as there is conflicting data about its clinical utility to predict fertility, the use of the test could potentially be more harmful than beneficial.

Aim: To investigate the psychosocial and reproductive behavioural impact of AMH testing on women who had the test performed to assess their fertility.

Method: A cross-sectional, anonymous online survey of women aged 18-55 years, who received an AMH test result in the last five years and had no history of difficulty conceiving. Participants were recruited using social media of women's health organisations.

Results: Of 251 participants (mean age=36 years, SD:4.7), 74% were full-time employed, 52% did not have children and 25% were unpartnered. Mean age of first AMH test was 33 years (SD:4.3). Most had the test because they were considering becoming pregnant soon and wanted to understand their chances (29%) or were curious about their current fertility (19%). Almost all (94%) understood that the test was a measure of ovarian reserve, 20% thought it was a measure of fertility. Almost half perceived their AMH as low (47%). Those who perceived their AMH as low (compared to normal or high) had poorer emotional response scores ($p<0.001$) and more Decision regret (compared to high) ($p=0.005$). Perceptions of low AMH also affected reproductive behaviours ($p<0.001$); specifically bringing forward plans to conceive ($p<0.001$), undergoing elective egg freezing ($p<0.001$) and considering fertility treatment ($p<0.001$).

Conclusion: Receiving a low AMH result has a psychological impact and influences women's reproductive decision-making. The findings from this study support the need to ensure informed consent and appropriate counselling when considering AMH testing.

This study was approved by the Office of Research Ethics and Integrity, The University of Melbourne (Reference number 2021-20963-18492-3, June 11 2021).

Women's Work: A scoping review of how reproductive responsibilities are shared between heterosexual partners

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Managing sexual and reproductive health across the life course is associated with numerous tasks and responsibilities disproportionately experienced by women. These extend beyond the physical side effects of pregnancy and can include the emotional burden of planning conception and the financial cost of accessing services. Although many of these burdens can be shared between heterosexual partners, how they are negotiated is not well understood. This scoping review explored how reproductive responsibilities were shared (if at all) between heterosexual partners during any reproductive life event. Key terms were entered into databases Medline (Ovid), CINAHL and Scopus in November 2021. Articles were included if they were original research published from 2015, set in a high-income country that discussed in some way how reproductive responsibilities and burdens were navigated between partners. A total of 17 articles were included, 14 were qualitative studies, two were surveys and one was a scoping review. Responsibilities were described across a spectrum of life events including planning conception, during childbirth and while actively preventing pregnancy. Multiple barriers limited men's engagement during these events, including a lack of acceptable male-controlled contraception, poor sexual health knowledge and the feminisation of family planning services. Men often felt conflicted in wanting to be involved in reproductive decisions while also wanting to respect their partner's bodily autonomy, and engagement was further shaped by traditional gender roles. Despite this, studies illustrated nuanced ways of sharing responsibilities such as companionship during birth and abortion, sharing costs of accessing health services and facilitating correct contraceptive use. Findings from this study highlight responsibilities across a spectrum of reproductive events as well as a myriad of individual and structural barriers that limit men's engagement. Although some men benefited from this, it also hindered their ability to achieve their own reproductive goals while increasing burdens experienced by women.

Disclosure of Interest Statement: Cassandra Caddy is supported by a University of Melbourne PhD Scholarship.

Eggsurance? A randomised control trial of a decision-aid for women considering elective egg-freezing

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Background: Elective egg-freezing offers women the potential to extend their reproductive years. The decision whether to freeze eggs is complex and better information and support is needed. Decision-Aids are the gold-standard for supporting complex health-related decisions. We developed a Decision-Aid according to International Patient Decision-Aid Standards criteria to support women contemplating elective egg-freezing.

Aims: Assess the impact of the Decision-Aid plus information against information alone on decisional conflict, involvement in decision-making, distress, time to decision, knowledge about egg-freezing and female infertility, informed choice and regret.

Methods: A single-blinded two-arm parallel group Randomised Control Trial. Overall, 306 participants were recruited across Australia using multiple methods including social media and Google advertising, newsletters and clinic referrals. Females aged ≥ 18 years, considering egg-freezing, residing in Australia, proficient in English, and with internet access were eligible to participate. Those considering egg-freezing for medical reasons, had already frozen eggs, been through menopause or pilot-tested the Decision-Aid were excluded. Participants received either the Decision-Aid plus existing information (intervention) or existing information alone from the Victorian Assisted Reproductive Treatment Authority (control), and completed surveys at recruitment (baseline), 6 and 12-months.

Results: Mean age was 30 years (SD: 5.2), 50% were single, 65% working professionals, and 96% had no children. Post-randomisation data are currently being analysed and results will be reported. The primary outcome measured decisional conflict at 12-months. Secondary outcomes explored differences between groups in: involvement in decision-making (Perceived Involvement in Care Scale); distress (Depression, Anxiety and Stress Scale); time to decision; knowledge about egg-freezing and female infertility (study-specific scale); informed choice (Multidimensional Measure of Informed Choice), and; decision regret (Decisional Regret Scale).

Implications: This is the first study to evaluate the effectiveness of a Decision-Aid to support women considering elective egg-freezing. If the Decision-Aid is found to be beneficial, it will be disseminated Australia-wide and internationally.

Ethical Compliance: Approved by the University of Melbourne Human Research Ethics Committee (2056457). All methods were performed in accordance with relevant guidelines and regulations.

Elective Egg Freezers' Disposition of Decisions: "Some things in life don't turn out, and its painful"

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Many women who undergo elective egg freezing do not return to use their oocytes. Consequently, there is now an abundant, but unquantified, number of women with surplus oocytes in storage. Due to 10-year oocyte storage limits in Australia and other countries, women are presently or shortly deciding the fate of their surplus oocytes. Our qualitative study aimed to explore factors that influence elective egg freezers' disposition decisions towards their surplus frozen oocytes. We interviewed 31 women at different stages of the disposition decision-making process (will decide later, currently deciding, decision already made). Five interrelated themes were constructed in the decision-making process: 1) Triggers for the final decision; 2) Achieving motherhood; 3) Conceptualisation of oocytes; 4) The impacts of egg donation on others; and 5) External factors affecting the final disposition decision. All women reported a trigger 'event' for making a final decision. Women who achieved motherhood were more open to donate to others but were concerned about implications for their child. Women who did not achieve motherhood are unlikely to donate to others due to the grief they are experiencing, often alone, and felt misunderstood and unsupported. Reclaiming oocytes and closure ceremonies helped women process their grief and donating to research was seen as a positive option to feel that eggs were not being wasted. There was also a general lack of knowledge around disposition options and their impacts, at all stages of the process, including understanding all their options and the eligibility criteria for donation. Counselling is recommended for all women who freeze their eggs at the beginning and end of the process. This should address the options available and their impacts on others, concerns related to options and the grief experience. Additionally, assisting women to communicate their feelings effectively could help them gain more support from others.

This research was approved by the University of Melbourne, Australia, Human Research Ethics Committee (2021-21648-22253-3).

The silent word of IVF

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Eight million children alive today were conceived utilising in vitro fertilisation (IVF). In 2019, these children represented 1 in 20 births in Australia. IVF is known to be a difficult experience for patients, with patients most commonly discontinuing treatment as a result of emotional, relationship and financial stress, or intolerable physical side effects of hormone treatments. However, despite the increasing use and public visibility of IVF, patients are routinely surprised by these common burdens of treatment. The unexpected nature of these burdens deprives both the patient and their clinician of the opportunity to prepare emotionally, financially, or medically. This leaves some patients in psychological distress and dissatisfied with their care.

Here we report on the results of a qualitative study in which we interviewed professionals working in ART and patients at various stages of treatment. Our data indicates there are indeed 'silences' within the therapeutic relationship of IVF. These include what the patient 'is not told' by their clinician or 'does not hear' and what the patient feels they 'cannot say'.

We argue that, although IVF clinics have many moving parts and blur the lines between commercial enterprise and doctors' surgery, the clinical and therapeutic relationship between doctor and patient remains pivotal to the experiences of patients. The performances of both patients and doctors in the complex ontological choreographies occurring within ART clinics lead to 'silences' surrounding the burdens of IVF treatment, which, in turn, impact negatively on both doctor-patient relationships and patient experiences.

Careful attention and increased societal awareness of the realities of the burdens of IVF (and an awareness of the performances that hide them) would allow both doctors and patients to converse more openly and engage in more genuine shared decision making. This, in turn, would reduce patient distress and increase patient satisfaction.

Ethical Statement: All individuals participating in this study were aged 18 or over and able to provide their own consent (no guardian/substitute decision makers involved). Ethics approval was provided by the University of Sydney Human Research Ethics Committee and consent for interview and collection of quotes/data and publication was obtained at the time of interview. Names or other identifying information have been removed.

Developing a web-based tool for predicting individualised risk of infertility in young breast cancer patients: an international multi-cohort study

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Background/Purpose: The potential for developing treatment-related infertility is a high priority for young breast cancer patients. Yet, current tools to predict fertility outcomes after breast cancer treatments are imprecise, with minimal applicability for clinical practice. We aimed to develop a web-based tool to provide an individualised risk of developing infertility for young breast cancer patients.

Methods: A literature review addressing the impact of chemotherapy for breast cancer on the risk of amenorrhoea was conducted. Authors of identified articles and known data registries were contacted and invited to contribute their data to the FoRECAST database. Logistic regression was used to develop risk prediction models, and prediction performance was evaluated internally using area under the receiver operating curve (AUC).

Results: Out of 7473 individual records in the FoRECAST database, menstrual history data was available for 2833 (37.91%) at 12 months and 2118 (28.34%) at 24 months. In multivariate analyses, common predictors for amenorrhoea (used as a surrogate marker of infertility) at 12 and 24 months were older age at diagnosis, lower body mass index, chemotherapy regimens, use of endocrine therapy, and higher pre-treatment follicle stimulating hormone level. In addition, history of smoking and alcohol consumption were also predictors for developing amenorrhoea at 12 months. Receiver-operator characteristic analysis produced an estimated AUC of 0.88 and 0.92 for amenorrhoea at 12 and 24 months. Internal validation with 1000 bootstrap resampling showed good discrimination for both models, C-index of 0.88 (95% CI 0.84–0.91) for amenorrhoea at 12 months and C-index of 0.93 (95% CI 0.90–0.94) amenorrhoea at 24 months. Based on these models, a web-based calculator is under development for implementing in clinical practice worldwide.

Conclusions: These models require external validation. However, the excellent prediction performance of the models and good precision in the estimate of accuracy in internal validation provides reassurance.

Ethical compliance: The study was reviewed and approved by the Human Research Ethics Committee of the Melbourne IVF, Australia (HREC reference number: 55/17-MIVF)

CONCURRENT SESSION 6B

The Psychology of Typology-Patient Typologies used by ART/IVF Health Care Professionals and Implications for Practice

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Patients undergoing in vitro fertilisation (IVF) treatment have reported that the treatment experience can feel like they are a 'number' or part of a 'factory processing line'. Conversely practitioners report that they work hard to provide patients with a nuanced treatment experience that best meets their needs. Something, therefore, appears to be lost in translation. We interviewed 31 professionals working in assisted reproductive technology and 25 women who had contemplated, received or were currently receiving treatment. These interviews suggests that there are a set of typologies that practitioners use to obtain a rapid understanding of their patients' needs in the clinical setting, with patients being variously typologised as: the 'patient as consumer'; the 'hopeful patient'; the 'misinformed patient'; the 'demanding patient'; the 'expert patient'; and the 'resolved patient'. In this presentation we describe these typologies and discuss how they may both reflect and entrench commercial norms, foment prejudices and preclude practitioners from seeing the individualities of each patient. We suggest that an awareness of the tendency to typologise may be helpful in ensuring individualised treatment for patients and a quality patient experience.

Ethical Statement: All individuals participating in this study were aged 18 or over and able to provide their own consent (no guardian/substitute decision makers involved). Ethics approval was provided by the University of Sydney Human Research Ethics Committee and consent for interview and collection of quotes/data and publication was obtained at the time of interview. Names or other identifying information have been removed.

“Natural” birth expectations in nulliparous women: How birth dissonance is born

Elizabeth Sutton (Monash Bioethics Centre, Monash University, Clayton)

Many women in Australia having their first baby hope for a normal (or in lay terms: “natural”) birth. Expectations about birth appear to be derived from pre-birth classes, social media, popular texts, and in some instances - family and friends. AIHW data tell us that a first birth without pharmacological pain relief is actually very hard to achieve as 79% of primiparous women used pain relief when labouring in 2020.

I argue in this presentation that a particular form of dissonance is created when women are given specific expectations about how birth ‘should’ be done, and they do not perform as expected leading women to think that they have ‘failed’ to birth ‘properly’. This will be based on data from interviews with 15 women who had their first baby between 2016-2017 and 12 interviews with health care professionals involved in direct maternity care over that same time. Women were eligible if they had no prior experience of labour and were hoping to have a natural/normal, intervention free birth. Women were interviewed three times, once at 36 weeks’ gestation, soon after delivery, and six months (or near) post-delivery. Only one woman in this study had the type of birth that she expected. All others had to engage pain relief over and above that which they thought they would require or intervention they did not think they would need pre-labour, or both. The mismatch between clear pre-birth expectations and outcomes appeared to cause dissonance that presented as a form of post birth trauma. Women who were denied or deferred pain relief or felt that their pain was badly managed, appeared to experience a more profound sense of trauma.

Ethical Statement: All individuals participating in this study were aged 18 or over and able to provide their own consent (no guardian/substitute decision makers involved). Ethics approval was provided by Monash University Human Research Ethics Committee and consent for interview and collection of quotes/data and publication was obtained at the time of interview. Names or other identifying information have been removed.

Genital Body Image in Young Adolescent Girls: A Pilot Study

Anne Nilesdni Fernando¹, Gemma Sharp¹

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There is seemingly a lack of knowledge of the anatomical structures of cisgender female genitals among adolescent girls. This lack of knowledge coupled with idealised and unrealistic representations of cisgender female genitalia in mainstream media is thought to contribute to rising levels of dissatisfaction in genital appearance with some considering risky cosmetic surgery to change their genital appearance. Research suggests that these genital appearance concerns can start in early adolescence and so the present pilot study specifically involved girls (n=6) aged 13-15 years to examine their knowledge and attitudes towards their own genitalia. Participants were presented with an online questionnaire to assess their genital anatomy knowledge and genital appearance satisfaction. This was followed by a semi-structured interview with a member of the research team via Zoom which involved a discussion of genital focused body image, sexual health education and a genital body image educational video previously shown to be effective with girls aged 16-18 years. In the questionnaire, there was a spread of genital anatomy scores with a mean score of 4.5 out of 8 (56.3%) anatomical features correctly identified. The mean genital appearance satisfaction level was moderate at 56.7%. In the follow-up interviews, most of the participants reported that they had not dedicated much thought to their genital appearance, however they reported learning new information from the educational video, namely the natural diversity in genital appearance. Additionally, most participants reported that their sexual education program in school had not addressed the concept of genital body image and instead focused on genital anatomy structure and function only. Overall, the participants reported that the educational video would likely be useful to introduce the concept of genital body image to girls in schools to inform young adolescent girls about genital appearance as they develop their own sense of genital body image.

Ethical compliance: Ethic approval was obtained from the Monash University Human Research Ethics Committee (Project ID: 19076).

Genital Body Image Education Research in Adolescent Cisgender Females: Exploring Issues of Parental Consent

Gemma Sharp¹, Francesca Beilharz¹, Anne Nilesni Fernando¹

¹ Monash University, Melbourne

Research studies investigating topics such as body image and sexual health typically require informed consent of parents/carers when involving adolescent participants. However, parental consent can be a significant barrier for adolescents' participation which can influence the reliability and validity of findings. Our research team previously demonstrated that a brief video could improve the genital focused body image of cisgender females aged 16-18 years and they were less likely to consider undergoing risky cosmetic genital surgery. We aimed to replicate this study in girls aged 13-15 years when genital appearance concerns usually first emerge, however, parental consent was required for this younger group. The present study aimed to examine the attitudes of parents towards involving girls aged 13-15 years in our genital body image intervention. Parents (N=182) in Australia completed an online questionnaire containing measures of demographic characteristics, sexual education history and general attitudes towards sex, body image satisfaction, and likelihood of consenting to their child aged 13-15 years to be involved in a genital body image intervention. The vast majority of parents (73%) indicated they "definitely would" consent to their 13-15 year old child to be involved in our intervention. In order to explore gender differences, we asked parents to rate this likelihood for consent for a hypothetical girl and boy child aged 13-15 years old. There was no difference in support between girl and boy children overall. However, if likelihood of consent was asked for the girl child first, this was significantly lower than when asked after the boy child. In terms of parent characteristics, they were more likely to give consent if they rated religion as less important and were not highly conservative in their attitudes towards sex. Overall, it appears most parents would consent to their young adolescent girls being involved in our genital body image research/intervention.

This research was approved by the Monash University Human Research Ethics Committee – Project ID 25784

The Sexual and Reproductive Health of Adolescent Women with Cerebral Palsy in Rural Bangladesh

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Adolescents with disability in the Global South have unique sexual and reproductive health (SRH) experiences and needs however are rarely included in SRH discourse. This qualitative study, conducted in rural Bangladesh, examined how adolescent women with cerebral palsy (CP) experienced their SRH from the perspective of twelve adolescent women with CP and 33 mothers. Participants were recruited from the Bangladesh Cerebral Palsy Register. Semi-structured focus groups explored SRH topics including feelings about growing up with CP; knowledge and beliefs about puberty, marriage and children bearing; and access to SRH information and education. Data were thematically analysed. Adolescent women with CP reported wanting to adhere to traditional feminine roles such as becoming married. However, marriage was considered dangerous for those who were unable to independently perform domestic tasks such as cooking and cleaning due to the risk of violence from their potential husband and his family. Marriage was considered "impossible" for those with high support needs. Adolescent women with CP hoped to become mothers in the future but were unsure if their impairment may prevent them from childbearing. Most participants were not enrolled in school and lacked peer networks which meant they had no access to SRH information. Menarche, discussed as "flower of the body", marked the sexual maturation of adolescent women, however, was shrouded in silence and secrecy and was perceived to increase the vulnerability of adolescent women with CP to sexual abuse. Mothers positioned providing care to their adolescent daughters with CP after menarche as "shameful" and "painful" although adhered to an imperative to care as "mother is not the kind of person who would abandon her child". Our findings suggest that disability, health and education services in Bangladesh need to adopt a life-course approach that incorporates the SRH of adolescents with CP. There is a need for SRH education that addresses the physical, cognitive and social needs of adolescents with CP.

Ethical compliance

This study has ethical approval from the Bangladesh Medical Research Council (BMRC/NREC/2013-2016/1165) and University of Sydney Human Research Ethics Committee (2016/646). All procedures performed in this study were in accordance with the ethical standards of these institutes and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

CONSENT PROTOCOL: The parents of eligible adolescents with CP were contacted by phone by a community-worker and they and their adolescent with CP were invited to participate in focus groups. Due to high rates of illiteracy in the study location information about the focus groups were provided verbally; including the purpose of the focus groups, topics and format. This information was provided again prior to each focus group to ensure understanding and free informed consent. Parents were also given a phone number they could call to ask questions about the interview. Prior to the interview, informed verbal and written consent was obtained for all individual participants. In cases of illiteracy, written consent was obtained by thumbprint. Minors (i.e. 14-18y) provided verbal assent and their parent or legal guardian provided written consent.

Establishing the Preventive Sexual and Reproductive Health Care Needs of Karen Women from Refugee Backgrounds in Victoria

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Background: Women from refugee backgrounds have poorer health outcomes than migrant and host country populations. Barriers to and enablers of preventive sexual and reproductive health (SRH) for this group of women are poorly understood. This project aims to generate evidence about the needs and experiences of Karen women from refugee backgrounds in Australia regarding accessing preventive SRH care.

Methods: A qualitative study using semi-structured interviews was conducted with women who meet following inclusion criteria; women of reproductive age (18 to 50 years) who entered Australia under the Humanitarian Program. Varied strategies were used to recruit a diverse sample. Interviews were conducted at a local community hub familiar to the participants. A bicultural worker assisted with interpretation during interviews. Audio recordings of English dialogue were later transcribed verbatim by the first author. NVivo software was used to organize and visualize data. Thematic analysis was used to analyze and report data.

Results: 13 Karen women were interviewed. Three major themes were identified; 1) Low prevention awareness was related to limited pre-arrival access to education and knowledge of services. Appreciation of the new health system upon resettlement lead to improved awareness and uptake of SRH services. Limited vaccination knowledge was a consequence of low literacy and lack of linguistically appropriate information; 2) Perceived need for prevention was strongly associated with the presence of symptoms; 3) Women's health seeking behaviour was positively influenced by information from GPs, community and family members. Perceived barriers included shyness, embarrassment, low volition and physical discomfort in clinical settings.

Conclusion: To improve access to preventive SRH services a multi-component strategy is needed. Recommendations informed by participants included; provision of post arrival preventive SRH care, education and information; peer support and community support interventions; and health care providers offering a diverse range of service and information provision options for Karen women unfamiliar with preventive SRH care.

Ethical Compliance Statement

There was no funding source for this particular study. Natasha Davidson is supported by an Australian Government Research Training PhD Scholarship. Jane Fisher is supported by the Finkel Professorial Fellowship which receives funding from the Finkel Family Foundation. The authors declare that they have no competing interests. All procedures performed in studies involving participants were in accordance with the ethical standards of Monash University. Informed consent was obtained from all individual participants involved in the study.

An evolutionary concept analysis of reproductive coercion: The evidence for a novel measure

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Reproductive coercion is predominately documented as male partner control of a female partner's reproductive autonomy over pregnancy, abortion, and/or birth control decisions. As new evidence and knowledge evolves, debate has arisen about definitions and measurement.

This research aims to advance conceptual understanding through a rigorous global review on reproductive coercion and surrogate terms. Roger's evolutionary method guided critical analysis of over 300/1600 publications from 2010-2022 (n=5 databases). An intersectional feminist lens and a human and reproductive rights approach underpinned analysis.

Reproductive coercion meets criteria for gender-based violence. Repetitively cited definitions and measures developed pre-2015 vary in conceptual depth. Exponential research growth (>40% of all papers) occurred post-2020 since the COVID-19 pandemic, notably conceptual and qualitative work. Behaviours cited are numerous, ranging within and across interpersonal to societal levels. A clear pattern in the literature describes reproductive coercion within intimate partner violence (IPV) and domestic abuse, distinct from relationships where abuse is isolated to infringement of reproductive autonomy. Perpetrator types extend beyond intimate and/or sexual partners and relatives to include close social and community networks. Research seldomly explored the role of families in high-income countries. In low- and middle-income countries, the concept has largely been investigated as reproductive autonomy, an equally contested concept. Little empirical evidence on abortion coercion/forced abortion exists. Scale design appears to drive knowledge gaps.

The range of abusive behaviours described as reproductive coercion map onto recognised forms of violence against women and girls (e.g., economic, psychological, physical, sexual). This helps explain emergence of the term reproductive violence and suggestions to adopt the socio-ecological model, a violence prevention framework. We propose reproductive coercion within domestic abuse be measured as a sub-domain in existing IPV scales. Current reproductive coercion definitions and measures do not match understandings which evolved over the past decade. A novel, comprehensive interpersonal measure is justified.

Ethical Compliance: No ethical approval was needed for this review which analysed data from previously published research. Authors of the included papers reported informed consent was obtained from all participants.

ABSTRACTS – SUNDAY

SESSION 7 – CONCURRENT FREE PAPERS

Concurrent Session 7A

Mapping the abject: Women's embodied experiences of premenstrual body dissatisfaction through body-mapping

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Women's body shame and body dissatisfaction increase in the premenstrual phase of the cycle, associated with premenstrual distress. However, the meaning and consequences of premenstrual body dissatisfaction remain underexplored. The aim of this study was to explore how women who report premenstrual body dissatisfaction construct and experience their bodies, using qualitative arts-based methods. Four hundred and sixty women completed online open-ended survey questions in response to a Facebook advertisement targeted at women who feel negatively about their bodies during the premenstrual phase of the cycle. Sixteen women took part in body-mapping involving visually illustrating experiences on a life-sized outline of the body, followed by a telephone interview. Thematic analysis identified three major themes: construction of the premenstrual body as abject, manifested by positioning of the body and self as fat, leaking and dirty; self-policing and self-regulation through increased scrutinising and concealment of the premenstrual body; and resistance of cultural constructions of idealised femininity. These findings emphasise the need to acknowledge changes in body dissatisfaction across the menstrual cycle, and the implication for women's feelings about the self. Internalisation of negative constructions of the female body plays a role in women's experience of premenstrual change and distress. There is a need for further research to examine the role of body management behaviours in premenstrual body dissatisfaction and distress.

Heavy menstrual bleeding and pelvic pain in adolescents: a systematic review of self-management strategies, quality of life and unmet needs

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Objective: Heavy menstrual bleeding (HMB) and primary dysmenorrhea (PDM) are common gynecological problems with a major impact on quality of life (QOL). We aimed to systematically review the needs, QOL, and effectiveness of self-management strategies amongst young women (12-26 years) with HMB and PDM.

Method: HMB and PDM relevant terms were searched through PubMed, EBSCO, Google Scholar, ProQuest, and Ovid between 2010-2022. The Joanna Briggs Institute (JBI) checklist was used to assess the quality of studies.

Result: The search returned 285190 studies, of which 55 were eligible for inclusion. These papers included a total of 42,649 young women. The prevalence of HMB and PDM ranged from 41.6% to 94%, and 2.2% to 62%, respectively. Over 80% of teenagers with PDM and HMB experienced physical and psychological problems such as physical pain, sleep issues, mood disturbances, diarrhea, and nausea. Academic performance and daily activities were severely affected, such as taste-taking ability and concentration in class, and school absenteeism. Most females (about 70%) named their mothers as their primary source of information, and friends as the secondary source (about 50%). The pain was the most common issue that drove young women to find treatment. There was a dearth of understanding of the pathophysiology of menstruation among young women with PDM and/or HMB. More than 70% of people preferred using medicines to reduce their pain. More than half chose home remedies (e.g., heat therapy, massages, herbal tea, hot drinks). Limited studies provided information about the efficacy of the medication and herbal remedies and dosage of use. There were diverse needs and unmet needs in three areas: school, social, and education.

Conclusion: HMB and PDM have a large impact on daily living, with large areas of unmet need. Limited access to information impairs the management of symptoms and consequent quality of life.

Endometriosis Diagnosis Pathways in South Australia: A qualitative study

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The objective of this study was to explore the lived experiences of people with endometriosis in South Australia regarding their diagnosis pathway and how this has shaped their experience living with this condition. This study responds to a call for more research into the diagnostic delay within Australia, potential reasons for this delay, and the impact of this delay on individuals living with endometriosis. Research has shown that there is significant delay in reaching a diagnosis worldwide, and this has been linked to increased rates of infertility, debilitating pain, and reduced quality of life. A qualitative study using in-depth interviews was conducted with 50 people living in South Australia over the age of 18 who had a surgical diagnosis of endometriosis. These semi-structured interviews used a narrative approach to gather information on people's experiences of endometriosis diagnosis. This study found that many participants experienced significant periods of time between onset of symptoms and surgical diagnosis. Prominent themes that emerged regarding barriers to timely diagnosis included normalisation of symptoms, lack of education of both the participant and health practitioners, and feeling as if health practitioners did not take their symptoms seriously. Delayed diagnosis impacted mental health, school and work attendance, pain, and financial burden. In addition, our findings show that delivery of a diagnosis is a key point in the endometriosis care pathway that needs to be conducted thoroughly and empathetically by health professionals with a patient-centred focus. This study highlights the need to improve care pathways for diagnosis of endometriosis. These results call for multi-faceted improvements in technology, advocacy, and education for students and health practitioners in order to improve timely diagnosis and patient-centred outcomes.

The most bothersome symptom – a new measure for endometriosis

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Change in the 'most bothersome' symptom was recently identified as part of a core outcome set for endometriosis clinical trials. This outcome has never been used in endometriosis research and no validated tool exists to measure it in this population. It is currently unclear whether 'symptom bother' is an appropriate construct to measure in the endometriosis population. As a first step in developing a novel tool to measure this outcome, our objectives were to consult women living with endometriosis to explore 'symptom bother' and to determine whether this construct is relevant to their lived experiences.

Australian women living with endometriosis were recruited via a private pelvic pain clinic and through social media to participate in a semi-structured 1:1 interview. Audio was recorded and transcribed verbatim and transcripts were evaluated using thematic analysis within a qualitative description methodology.

Interviews were undertaken with 18 women. The 'bother' caused by endometriosis symptoms was found to be linked to negative emotional reactions and was different for each individual. This variation was dependent on the value placed on particular symptoms and the potential for symptoms to interfere with normal daily functioning. Whilst participants recognised that symptoms of endometriosis are bothersome, most revealed that this terminology does not fully capture the intense experience of symptoms and the seriousness of the consequences on daily life that often result. Most participants resonated with 'impact' as a more understandable and generalisable construct and would prefer our tool to measure the 'most impactful' symptom instead.

The concept of 'bother' caused by endometriosis-related symptoms was found to be diminishing of the substantial pain, burden, and suffering experienced by people living with endometriosis. Measuring the 'impact' of symptoms was the preferred construct amongst participants. As such, our new tool will measure change in the 'most impactful' endometriosis symptom.

This study was approved by The University of Melbourne Human Ethics Committee (2022-23687-28785-5)

How might we screen for psychosocial factors in individuals with pelvic pain? An electronic-Delphi study

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Persistent pelvic pain is a complex condition often influenced by psychological factors. Currently there is no instrument to screen for multiple psychological factors in individuals with pelvic pain. The aim of this study was to firstly determine the relevant psychological factors that should be screened for and secondly, the most appropriate statements to represent these psychological factors.

A focus group with eight pain/pelvic pain experts determined the relevant psychological factors to screen for in individuals with pelvic pain. A panel of 14 pain/pelvic pain experts conducted three rounds of electronic-Delphi online surveys and two teleconference discussions to establish the most appropriate statement to screen for each of the psychological factors identified in the focus group. Experts were asked to assess the screening statements using a 100-point allocation system and could reword and suggest new statements. Statements were assessed for consensus and stability and were eliminated as the rounds progressed if they met the exclusion criteria.

Thirteen relevant psychological factors were identified in the focus group. At the termination of the electronic-Delphi, 15 statements remained across the 13 psychological factors, including: catastrophisation (helplessness, rumination, magnification); fear; avoidance; self-efficacy; depression; anxiety; hypervigilance; health anxiety; sexual assertiveness; stress; and trauma.

The final list of 15 statements will assist clinicians in screening for psychological factors in individuals with pelvic pain and is an important step for clinicians in providing psychologically informed care to these individuals. Future research should determine the psychometric properties of the statements to determine their clinical utility as a questionnaire.

Primary Health Care Providers' views on providing Menopause-related Care to Migrant Women from Low- and Middle-Income Nations: What are the Barriers and what are the Facilitators?

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Australia is a multicultural society where nearly a third of the population was born overseas. Migration and settlement require getting to know new systems including the health care system. However, migrants often describe difficulties accessing health care which in part is due to the complexities in understanding and navigating the system. Consequently, migrant populations are less likely than people born in the destination country to access health promoting care. The risk of chronic conditions increases in midlife. In women this phase coincides with menopause. Health behaviour in midlife is linked to health outcomes in older age. Menopause-related care provided in primary health care consultations offers an opportunity for promoting knowledge about optimal health behaviour in midlife and beyond.

This study reports the qualitative results of a mixed methods investigation that explored Primary Health Care Providers' (PHCPs) opinions about menopause-related care needs of migrant women from low- and middle-income countries including what they believe to be the barriers and facilitators for providing this care. Of the 139 PHCPs who responded to the online survey 77 completed the open-ended response questions exploring the barriers and enablers to providing menopause-related care. Data was analysed thematically.

Respondents viewed migration and settlement experiences, health care system responsiveness and culturally informed beliefs and behaviours as the most common barriers to providing comprehensive culturally competent menopause-related care. Recommendations to address these include flexible and innovated approaches to care, community engagement and consultation, greater availability of community led health information workshops and training towards culturally competent care for health care providers. These findings suggest that the current model of primary health care may need additional resources to provide comprehensive and optimal care to migrant women. Resource mobilisation from within the migrant community might improve access to health promotion information.

This study meets the requirements of the 'National Statement on Ethical Conduct in Human Research' and approval was granted by the Monash University Human Research Ethics Committee.

Protecting the virtues of (good) womanhood: How culture and religion shape Middle Eastern women's experiences of period pain

Dr Alexandra Hawkey, Christine Saleh and Dr Mike Armour*

Menstrual health literacy, and the ability to manage menstrual symptoms, including pain, is informed by social, cultural and religious beliefs and practices. In Australia, much of the current literature explores experiences and management of menstrual pain among White Australian born women, meaning the experiences of women from other cultural contexts is poorly understood. The aim of this pilot project was to explore how cultural and religious beliefs and practices impact on knowledge and diagnosis of menstrual disorders and management of period pain among Middle Eastern women in Australia. A total of 75 survey participants and 12 focus group participants from Middle Eastern backgrounds (18-45 years) participated in the study. Data was collected between November 2020 and June 2021. Menstruation was a taboo topic with negative implications for experiences of menarche and menstrual literacy, leading to difficulties with menstrual management in girlhood. Cultural expectations surrounding premarital virginity and motherhood impacted on some women's diagnosis of menstrual disorders, limited the types of menstrual products women were permitted to use and influenced treatments offered to women to manage period pain. Period pain was culturally constructed as 'normal' and something to be endured by women, with participants adopting contemporary and culturally prescribed self-management pain strategies. While these included medication, heat, prayer, and traditional herbs, many women were dissatisfied with their pain management options and experienced barriers to addressing their pain with healthcare professionals. To ensure women know their treatment options and can access appropriate period pain management, findings from this pilot highlight the need for increased awareness of 'normal' period pain through co-designed, culturally sensitive menstrual health promotion activities. Healthcare professionals working with culturally diverse communities would also benefit from being aware of additional barriers that women from Middle Eastern backgrounds may face when seeking diagnoses and treatment for period pain.

CONCURRENT SESSION 7B

What are the barriers to implementing psychosocial assessment in the private sector?

1. Tanya Connell, 2. Bryanne Barnett

1. PhD candidate, University of Sydney

Approximately 30-40% of obstetric women choose to deliver in the private sector in Australia. Compared to the public sector, women in the private sector are more likely to have an induction of labour, a caesarean section, an instrumental delivery and a longer postnatal stay. Obstetricians and midwives in the private sector note that the role of obstetricians in postnatal care is minimal.

Psychosocial assessment, including depression screening, as part of perinatal care has been deemed good practice in the national clinical guidelines for perinatal depression and anxiety. However, little is known about psychosocial assessment in the private hospital sector. The primary aim of this study was to establish what is known about such assessment for women who choose private obstetric/maternity and postnatal care, particularly the availability and appropriateness of referral pathways and barriers to implementation. The study included implementing psychosocial assessment as part of the booking-in process at a regional private hospital in NSW.

This presentation reports on the barriers encountered in introducing psychosocial assessment to the pilot site. Recommendations for how to identify and overcome some of these barriers will be presented, with the aim of facilitating the introduction of this assessment at other private hospitals.

Access to information on risks to maternal and infant health is considered a fundamental privilege of antenatal care. Routinely assessing and measuring psychosocial risks and mental disorders are essential activities in evaluating the need to provide appropriate and timely responses to identified risks, to reduce infant mortality, preterm births and low birth weight infants. The perinatal period provides a unique opportunity to identify and intervene in perinatal anxiety and depression, partner violence, substance use problems, unresolved loss and other traumatic history. There is an increasing move internationally to standardise and make routine the psychosocial assessment and depression screening of all pregnant women.

I guess I see it as an odd thing for someone my age to be concerned about" - why haven't young people discussed sexual and reproductive health care needs with a GP?

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General Practitioners (GP) plays an important role in providing sexual and reproductive health (SRH) care. However, many young people and healthcare providers experience barriers to discussing SRH and little is known of the SRH topics young people would like to discuss. We explored SRH topics that young people would like to discuss with a GP, and any barriers to doing so.

We conducted an online survey of Australians aged 16-29 years during May–June 2022. Respondents were asked to select SRH topics and specify if they had discussed, wanted to discuss, or never wanted to discuss the topic with a GP. Those selecting one or more topic they wanted to discuss were considered as having ‘unmet need’ and asked a free-text question about why they had not discussed the topic/s with a GP. We explored characteristics associated with having unmet need to discuss SRH using multivariate logistic regression and analysed free-text comments using content analysis.

From a total of 1887 respondents (67% women, 49% heterosexual) almost half (46%) reported SRH topic/s for which they had unmet need to discuss with a GP. The most common topics people wanted to discuss were cervical screening, female sexual problems, male sexual problems and sexually transmissible infections. Respondents who were male, older, heterosexual, and with a regular GP were less likely to have unmet need. Barriers to discussing SRH topic/s included discomfort, limited opportunity, fear of negative outcomes, and uncertainty about the role of discussing SRH with a GP.

Young people face barriers to discussing SRH topics but should be reassured that all SRH issues, including sexual difficulties are appropriate to discuss with a GP. GPs should be aware that many young people would welcome preventative SRH care and be prepared to discuss and provide support for issues relating to sexual difficulties.

Ethics: This research has been approved by The University of Melbourne Ethics Committee (ID: 22475).

Understanding the information needs of people making decisions about using a contraceptive implant or intrauterine device: findings from a scoping review and online survey

Jacqueline Coombe¹, Cassandra Caddy¹

1 Sexual Health Unit, Melbourne School of Population and Global Health, University of Melbourne, Carlton, Victoria.

Intrauterine devices and contraceptive implants are the most effective reversible contraceptive methods available in Australia, but the least used. Most people make decisions about their contraceptive use before they visit a healthcare provider, often using the internet as a key source of information. It is vital that the information available online about intrauterine devices and contraceptive implants supports informed contraceptive decision making, and that those who may wish to use these methods are supported to do so. In this presentation we report on data arising from a project exploring the information needs of health consumers regarding intrauterine devices and contraceptive implants. We conducted a scoping review of information available online about these methods, and an online survey with Australian women of reproductive age to investigate what information about these methods was desired. Results from the scoping review demonstrate significant variability in the information available online, despite many being published by reputable sources (including state health departments and peak sexual and reproductive health organisations). Just over half of the pages reviewed included contraceptive efficacy, and many did not include information regarding cost, how and where to access the devices, or their mechanism of action. While most webpages reviewed included potential side effects, the depth of these varied considerably and were often contradictory to other sources. Comparatively, results from the 1800 survey respondents highlight that this information is crucial to health consumers. Side effects, effectiveness, cost and signs that something is wrong and when to seek help were all considered important information to know prior to deciding whether or not to use these methods. Findings from this study highlight the importance of ensuring that the information provided online is not only consistent across sources and medically accurate, but that it also meets the needs of consumers to support informed contraceptive decision making.

Ethical approval: This study received ethical approval from the University of Melbourne Human Research Ethics Committee, ID: 2022-23972-30708-4

An examination of a free safer sex program at the University of Melbourne: what worked and what did not

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¹Department of General Practice, The University of Melbourne, Australia

²Melbourne School of Population and Global Health, The University of Melbourne, Australia

The Safer Sex Practices Program at the University of Melbourne is a free, online condom and safer sex products distribution program that was made available in July 2019 to all enrolled students. It aims to promote safer sex practices by offering students male and female condoms, dental dams, and personal lubricant, as well as some sexual health information. This study aimed to understand students’ views of the program, to determine what worked well and what can be improved.

Purposive sampling was utilised to recruit students who have and have not used the program. Semi-structured interviews were conducted and students who have used the program were asked about their experience of the program, what they liked and/or disliked, and how the program can be improved. Students who have not used the program were asked why they chose not to use the program and how the program can be improved to address their concerns. Thematic analysis was conducted.

Twenty students aged 18-26 years shared their views on the program, where half of the students (n=10) had used the program. Fourteen of the 20 students (70%) were international students. Results were categorised into two major themes: what worked well, and what can be improved. Overall, students thought the program was a good initiative because it was free, easy to use, discreet, and provided a diverse and holistic approach to promoting safer sex practices. However, students also expressed concerns about the quality of products; they wanted more sexual health information and additional sexual health support; and believed that the program needed to be better promoted. Suggestions were made.

The need for a sexual health program on campus was highlighted. The Safer Sex Practices program was deemed beneficial; however, some improvements are needed to meet students' sexual health needs on campus.

Disclosure of ethical compliance

The Safe Sex Practices program at the University of Melbourne was and continues to be funded by the Bupa Health Foundation. However, analysis of this study was not affected by the funding body. JH is supported by a National Health and Medical Research Council Fellowship (1136117).

Ethics approval was granted by the Human Ethics Advisory Group at the University of Melbourne (1954116.1).

Construction and Experiences of Hormonal and Non-Hormonal Contraception

Susan Manners¹, Alexandra Hawkey¹, Jane Ussher¹ (Western Sydney University, NSW)

1 Translational Health Research Institute, Western Sydney University, Campbelltown, NSW, 2560

The unintended pregnancy rate in Australia is estimated to be 30%. A significant contributor to this is the inconsistent use or discontinuation of contraception. There is little existing literature that focuses on the material, discursive, and intrapsychic experiences of contraception use. The aim of this study was to explore the subjective and embodied experiences of contraception users with a cervix in Australia. 1190 participants completed an online survey, which asked about physical, emotional, and sexual experiences of their contraception use, interactions with healthcare providers, reproductive autonomy, and satisfaction with, influences on, and communication about their contraception. 18 participants completed a subsequent timeline of contraception use and body map (an arts-based, embodiment-centred data collection method), and 17 participants completed an in-depth interview, both of which further explored their construction and negotiation of contraception. Participants were from a diverse range of cultural backgrounds, sexualities, and genders. Both positive and negative embodied experiences had significant influence over the methods of contraception people chose to adopt. Many factors were found to intersect with contraception experiences, including pre-existing chronic health conditions, past abuse and/or trauma, self-identity, and sexual practices. Subjective communication about contraception was described as required information alongside medical expertise. Control and autonomy in participants' contraception journeys was a common modulator of whether the journey was positive or negative. Findings from this study highlight the importance of embodied experiences in the choices people make about their sexual and reproductive health and wellbeing. Findings also support patient-centred contraception care, where patient practices, lifestyle, experiences and preferences are foregrounded, and where possible given priority in contraception counselling and recommendations.

Statement of Ethical Compliance: The authors report there are no competing interests to declare. This study was approved by the Western Sydney University Human Research Ethics Committee, approval number H14172.

POSTER PITCHES

[07] Staff Perceptions of Facilities and Support for Early Menarche in Australian Primary Schools: A Qualitative Interview Study

Olivia Bellas, O¹, Prichard, I¹, Mulholland, M², Velardo, S³, Sivertsen, N¹, Kemp³, E and Shipman, J¹

¹ College of Nursing and Health Sciences, Flinders University, South Australia

² College of Humanities, Arts and Social Sciences, Flinders University, South Australia

³ College of Education, Psychology and Social Work, Flinders University, South Australia

This paper reports on staff perceptions of the facilities and support available in Australian primary schools for students who experience early menarche. The onset of menstruation, termed menarche, is an important developmental and clinical indicator of girls' physical, nutritional, and reproductive health. Worldwide the average age of menarche has been steadily declining with approximately 12% of Australian girls now getting their first period between 8-11 years of age. Research shows that early menarche is associated with poorer adolescent mental health outcomes. The current guidelines from the Australian Curriculum Assessment and Reporting Authority state that menstruation education should be introduced to students between year levels 5-6. Students are aged between 10-12 at this stage and many are likely to have already begun puberty. As such, there is a clear rationale to explore how girls experiencing early menarche are currently supported in primary schools. Semi-structured interviews were conducted with primary school staff, including teachers, principals, school support officers, and school counsellors. This paper will present the results of thematic analysis that is currently underway. Our analysis builds upon recent calls for improvements to facilities, awareness, training and curriculum related improvements in the area of menstrual health and wellbeing in schools. Findings will inform menstruation education policy and curriculum in Australian primary schools. Results will assist in determining how staff can appropriately prepare and support girls experiencing early menarche in the school environment.

This study has been approved by Flinders Human Research Ethics Committee: Project no. 5257.

[10] The relationship between the intensity of domestic violence and the level of adherence to home quarantine among pregnant women in the context of COVID-19: a cross-sectional study in Bojnourd, Iran

Ashraf Saber¹, Maryam Omid², Fereshteh Eidy³, Mahdis Mehrabi Bardar², Zahra Moghadasi⁴, Shiva Pourali Roudbaneh⁵, Dr. Rahman Panahi⁶, Dr. Ahmadreza Shamsabadi⁷

¹ Instructor, Department of Nursing, Master of Midwifery, School of Medical Sciences, Esfarayen Faculty of Medical Sciences, Esfarayen, Iran.

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⁷ Assistant Professor, Department of Health Information Management, School of Medical Sciences, Esfarayen Faculty of Medical Sciences, Esfarayen, Iran.

Pregnant women experience significant physical and psychological stress during the COVID-19 pandemic due to their special situation and additional stressors like violence. This study aims to investigate the relationship between the severity of domestic violence and the level of adherence to home quarantine among pregnant women in the context of the Covid-19 pandemic.

This cross-sectional study was conducted with 133 pregnant women who were referred to the maternity ward of Bent Al-Hoda Hospital, Bojnord city (July 2020 to September 2021). Participants were recruited by convenience sampling method. The questionnaire used in this study is divided into three sections including a socio-demographic questionnaire, a domestic violence questionnaire, and an adherence to home quarantine questionnaire. Then, data was imported to SPSS version 24. Multiple Linear Regression (Backward Elimination Technique) was used to determine the relationship between the severity of domestic violence and the level of adherence to home quarantine.

Both the severity of domestic violence and the level of adherence to the home quarantine were mild and medium, respectively. According to the results of the logistic regression test, the baby's gender, the women's education level, and adherence to home quarantine were the factors that significantly influenced the severity of domestic violence.

The severity of domestic violence was higher among pregnant with a baby boy, lower educational levels, and moderate levels of adherence to home quarantine. Therefore, to minimize the negative effects of domestic violence and prevent its occurrence, it is crucial to support these women by developing and implementing specific educational and support programs.

[11] The Frequency, Severity and Interference of Vasomotor Symptoms in Cancer Survivorship: A systematic Literature Review

Nipuni Susanto¹, Mariana S. Sousa², Sabina Vatter³, Jasmine Yee³, Shiva Pourali Roudbaneh¹, Martha Hickey¹, Michelle Peate¹

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²Improving Palliative, Aged and Chronic Care through Clinical Research and Translation (IMPACCT), University of Technology Sydney, NSW

³The University of Sydney, Sydney, NSW

There are over 500,000 female cancer survivors in Australia and, regardless of tumour type or location, survivors commonly experience vasomotor symptoms (VMS, hot flushes and night sweats) due to cancer treatment. VMS can significantly affect adherence to treatment and lead to low quality of life (QoL). In order to reliably measure VMS among this population to determine appropriate symptom management, a high-quality patient reported outcome measurement (PROM) is needed.

To systematically review the literature evaluating patient reported prevalence, severity and interference of VMS in female cancer survivors in accordance with the core outcomes in menopause.

A comprehensive literature search was performed in MEDLINE, EMBASE, PsycINFO databases between 2010 and 2021. Study and patient characteristics, and VMS PROM-specific details were extracted. Six authors assessed risk of bias using the Standard Quality Assessment Criteria.

The search returned 521 studies, of which 64 were eligible for inclusion. Majority of studies were conducted in breast cancer survivors (n=58), followed by patients with cervical cancer (n=2), ovarian cancer (n=2) and a combination of tumour types (n=2). Surveys (n=52) and/or diaries (n=21), were the main source of PROMs used. There were 11 cancer-based instruments (n=25), ten menopause-based instruments (n=21), and five VMS scales (n=15). Only the Hot Flush Rating Scale, which was used by 4 studies, was found to measure frequency, severity and interference. Across studies 6 assessed frequency only, 10 severity only, 9 bother only and 2 interference only. No studies compared VMS across tumour streams. Data has been extracted on frequency, severity and interference of symptoms and is currently being collated.

Results will be presented at the conference.

SESSION 8 – COMPLEX PELVIC PAIN

Complex Pelvic Pain, a GP perspective, Individualising Care and Building your team

Carmel Reynolds (GP, Adelaide Health Care)

Presentation of a typical case of complex chronic pelvic pain in General Practice. Suggestions for consult structure, management principles and building a multi-disciplinary team. Dr Carmel Reynolds, GP at Adelaide Health Care, SA Board Member for the Australasian Menopause Society, Member of the Adelaide Pelvic Pain Network and Clinical Lecturer at The University of Adelaide.

A relational perspectives on treatment of complex pelvic pain

Amanda Gierasch (Adelaide Health Psychology, SA)

Complex pain is known to be multi factorial in origin, yet treatment modalities often ignore the relational components of pain, and by extension, relational treatments. Recommended treatment strategies included pacing, exercise, relaxation, desensitization, all of which are important and helpful. None of these, however, touch on how relationships impact pain, and evidence suggests that relationships have a profound impact on pain.

One recommendation for treating complex pain having multi disciplinary treatment teams, so that the individual is supported in a wholistic manner. However, the structures of our healthcare system make this difficult, on a variety of levels.

Further, many of our patients arrive with medical trauma, and feeling that the system has minimized, invalidated and ignored their needs. Such trauma requires a relational approach to treatment, an approach frequently glossed over in both medical and allied health training. I will give a brief overview of the components of relational treatment, incorporating the concepts of power dynamics, boundary setting and ability to engage in productive conflict.

Why is Pelvic Pain So Complex? Physiotherapy perspectives on the Top 4's.

Shan Morrison (Australian College of Physiotherapists and Specialist Women's, Men's & Pelvic Health Physiotherapist)

This presentation will share a Physiotherapists perspective on the top 4 complexities, top 4 essentials of assessment and top 4 principles of managing persistent pelvic pain. For clinicians it can sometimes feel like a difficult jigsaw puzzle with pieces missing. For the person having the lived experience it negatively impacts the quality of every aspect of their life. Persistent pelvic pain (PPP) syndrome is recurrent pain perceived in structures related to the pelvis for at least 3-6 months without a confirmed infection or other obvious local pathology. It is associated with negative cognitive, behavioural, sexual and emotional consequences. In addition to pain, PPP syndrome is associated with symptoms of lower urinary tract, bowel, gynaecological, sexual and pelvic floor dysfunction. The words used in the definition identify main reasons for the complexity of PPP – symptoms presenting in multiple viscera- bladder, bowel and reproductive organs, impacting muscles and functions essential for survival – reproduction and elimination. We can also see that the consequences are associated with cognitions and emotions, adding another layer of complexity – the nervous system and how we think and feel. We know that pain is a sensory and emotional experience and is influenced to varying degrees by biological, psychological and social factors. As such it is essential that assessment involves a multi-disciplinary team and through a clinical reasoning process gathers biopsychosocial puzzle pieces that are specific and individualised. Underpinning management is always person-centered care, development of a positive therapeutic relationship, meaningful goal setting, trauma informed and coaching for self-management. Key management principles also include education to make sense of how the puzzle pieces might fit together, and psycho and pain education. The use of specific movement practices and utilising other targeted top down and bottom up strategies to calm down the nervous system are chosen through shared decision making.

SPEAKERS

Bateson, Deborah (NSW)

Deborah Bateson is Professor of Practice at the Daffodil Centre, The University of Sydney, and formerly Medical Director of Family Planning NSW and Global Medical Director of Marie Stopes International. She has worked for over 25-years as a clinician, researcher, educator and advocate in sexual and reproductive health.

Bellas, Olivia (Flinders University, SA)

Olivia Bellas worked on this study as a Research Assistant in the College of Nursing and Health Sciences at Flinders University. She is now a PhD student with the University of Adelaide.

Caddy, Cassandra (University of Melbourne)

Cassandra has a background as a physiotherapist and is a current PhD candidate within the Sexual Health Unit at the University of Melbourne. Cassandra has a particular interest in exploring sexual and reproductive health topics through qualitative research methods.

Caughey, Lucy (University of Melbourne)

Lucy is a research scientist currently examining the disposition decisions of elective egg freezers for her PhD. She holds a Bachelor of Behavioural Science (Honours Psychology) with First Class Honours and is based at the Psychosocial Health and Wellbeing Research Group, Department of Obstetrics and Gynaecology, University of Melbourne.

Chalmers, Jane (Uni SA)

Jane Chalmers is currently a Lecturer in Physiotherapy at Western Sydney University, and has just completed her PhD through the University of South Australia. Her PhD investigated the pathophysiology, assessment, and treatment of women with pelvic pain, with a focus on vulvodynia.

Connell, Tanya (AUT.NZ)

Dr. Tanya Connell is an R.N, midwife, child and family health nurse, lactation consultant, childbirth educator and has a, PhD in midwifery, a masters in adult education and a masters in science-research.

Tanya is currently working as a Senior Lecturer in Nursing at AUT,NZ. She is wanting to move back to Australia asap. Tanya's passion is ensuring that ALL women have perinatal mental health assessment, screening and services.

Coombe, Jacqueline (University of Melbourne)

Dr Jacqueline Coombe is a Research Fellow at the University of Melbourne. Her research interests broadly lie in sexual and reproductive health, with a focus on the use of long-acting reversible contraception and accessing sexual and reproductive health care in general practice.

Cyna, Allan

Dr Allan Cyna is a Senior Consultant Anaesthetist at the Women's and Children's Hospital and Clinical Associate Professor at the University of Adelaide. His anaesthesia interests are primarily in paediatric burns anaesthesia and obstetrics. Dr Cyna is Editor in chief of the Handbook of Communication in Anaesthesia & Critical care.

Davidson, Natasha (Monash University)

Natasha Davidson is a PhD candidate at Global and Women's Health, Monash University. Her PhD focuses on access to preventive sexual and reproductive care for women from refugee-like backgrounds. Her background is in health service provision, public health, epidemiology and humanitarian aid. She has a strong interest in enhancing health equity and the social determinants of health.

Fernando, Anne (Monash University)

Nileshni Fernando is a research assistant in the Body Image and Eating Disorders research group in the Department of Neuroscience at Monash University. Lead by Associate Professor Gemma Sharp, Nileshni's research is focused on genital body image.

Gierasch, Amanda (Adelaide Health Psychology)

Amanda Gierasch is a health psychologist and director of Adelaide Health Psychology. She has been treating complex chronic pain for 13+ years, and has a strong interest in the areas of women's health, feminism, and complex pelvic pain. She is a member of the Adelaide Pelvic Pain Network and the AAPI.

Hawkey, Alex (Western Sydney University)

Alex Hawkey is a Research Officer at the Translational Health Research Institute, Western Sydney University. She has recently submitted her PhD which explored migrant and refugee women's sexual and reproductive health. She has an interest in qualitative research in women's sexual and reproductive health, particularly menstruation, sexuality and fertility

Jain, Vrinda (Western Sydney University)

Vrinda Jain is a final year medical student studying at Western Sydney University (WSU). She has an interest in Obstetrics and Gynaecology, and is particularly passionate about mental health, and the psychosocial aspect of women's health. She aspires to continue research, advocate for mental health, and promote holistic patient care.

Khaw, Carole (Adelaide Sexual Health Centre, Infectious Diseases Unit, Royal Adelaide Hospital and Clinical Associate Professor, School of Medicine, University of Adelaide)

Associate Professor Carole Khaw is Senior Consultant Sexual Health Physician at Adelaide Sexual Health Centre, Infectious Diseases Unit, Royal Adelaide Hospital and Clinical Associate Professor, School of Medicine, University of Adelaide. She is also Chair of the Advanced Training Committee, Chapter of Sexual Health Medicine, Royal Australasian College of Physicians.

Kneebone, Ezra

Ezra Kneebone received her Bachelor of Science and Graduate Diploma in Reproductive Sciences at Monash University. Her research interests include the social, legal and ethical implications of assisted reproductive technologies and she is currently researching surrogacy arrangements and mitochondrial donation.

LaGrappe, Desirée (La Trobe University's Judith Lumley Centre)

Desirée LaGrappe is a public health nurse and NHMRC PhD scholar at La Trobe University's Judith Lumley Centre. She is clinically accredited in Sexual and Reproductive Health and a PhD student of SPHERE, the NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care.

Leiman, Tania (Flinders University)

Professor Tania Leiman is Dean of Law at Flinders University. She is a teaching specialist clinical practitioner with a background in legal practice and pioneered the introduction in 2020 of Flinders Law's highly innovative undergraduate law curriculum. She is committed to growing legal professionals who can identify opportunities for innovation, understand impacts of emerging technologies and use this knowledge and skill to increase access to justice. She has a particular interest in the intersection between law and emerging technologies – especially in relation to automated vehicles, sex robots and has published and presented widely on those topics.

Lensen, Sarah (University of Melbourne)

Dr Sarah Lensen is a Research Fellow at the University of Melbourne. Broadly, her research aims to improve and facilitate evidence-based healthcare of people undergoing fertility treatment. Her current research focusses on the evidence-base behind IVF 'add-ons' and finding ways to translate this information for IVF patients and professionals.

Lim, Madeleine (University of Melbourne)

Madeleine Lim is a final-year PhD student at the Department of General Practice at the University of Melbourne. Her PhD research is on the sexual health of young people at university, with a focus on international students. She works to understand their sexual behaviours and their views on a safer sex program to gain a broader understanding of their sexual health needs.

Lunnay, Belinda (Torrens University Australia, SA)

Belinda Lunnay is a post-doctoral researcher and public health sociologist working in the Research Centre for Public Health, Equity and Human Flourishing at Torrens University Australia. She is currently managing an Australian Research Council funded project exploring women's decision-making concerning alcohol consumption and breast cancer risk. Her focus is on disparities in women's trust in risk information and preferences for message delivery in accordance with their social class.

Mohajeri, Mahta (Western Sydney University)

Mahta Mohajeri, 5th year medical student from Western Sydney University. She completed high school in Melbourne and then moved up to Sydney for University. Her specific interests are in mental health, woman's health and general practice.

Manners, Susan (Western Sydney University)

Susan is a PhD student at Western Sydney University, in the Translational Health Research Institute. Her background is in biochemistry and pharmaceutical sciences, and her PhD is exploring the construction and experiences of hormonal and non-hormonal contraception.

McLachlan, Helen (La Trobe University, Melbourne)

Helen McLachlan is Professor of Midwifery at La Trobe University in Melbourne. She is an internationally renowned midwifery researcher who has led major projects in the areas of continuity of care, First Nations health, breastfeeding, perinatal depression, and translating research into practice. Helen has received multiple awards for the impact of her research in maternity care provision.

Mitchell, Alice (University Of Melbourne)

Alice is a physiotherapist and second year PhD candidate at the University of Melbourne. Her PhD aims to develop and validate a new questionnaire to measure the 'most bothersome symptom' in endometriosis. It is hoped that this questionnaire will be used in all future clinical trials for endometriosis interventions.

Moore, Vivienne (University of Adelaide)

Vivienne Moore is professor of social epidemiology at the University of Adelaide. She has many interests in women's health and reproductive health from biomedical and life course perspectives, but also seeks to understand the roles of gender, ethnicity and class in shaping women's subjectivities, daily lives, health and wellbeing.

Morrison, Shan (University of Melbourne, Australia College of Physiotherapists)

Shan Morrison is a fellow of the Australian College of Physiotherapists and Specialist Women's, Men's & Pelvic Health Physiotherapist. She is the director of Women's & Men's Health Physiotherapy, a private practice in Melbourne. Shan lectures at the University of Melbourne post graduate pelvic floor course and has presented at numerous national conferences. Shan's clinical focus is integrating a true biopsychosocial approach to those with persistent pelvic and sexual pain.

Newnham, Liz (University of Newcastle)

Dr. Elizabeth Newnham is a senior lecturer and midwifery program convenor at the University of Newcastle. Her 20-year career includes clinical midwifery practice, advocacy, teaching and research. Research interests include cultural and political aspects of birthing practice, and the role of midwives in promoting physiological and humanised birth.

Obst, Kate (University of Adelaide, Women's, Children's Health Network)

Dr Kate Obst is a Psychologist and Postdoctoral Research Officer at the University of Adelaide. Her research interests lie in the field of health psychology, particularly relating to family/reproductive health, and loss and grief. Her PhD investigated the psychological impact of pregnancy loss and neonatal death on men.

Power, Rosalie

Associate Research Fellow, Book/ Media Review Editor, Women's Reproductive Health, Translational Health Research Institute | THRI

Reynolds, Carmel (GP, Adelaide)

Carmel is a GP in inner city Adelaide with a strong interest in women's health, especially in the areas of pelvic pain, menopause, and mental health. She is the SA Board member for the Australasian Menopause Society and current chair of the Adelaide Pelvic Pain Network.

Roddy Mitchell, Alexandra (University of Melbourne)

PhD candidate, Department of Obstetrics and Gynaecology, The University of Melbourne, Mercy Hospital for Women

Roudbaneh, Shiva (University of Melbourne)

Ph.D. student at the University of Melbourne, Department of OB and GYN

Ryan, Samantha (Translational Health Research)

Dr Samantha Ryan is a research assistant at the Translational Health Research Institute with an interest in women's sexual and reproductive health. Samantha's PhD explored women's experiences of premenstrual embodiment in the context of body dissatisfaction and body management behaviours utilising an arts-based method, body mapping.

Sandhu, Sherine (University of Melbourne)

Sherine Sandhu is completing her PhD in the Department of Obstetrics and Gynaecology, University of Melbourne. Her main areas of interest are in reproductive decision-making and digital health. Sherine's research aims to develop and evaluate a decision-support tool for women considering elective egg freezing.

Sharp, Gemma (Monash University)

Associate Professor, Department of Neuroscience, Monash University

Shea, Gabby (Flinders University)

Gabby is a post-graduate medical student at Flinders University, undergoing a research project with Dr Jessica Shipman as part of her degree. She is based in the Riverland this year for placement. Gabby is interested in women's health, particularly chronic health conditions and the stigma associated with women's health conditions.

Shi, Kay Chengen (Western Sydney University)

Kay Shi is a 5th year medical student at Western Sydney University. He grew up in the diverse communities of Western Sydney and is especially interested in women's health in refugee and immigrant communities.

Stanzel, Karin (Monash University)

Dr Karin Stanzel is a Research Fellow the Global and Women's Health Unit at Monash University. She is a Registered Nurse/Midwife with 20 years experience as a women's health nurse. Her PhD examined health literacy and health care needs in midlife among women who have migrated from low- and middle-income countries to Australia. Karin's main research interests are health literacy; women's health in midlife; sexual and reproductive health; women's peri and postnatal health.

Susanto, Nipuni (University of Melbourne)

Study Coordinator, Department of Obstetrics & Gynaecology, The University of Melbourne

Sutton, Elizabeth (Director of Research at CALHN, Monash University)

Liz is currently the Director of Research at the Central Adelaide Local Health Network and a Research Affiliate at Monash University. She is a medical anthropologist with an interest in reproductive health and patient agency. She tweets as @believeimeithurt - because it did.

Taffs, Louis (Royal Women's Hospital, Sydney University)

Louis Taffs is a postgraduate medical student. Working with emPoWeR Unit at the Royal Women's Hospital and Sydney Health Ethics at Sydney University, he has begun to engage with the debates surrounding what constitutes good patient care, how we should achieve it, and who is afforded such a privilege.

Thompson, Rachel (University of Sydney)

Rachel Thompson is a Senior Lecturer at The University of Sydney and Head of the Discipline of Behavioural and Social Sciences in Health. Rachel teaches and conducts research in evidence-based, patient-centred health care with a focus on reproductive and perinatal health.

Urry, Kristy (University of Adelaide)

Kristi Urry is a lecturer in psychology at the University of Adelaide. Her research sits in the field of critical health psychology, spanning a range of foci including sexuality and sexual health (care and rights), LGBTQIA+ health, provision of person-centred health care, and healthcare systems as social structures.

Ussher, Jane (Western Sydney University)

Jane M. Ussher is Professor of Women's Health Psychology, in the Translational Health Research Institute, Western Sydney University, Australia. She is editor of the Routledge Women and Psychology book series, and the journal Women's Reproductive Health, and is author of over 300 papers and chapters, and 13 books, in the field of reproductive health.

Vakkas, Anastasia (Mercy Hospital for Women)

Dr Anastasia Vakkas is a second year resident currently working in Obstetrics and Gynaecology at Mercy Hospital for Women. She has a keen interest in fertility medicine and the impacts of fertility concerns on women and their families.

Warin, Megan (University of Adelaide)

Megan Warin is a Professor and social anthropologist at the University of Adelaide. Her research focuses on the gendered dynamics of disordered eating, structural disadvantage and obesity, public health interventions, and the politics of gender and racism in the field of developmental origins of health and disease and epigenetics in relation to nutritional (and other) exposures.

Watson, Emma (John Hunter Hospital, NSW)

Emma has just commenced her intern year at John Hunter Hospital in NSW. Emma is passionate about women's health, gender equity, and the climate crisis. In her spare time Emma enjoys running, hiking, and finding spots for good food and wine.

Webb, Amy (Monash University)

Amy is a reproductive biologist and women's health researcher with a keen interest in e-health resource development. She is currently working in the area of miscarriage support and assisted reproduction bioethics at Monash University.

Whitburn, Laura (La Trobe University)

Dr Laura Whitburn is a physiotherapist and Senior Lecturer in Anatomy at La Trobe University. Her research aims to improve women's childbirth experiences, with a particular focus on better understanding the role of cognitive, social and environmental factors in shaping this experience. Her research covers concepts including theoretical models of pain and perception.

Ziersch, Anna (Flinders University)

Anna Ziersch is Associate Professor in the College of Medicine and Public Health at Flinders University in South Australia. Anna is a public health social scientist and her research focuses on the social determinants of health and health equity, with a particular emphasis on migrant and refugee health.

ASPOG 2023 DELEGATE LIST

Last Name	First Name	Organization	State
Bateson	Deborah	University of Sydney	NSW
Bellas	Olivia	Flinders University	SA
Caddy	Cassandra	University of Melbourne	WA
Caughy	Lucy	University of Melbourne	VIC
Chalmers	Jane	University of South Australia	SA
Connell	Tanya	AUT	NZ
Coombe	Jacqueline	University of Melbourne	VIC
Cyna	Allan	Women's and Children's Hospital	SA
Davidson	Natasha	Monash University	VIC
Davies	Sarah	Tempo Sexology	QLD
Fernando	Anne	Monash University	VIC
Frawley	Natasha	Grampians Health	VIC
Guerascg	Amanda	Adelaide Health Psychology	SA
Haines	Fiona	Healthy Women Medical	QLD
Hawkey	Alex	Western Sydney University	NSW
Hayles	Catherine	University of South Australia	SA
Homan	Gillian	Repromed	SA
Jain	Vrinda	Western Sydney University	NSW
Johnson	Emma	Fiona Stanley Hospital	WA
Khaw	Carole	Adelaide Sexual Health Centre	SA
Kneebone	Ezra	Monash University	VIC
LaGrappe	Desiree	La Trobe University	VIC
Lambert	Jo	NZ College of Sexual and Reproductive Health	NZ
Leiman	Tania	Flinders University	SA
Lensen	Sarah	University of Melbourne	VIC
Lim	Shao Yin [Madeline]	University of Melbourne	VIC
Long	Marita	GP	VIC
Lunnay	Belinda	Public Health Equity & Human Flourishing Adelaide Campus	SA
Manners	Susan	Western Sydney University	NSW
Marino	Jennifer	University of Melbourne	VIC
McLachlan	Helen	La Trobe University	VIC
Mitchell	Alice	University of Melbourne	NSW
Mohajeri	Mahta	Western Sydney University	NSW
Moore	Vivienne	University of Adelaide	SA
Morrison	Shan	University of Melbourne	VIC
Moten	Amy	Shine SA	SA
Newnham	Liz	University of Newcastle	NSW
Obst	Kate	Adelaide University	
Olsson	Anne	GP, Burnside Hospital	SA

Last Name	First Name	Organization	State
Peate	Michelle	University of Melbourne	VIC
Perz	Jannette	Western Sydney University	NSW
Power	Rosalie	Western Sydney University	NSW
Reynolds	Carmel	GP, Adelaide Health Care	SA
Roberts	Bronwen	Repromed	SA
Roddy Mitchell	Alexandra	University of Melbourne	VIC
Roudbaneh	Shiva	University of Melbourne	VIC
Ryan	Samantha	Western Sydney University	NSW
Sandhu	Sherine	University of Melbourne	VIC
Serwaa	Dorcas	University of Melbourne	VIC
Sharp	Gemma	Monash University	VIC
Shea	Gabby	Flinders University	SA
Shi	Kay	Western Sydney University	NSW
Shipman	Jessica	Flinders University	SA
Stacy	Jackie		NSW
Stanzel	Karin	Monash University	VIC
Stevenson	Tahlee	Adelaide University	SA
Susanto	Nipuni	University of Melbourne	VIC
Sutton	Liz	Monash University	VIC
Taffs	Louis	University of Sydney	VIC
Temple-Smith	Meredith	University of Melbourne	VIC
Thompson	Rachel	University of Sydney	NSW
Urry	Kristi	University of Adelaide	SA
Ussher	Jane	Western Sydney University	NSW
Vakkas	Anastasia	University of Melbourne	VIC
Warin	Megan	Adelaide University	SA
Watson	Emma	John Hunter Hospital	NSW
Webb	Amy	Monash University	VIC
Whitburn	Laura	La Trobe University	VIC
Ziersch	Anna	Flinders University	SA

