Australian Society for Psychosocial Obstetrics & Gynaecology

40th Annual Scientific Meeting

"Women's Health from The Top End"

7-9 August 2014

Vibe Hotel
Waterfront, Darwin
Northern Territory, Australia

Contents

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Welcome

Welcome to Darwin and the 40th Annual Scientific Meeting of the Australian Society for Psychosocial Obstetrics and Gynaecology (ASPOG).

We aim to provide you with a stimulating scientific program covering diverse topics such as menopause, vulval disease, cancer, reproductive health and birthing in the Northern Territory. We are delighted to incorporate into our meeting sessions from the Australasian Menopause Society and the ANZ Paediatric and Adolescent Gynaecology Society and we thank them for their participation.

No conference is complete without some work/life balance! Please take a moment away from the science to enjoy the Darwin Aboriginal Art Fair at the Convention Centre (8-10 August) and partake in the events of the Darwin Festival.

I would like to thank all our speakers and the members of the Organising Committee for their assistance and also our conference organiser, Bianca Scarlett, for her expertise.

We hope you enjoy your time in Darwin and thank you for your attendance at this conference.

Yours sincerely,
Ann Olsson

On behalf of the Organising Committee:
Jacqueline Boyle
Tamsin Cockayne
Heather Rowe
Elizabeth Farrell
Rebecca Deans
Leanne March
Jane Thorn

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 disciplines, e.g. medicine, midwifery, nursing, psychology, social work, social sciences, etc.

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

The **objectives** of ASPOG are

- To promote the scholarly, scientific and clinical study of the 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.

Conference Manager

Ms Bianca Scarlett
Scarlett Events
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Parap NT 0804
P: 08 8942 1240
F 08 8942 1230
E: bianca@scarlettevents.com.au

Airport Transfers
A taxi fare between Darwin Airport and the city is approximately $25. The airport is located 15km from the city and is approximately 15 minute journey.

Certificates of Attendance and CPD points
If you require a certificate of attendance, please ask the registration desk.

General Certificates
Certificates of attendance are available at the conclusion of the conference. Please complete the attendance list at the registration desk if you would like one.

RANZCOG
This meeting has been approved as a RANZCOG approved O&G Meeting and eligible Fellows of this College will earn CPD points for attendance as follows:
Full attendance 14 points (Conference Only)

Thursday 7 August 2014	4 points
Friday 8 August 2014	7 points
Saturday 9 August 2014	4 points

RACGP
This Meeting has not been allocated QA&CPD points. However the RACGP acknowledges the personal learning value of various activities. GPs are therefore welcome to self-record this activity using the QA&CPD online services. http://www.racgp.org.au/

Annual General Meeting
ASPOG invites all members to attend the Annual General Meeting. The meeting will be held at 1650 on Thursday 7 August 2014 in the Neptuna / Mavie room and will conclude at 1720.

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

Liability
In case of industrial disruption or other external events causing disruption to the ASM, the Organising Committee of the ASPOG 2014 ASM accepts no responsibility for loss of monies incurred by delegates.

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

Pharmacy
The nearest Pharmacy is Amcal Pharmacy, 39 Smith Street Mall, Shop 1, 08 8981 2333.

Post Office
The nearest Australia Post Office is located 48 Cavenagh Street, Darwin

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. Our Audio Visual Technician will be available in the conference rooms to assist you at this time.

Social Functions

Welcome Reception

Thursday 7 August 2014 *1720-1920*
Venue: Level 1, Vibe Hotel
Cost: Included in full registration fees
$65 per person (day delegates)

Conference Dinner

Derek Llewellyn-Jones Oration
"Opportunities for Health in the Top End"
To be presented by **Dr Christine Connors,** General Manager Primary Health Care, Top End Health Services

Friday 8 August 2014 *7.00 for 7.30pm -10.30pm*
Venue: Crustaceans on the Wharf, **Stokes Hill Wharf**
http://www.crustaceans.net.au/
Dress: Smart casual
Delegate cost (including accompanying person)
$125 per person (not included in registration fees)

Travel Insurance

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

Visitor Information

6 Bennett St, Corner Bennett and Smith Streets
Darwin City Centre – Darwin NT 0800
Ph: 08 8980 6000 or 1300 138 886
Email: info@tourismtopend.com.au

Opening hours:
Monday to Friday 8.30am- 5pm
Saturday and Sunday 9am-3pm
Public Holidays 10am-3pm

Darwin Day Tours
Shop D4B, Wharf One, Darwin Waterfront
Ph: 1800 811 633.
Darwin Day Tours offers a wide range of full or half day tours in the Top End. Visitors can experience the best of the Top End with Darwin Day Tours including Kakadu and Litchfield National Parks, Katherine Gorge, the Tiwi Islands and the historic and cultural sights of Darwin.

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.


McMinn Street
Stokes Hill Road
Lighthouse Drive
DARWINWATERFRONT
KEY
1. DARWIN CONVENTION CENTRE
2. WAVE LAGOON
3. MEDINA HOTEL
4. MULTI-STOREY CARPARK
5. VIBE HOTEL
6. RECREATION LAGOON
7. WHARF ONE
- RESIDENTIAL
- RETAIL
- COMMERCIAL
8. SEA WALL
9. CRUISE SHIP TERMINAL
10. STOKES HILL WHARF
11. STAGE TWO
- RESIDENTIAL
- RETAIL
- COMMERCIAL
12. FOOTBRIDGE
(LINK TO DARWIN CBD)
13. PENINSULA SITE
14. WWII OIL STORAGE TUNNELS

Science For A Better Life

The **Women's HealthCare** division of Bayer Pharmaceuticals has a long and proud history in providing hormone products for the benefit of women's health.

Bayer Pharmaceuticals is a world leader in contraception with a range of oral contraceptives including **YAZ FLEX® YAZ®, Yasmin®** and **Microgynon®.**

The Women's HealthCare range now also includes **Qlaira®** the first oestradiol OC, and the Intrauterine System, **Mirena®.**

Bayer Pharmaceuticals is actively involved in ongoing research and continues to develop new and exciting products and services to assist doctors in providing for the health and well-being of their patients.

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Lawley Pharmaceuticals is a Perth based Australian pharmaceutical company specialising in the production of bio-identical pharmaceutical grade hormone creams. Clinically trialled and TGA listed our products are:

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AndroForte® 2 and AndroForte® 5 Testosterone creams for men
ProFeme® 3.2 and ProFeme® 10 Progesterone creams for women

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Please contact Peter Clark, National Sales Manager, on 0419 634 567 for further information.

www.lawleypharm.com.au

MSD

Today's MSD is a global healthcare leader working to help the world be well. MSD is a trade name of Merck & Co., Inc., with headquarters in Whitehouse Station, N.J., U.S.A. Through our prescription medicines, vaccines, biologic therapies, and consumer care and animal health products, we work with customers and operate in more than 140 countries to deliver innovative health solutions. We also demonstrate our commitment to increasing access to healthcare through far-reaching policies, programs and partnerships. For more information, visit www.msd-australia.com.au.

THURSDAY 7 AUGUST 2014

1320-1500	**ASPOG SESSION 1** **MENOPAUSAL ISSUES**
	Chairs: Dr Ann Olsson & Dr Jenny Thomas
1320-1330	Welcome
1330-1400	Dating again? The 'birds and the bees' for the woman over 40 Dr Tonia Mezzini, SA
1400-1430	How to Manage Unexpected Bleeding around Menopause Dr Liz Farrell, VIC
1430-1500	Menopause In Asian Women Prof Tony Chung, Hong Kong
1500-1530	AFTERNOON TEA
1530-1710	**ASPOG SESSION 2** **TRAINEE PRESENTATIONS & FREE COMMUNICATIONS**
	Chairs: Dr Amanda McBride & Dr Jacqueline Boyle
1530-1550	Gender Specific Intrapartum and Neonatal Outcomes in Term Babies Dr Liam Dunn, Mater Medical Research Institute, QLD
1550-1610	The Effect of Sexual Intercourse on Vaginal Colonisation with Candida Dr Cathy Watson, University of Melbourne, VIC
1610-1630	Do Work Characteristics Affect Women's Experience of the Menopause? Ms Emily Bariola, La Trobe University, VIC
1630-1650	Violence and Trauma in Aboriginal Women: A Risk Factor for Adverse Health Outcomes Dr Carly Brazel and Dr Caitlin Dallas, St Vincent's Hospital, NSW
1650-1720	**ASPOG Annual General Meeting**
1720-1920	**ASPOG WELCOME RECEPTION** Vibe Hotel, Level 1, Trade Display Area

FRIDAY 8 AUGUST 2014

0900-1030	**ASPOG SESSION 3** **CULTURAL ASPECTS OF INDIGENOUS WOMEN'S HEALTH**
	Dr Tamsin Cockayne & Dr Jane Thorn
0900-0930	Aboriginal Context in Preventing Fetal Alcohol Spectrum Disorders and the Role of Health Professionals Ms Heather D'Antoine, NT
0930-1000	Strong Women Strong Baby Strong Culture Ms Marlene Liddle and Ms Barbara Cox, NT
1000-1030	Why Aboriginal Community Controlled Health Services? Ms Leeanne Pena, NT
1030-1100	MORNING TEA
1100-1220	**ASPOG SESSION 4** **FREE COMMUNICATIONS**
	Dr Ann Olsson & Dr Bronnie Williams
1100-1120	The Fear of Birth Scale (FOBS):A Clinically Practical Way to Identify Childbirth Fear in Pregnant Women Dr Helen Haines, The University of Melbourne, VIC
1120-1140	Study on Prevalence and Coping Methods in Premenstrual Syndrome and Premenstrual Dysphoric Disorder using a Questionnaire for Female Medical Students Jinko Yokota, Tokyo Women's Medical University, Japan
1140-1200	Correlation Between Body Image Dissatisfaction and Rates of Depression and Anxiety and Quality of Life in Overweight and Obese Pregnant Women: Findings from the LIMIT Randomized Trial Dr Kate Andrewartha, The Women's and Children's Hospital, SA
1200-1220	Distribution of Accidental Pregnancy in Contemporary Australia: A National Survey Dr Heather Rowe, Monash University, VIC
1220-1330	LUNCH
1330-1500	**ASPOG SESSION 5** **VULVAL DISEASE IN THE TOP END**
	Chairs: Dr Heather Rowe
1330-1400	Vulval Disorders: An Overview Dr Ann Olsson, SA
1400-1430	Vulval Disease in Indigenous Women Dr Jane Thorn, NT
1430-1500	Barriers to Diagnosis and Treatment Dr Jacqueline Boyle, VIC and Ms Marlene Liddle, NT
1500-1530	AFTERNOON TEA

1530-1700	**ASPOG SESSION 6** **BIRTHING IN THE TOP END**
	Chairs: Dr Suzanne Abraham & Dr Jackie Stacy
1530-1600	Cultural Aspects of Birthing Dr Terry Dunbar, NT
1600-1630	Darwin Midwifery Group Practice – Working with Indigenous Women from Remote Communities Ms Desley Williams and Ms Elizabeth Coombes, NT
1630-1700	Impact of Social Determinants in Pregnancy in the Top End Dr Christine Connors, NT
1900-1030	ASPOG Conference Dinner Crustaceans on the Wharf, Stokes Hill Wharf Derek Llewellyn-Jones Oration Dr Christine Connors, General Manager Primary Health Care, Top End Health Services "Opportunities for Health in the Top End"

SATURDAY 9 AUGUST 2014

0900-1030	**ASPOG SESSION 7** **REPRODUCTIVE HEALTH**
	Dr Kirsten Black & Dr Tonia Mezzini
0900-0930	Sexual Difficulties…The Communication Gap Dr Susan Carr, VIC
0930-1000	The Passing on, of Sexual Health Knowledge in Rural and Remote Aboriginal Communities Ms Susan Arwen and Ms Kathy Edwards, SA
1000-1030	Contraception Conundrums Dr Meredith Frearson, SA
1030-1100	MORNING TEA

1100-1230	**ASPOG SESSION 8** **CANCER**
	Chairs: Dr Fiona Haines & Dr Susan Carr
1100-1130	An overview of the National Indigenous Cervical Screening Project (NICSP) Dr Suzanne Moore, QLD
1130-1200	Breast Cancer in Indigenous Women Dr Suzanne Moore, QLD
1200-1230	Fertility-Related Health Care Needs of Women Diagnosed With Breast Cancer While of Reproductive Age Prof Jane Fisher, VIC
1230-1330	LUNCH & PRESENTATION OF ASPOG PRIZES

Dating again? The 'birds and the bees' for the woman over 40

Dr Tonia Mezzini
Shine SA, SA

Women over 40 years of age who find themselves back on the dating scene may need information on the 'birds and the bees' (Version 2.0). The new story of the 'birds and the birds' needs to include chapters on social media (what's Tinder?), sexually transmitted infections and how to avoid them, as well as how to communicate your sexual and emotional needs to a new partner. All of this while juggling children and/or grandchildren (his and hers), work, ageing parents, the odd hot flush, patches that won't stick, his erectile dysfunction, your Vitamin D tablets, mammograms and Spanx. And a culture that makes a menopausal woman feel like an invisible woman. This presentation will uncover what goes on behind closed doors in a sexual health consultation with a woman at mid-life and explain why a 15 minute consultation isn't nearly long enough.

How to Manage Unexpected Bleeding Around Menopause

Dr Elizabeth Farrell
Monash Medical Centre, Monash Health, Clayton, Victoria

The effect of abnormal uterine bleeding may impact in many ways on a woman's life. It may cause disruption to a woman's ability to function normally, reducing her quality of life and her productivity.
Bleeding in the perimenopause may present with different patterns, which may be physiological or pathological due to abnormalities, for example, fibroids. Physiological changes such as Luteal out of Phase ovulation may lead to menstrual irregularity.

It is important to recognize when to investigate to exclude abnormal pathology.

Bleeding after the menopause must be investigated to exclude endometrial cancer.
Unexpected bleeding is less likely under sequential than continuous therapy during the first year of therapy but there is a suggestion that continuous therapy over long duration is more protective than sequential therapy in the prevention of endometrial hyperplasia.

Unexpected bleeding on HRT may be similar to abnormal bleeding on long acting progestogen contraceptives. Bleeding is thought to arise from small veins and capillaries on the endometrial surface, that become more fragile (vascular fragility) following progestogen exposure.

Menopause In Asian Women

Prof Tony Chung
The Chinese University of Hong Kong, Hong Kong

Asia is aging rapidly. Dramatic gains in prosperity, nutrition, public health and peace are reflected in the life expectancy of a baby girl born in Hong Kong today; she can expect to live 86 years. She can expect to spend more than a third of her life in the menopause. The menopause has always evoked a greater reaction in Western cultures compared to many Asian cultures, which has usually treated menopause as a normal part of life. Culturally, the loss of reproductive capability is seldom mourned and in many societies, older women are accorded enhanced social status. Symptoms associated with the menopause transition are different in Asian women. Long term problems such as osteoporotic fractures and heart disease are prevalent but they occur at different rates in different Asian countries and are associated with a variety of risk factors. This makes medical and other preventative measures problematic. Interventions may be overwhelmed by background socioeconomic trends. Hormone therapy uptake is low even in rich Asian societies and is unrealistic in the poorer countries. Asian women who migrate to western countries have manifested disease patterns somewhere between the home countries and their destination countries. When caring for these women in the West, individual attention rather than stereotypic wisdom is more likely to be fruitful.

Gender Specific Intrapartum and Neonatal Outcomes in Term Babies

Liam Dunn MBBS[1] , Tomas Prior MBBS[2], Sailesh Kumar PhD[1,2]
1- Mater Medical Research Institute, South Brisbane.
2- Institute for Reproductive and Developmental Biology, Imperial College, London

More male than female babies are born, however obstetric and perinatal outcomes are substantially worse for male babies. This study documents the gender specific intrapartum and neonatal outcomes in term, singleton, appropriately grown babies. The de-identified records of all women at Mater Mothers' Hospital meeting inclusion criteria between 2001 and 2011 were examined (n=9,229). Inclusion criteria were public (non insured) patient status, singleton pregnancy, term gestation and an appropriately grown fetus. In this retrospective cohort study, we estimated adjusted odds ratios (ORs) and 95% confidence intervals (CIs) with multivariable logistic regression. Maternal demographics, mode of delivery and neonatal outcomes measured by birthweight, APGAR score, cord blood acidaemia, respiratory distress, resuscitation, nursery transfer and stillbirth rates were assessed. The overall sex ratio of male babies was 1.05:1 (4,718 males; 4,511 females). Compared to females, male babies were more likely to be born by instrumental delivery (p=0.004) or cesarean delivery (p=<0.001). Despite having a greater birthweights (p=<0.001), male babies were more likely to have lower APGAR scores at 5 minutes (p=0.004), require some form of neonatal resuscitation (p=<0.001), develop respiratory distress (p=0.005) and require nursery transfer (p=<0.001). No statistical difference was found for cord blood acidaemia (p=0.58) or stillbirth (p=0.49). This large cohort study demonstrates term, appropriately grown male babies fare more poorly in the intrapartum and neonatal period compared to female babies, though the underlying contributing physiology is not thoroughly established. The gender of the baby perhaps should be considered when counselling parents in the antenatal period.

The submitted abstract reports on research or clinical material from human participants or patients with approval from an Institutional Human Research Ethics Committee.

The Effect of Sexual Intercourse on Vaginal Colonisation with Candida

Cathy J Watson[1,2], Christopher K Fairley[3] Suzanne M Garland[4], Stephen Myers[5], Marie Pirotta[1]
[1]Department of General Practice, University of Melbourne, Melbourne
[2]Women's Health Clinics, Royal Women's Hospital, Melbourne
[3] School of Population Health, University of Melbourne; Melbourne Sexual Health Centre, Alfred Health, Melbourne
[4] Dept Microbiology Infectious Diseases, Royal Women's Hospital; Department of Obstetrics and Gynaecology University of Melbourne, Melbourne
[5] NatMed-Research, Southern Cross University, Lismore

Introduction: Recurrent vulvovaginal candidiasis (RVVC) results in significant physical, financial and psychological sequelae for women, and many women report that VVC affects their intimate relationships. The aetiology of RVVC remains uncertain, and some studies suggest sexual intercourse may be responsible for transmission of *Candida* species. No publications have documented the affect of sexual intercourse on vaginal candida colonisation.

Methodology: Fifty nine participants who were culture positive for *Candida* spp. at screening took part in a randomised controlled trial investigating the effect of oral garlic and placebo on vaginal candidal colonisation. Participants self-collected daily vaginal swabs during the two weeks before menstruation. They kept a daily diary and recorded incidence of sexual intercourse and abnormal vaginal symptoms. Swabs were analysed for quantitative colony counts of candida before and after sexual intercourse.

Results: There were 149 episodes of sexual intercourse in participants reporting sexual activity (n=38) over the two week study period. Colonisation levels rose the day following sexual intercourse in 51 episodes, and fell in 56 episodes. In 42 episodes of sexual intercourse, the levels remained the same or women were culture negative on the day following and two days following sexual intercourse. On fifty occasions women had symptoms (itch, abnormal vaginal discharge) on the day of sexual intercourse, and 41 women reported abnormal symptoms two days after sexual intercourse. In 75 episodes, there were no abnormal symptoms the day of, or the day following sexual intercourse.

Conclusion: In this study, sexual intercourse, colonisation levels and abnormal vaginal symptoms appeared to be unrelated. Further investigation is recommended into dyspareunia and abnormal vaginal symptoms following sexual intercourse experienced by women with RVVC.

The submitted abstract reports on research or clinical material from human participants or patients with approval from an Institutional Human Research Ethics Committee.

Do Work Characteristics Affect Women's Experience of the Menopause?

Emily Bariola[1], Marian Pitts[1], Gavin Jack[2], Kathleen Riach[3], Jan Schapper[2]
[1] Australian Research Centre in Sex Health & Society, La Trobe University, Melbourne
[2] Department of Management, La Trobe University, Melbourne
[3] Department of Management, Monash University, Melbourne

17% of the Australian workforce are women over the age of 45. Most of these women will have recently, or are currently experiencing menopause in a work setting. However, the well-being of older working women as they transition through menopause is understudied in organisational contexts.

In an Australian first, this study explored the relationships between work characteristics, employment conditions and menopausal symptoms. Data were collected via an online survey. Participants were academic and professional staff members employed at one regional and two metropolitan Australian universities. 601 peri-menopausal and post-menopausal women (age: *M*=53.8, *SD*=6.1) completed the survey. Menstrual status was determined via the STRAW+10 staging system (Soules et al., 2001; Harlow et al., 2012) and menopause symptoms were assessed via the MENSI scale (Sarrel et al., 1990).

A multivariate regression analysis revealed that low supervisory support, employment on a part-time or casual basis and lack of control over workplace temperature were associated with greater menopause symptom reporting (frequency of symptom experience), after controlling for age, parity, HRT use and surgical menopause. Length of tenure, flexible working hours and job autonomy were unrelated to symptom reporting.

Thematic analysis of responses to an open-ended survey question on work and menopause revealed similar findings. Work conditions (such as temperature control, and lack of supervisory support) were identified as problematic for menopausal women.

These findings indicate that poor working conditions may serve to exacerbate women's experience of the menopause. They call for the development of tailored workplace policies and procedures that support women as they transition through the menopause.

Ethical Compliance
The submitted abstract reports on research from human participants with approval from an Institutional Human Research Ethics Committee (La Trobe Human Ethics Committee).

Violence and Trauma in Aboriginal Women: A Risk Factor for Adverse Health Outcomes

Carly Brazel [1] Caitlin Dallas [2]
[1] St Vincent's Hospital, Sydney
[2] Western Hospital, Melbourne

Violence against women is a pandemic global issue; it is a human rights violation that disempowers women, fractures communities, displaces families and impedes development. It is increasingly prevalent worldwide and thus its elimination has been called upon as a key theme in achieving the United Nations Millennium Development Goals.

Interpersonal violence has been identified as a precursor to an increased incidence of long term physical and psychological health problems, psychosocial difficulties, risk taking behaviours, avoidance of preventative healthcare activities, and premature death in women. Research has shown the negative toll that the trauma of violence can take on the healthcare outcomes of future generations.

Australian Aboriginal women are particularly overrepresented as victims of interpersonal violence. There is a complex interplay of intergenerational trauma experienced by Aboriginal women. The traumas that negatively influence their health outcomes are a combination of displacement, oppression, persistent racism and colonialism, and also domestic and sexual violence.

Literature has also exposed that doctors do not ask, and patients do not tell. Therefore, it is imperative that we be aware of these issues and their influence when dealing with all patients. The National Yarn Up in 2013 highlighted the opinions of many indigenous women who have experienced violence. It gave health professionals insight into how best to deal with the unique situation of indigenous women; in order to avoid retraumatisation, and optimise healthcare outcomes.

Our presentation will review the findings of this national forum, along with the relevant literature highlighting key findings for healthcare providers dealing with violence and trauma in Australian Aboriginal women. We will discuss in further detail the unique complexities experienced by Aboriginal women along with the importance of cultural awareness and cultural safety, of a strengths based approach, and of interconnectedness when dealing with survivors of violence. Furthermore, we will highlight the need for further research into how best to approach interpersonal violence in Aboriginal communities.

Aboriginal Context in Preventing Fetal Alcohol Spectrum Disorders and the Role of Health Professionals

Ms Heather D'Antoine
Menzies School of Health Research, NT

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella that covers the range of outcomes associated with prenatal alcohol exposure including fetal alcohol syndrome (FAS), partial FAS, alcohol related neurodevelopmental disorders and alcohol related birth defects. Preventing FASD requires addressing alcohol and pregnancy. Health professionals play an important role in supporting women to not drink alcohol in pregnancy by asking all pregnant women, and women of child-bearing age, about and advising them on alcohol use during pregnancy. However, they need to have an understanding of why women drink alcohol in pregnancy.

In regards to the Aboriginal population, Aboriginal women may be less likely to drink alcohol in pregnancy when compared to non-Aboriginal women but they are more likely to drink alcohol at harmful levels. The reasons why Aboriginal women may drink alcohol in pregnancy are complex and multifactorial. It is shaped by the experiences they are born into, whether or not they were prenatally exposed to alcohol, the circumstances under which they conceived, the partner's alcohol drinking pattern and stresses they incur throughout their pregnancy. This highlights the importance of working with Aboriginal people and communities to address alcohol and pregnancy. It also highlights the importance of multiple strategies to create an environment to support to Aboriginal women to not drink alcohol in pregnancy. This presentation will provide an Aboriginal context to the prevention of FASD.

Strong Women Strong Baby Strong Culture
Ms Marlene Liddle & Ms Barbara Cox, NT

The Strong Woman Strong Babies Strong Culture Program is a Primary Health Care Program delivered by Aboriginal Women for Aboriginal women.

Aims: To implement a bi-cultural holistic primary health care approach to enhance the health and wellbeing of young girls/women, pregnant women, postnatal women and their babies.

Strong Women Coordinators have an advocacy role to address the social determinants of women's health in the local environment, including providing employment opportunities, providing accurate and up to date information to our local community based Strong Women Workers, and our target groups.
This information is delivered at girl's camps, in classrooms, anywhere in an environment that the women identify as a supportive, private area and where the women/girls feel comfortable.
It is delivered in a culturally appropriate way and is explained in language by the Strong Women Workers or senior community women who work in partnership with Strong Women Coordinators and other relevant service providers within our Health Development Team
Some of the issues of concern that have been identified are sexual health, contraception, healthy lifestyles, health and wellbeing, underage, pregnancies, FAS, SIDS etc.
We would like to share with you (via this power-point presentation) how we work with the women in our communities.

Aboriginal Community Controlled Health Organisations
Ms Leeanne Pena, NT

An Aboriginal Community Controlled Health Service is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.

Local Aboriginal community control in health is essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures. NACCHO represents local Aboriginal community control at a national level to ensure that Aboriginal people have greater access to effective health care across Australia. NACCHO provides a coordinated holistic response from the community sector, advocating for culturally respectful and needs based approaches to improving health and wellbeing outcomes through ACCHSs.

This power point presentation demonstrates and validates the existence of Aboriginal Community Controlled Health Organisations from its historical beginnings. This presentation is purely a snapshot that introduces the concept and the history of Aboriginal Community Controlled health care in Australia which is 40 years old this year. Some of the questions answered will be as follows:

- Where did it come from
- Why is it important
- Successes
- Challenges
- Closing the gap

The Fear of Birth Scale (FOBS): A Clinically Practical Way to Identify Childbirth Fear in Pregnant Women

Helen M Haines [1, 2, 3] ,Julie F Pallant [1],Christine Rubertsson [3],Jennifer Fenwick [4],Jenny Gamble [4], Jocelyn Toohill [4], Ingegerd Hildingsson [2, 3]
[1] The University of Melbourne, Rural Health Academic Centre, Shepparton, Victoria.
[2] Uppsala University, Department of Women's and Children's Health, Sweden
[3] Karolinska Institute, Department of Women's and Children's Health, Stockholm, Sweden
[4] Griffith University, School of Nursing and Midwifery, Logan Campus, Queensland

Background: Fear of childbirth has received significant research effort and clinical response in the Nordic countries, where it is estimated to affect 20 % of pregnant women. Attention is growing in Australia where studies have demonstrated that the prevalence may be even higher. The 33 item Wijma Delivery Expectancy Questionnaire (WDEQ-A) is the most frequently used instrument to measure childbirth fear. The clinical utility of WDEQ has been questioned with new studies suggesting a simple visual analogue scale (VAS) may be an accurate and practical approach.

Aim: To compare a two item VAS (Fear of Birth Scale) with the WDEQ- A and determine a suitable cut-point for identifying high fear.

Method: Secondary analysis of a randomized control trial of a midwife-led psycho-educational intervention to reduce childbirth fear in Queensland, Australia. Pregnant women completed WDEQ-A with possible scores ranging from 0-165 and Fear of Birth Scale (FOBS) with possible scores ranging from 0-100. Associations between FOBS and the W-DEQ were determined. A receiver operating curve (ROC) was calculated for prediction of fear of birth using the FOBS, based on W-DEQ score of ≥85 (high fear). Sensitivity and specificity were determined for an optimum FOBS cut-point.

Results: 1377 women completed FOBS and WDEQ-A. Internal consistency of W-DEQ and FOBS was 0.94 and 0.91 respectively (Chronbach Alpha). Correlation between the two measures was 0.66 (Spearman's rho, $p<0.001$). When FOBS mean score was compared to the WDEQ score of ≥85 the ROC statistic was 0.89. Youden Index was 68 with sensitivity 89 % and specificity 79% at a FOBS cut-point of 54.
Conclusion: FOBS at a cut-point of 54 has high sensitivity and specificity when compared to the WDEQ score of ≥85. FOBS is a simple instrument which clinicians may find very useful in identifying women with fear of birth in the antenatal period.

The submitted abstract reports on research or clinical material from human participants or patients with approval from an Institutional Human Research Ethics Committee.

Study on Prevalence and Coping Methodsin Premenstrual Syndrome and Premenstrual Dysphoric Disorder using a Questionnaire for Female Medical Students

Jinko Yokota [1], Azusa Shinozaki [1], Keiko Uchida [1], Toshiko Kamo [1], Fumi Horiguchi[2]

1) Tokyo Women's Medical University, Tokyo, Japan
2) The Fumi Horiguchi Institute for Research and Education in Women's Health, Tokyo, Japan

Background: The "Premenstrual Syndrome (PMS)" is said to afflict 20% of all women in reproductive age, and the "Premenstrual dysphoric disorder (PMDD)" by 3~7% of all women in reproductive age. But the knowledge about the affliction and the method of coping with it has not made much progress since it was introduced to Japan in the last ten or so years. In our recent study we examined the knowledge and the prevalence rate among our medical students.

Purpose: We aimed at elucitating the actual situation concerning PMS and PMDD among medical students at Tokyo Women's Medical University.

Method: This is a cross-sectional study using questionnaire sheets. We presented the questionnaire to 100 third-year students and 65 sixth-year students of the Medical Department. The questionnaire was prepared by citing a part of the diagnostic basic standard in DSM-IV-TR.

Results: Answers were returned by 147 students which amounts to a 89.1% return rate.There were 15 students (10.2%) reaching the diagnostic standard for PMDD, apart from PMDD, there were 33 persons (22.4%) who fulfilled the diagnostic standard of PMS. 11 students (7.4%) had premenstrually as well as intramenstrually no symptoms. 66.6% of those diagnosed with PMDDand 60.6% with PMS took some drugs and/or underwent some kind of non-chemical treatment. The rest (33.3% respectively 39.4%) took no special measures while feeling afflicted nonetheless to a certain degree by menstrual troubles in daily life.

Conclusion: This lead us to acknowledge the necessity of further guidance and self-care education regarding menstruation related symptoms.

Ethics: Ethical Approval for this study was granted by the Ethics Committee of Tokyo Women's Medical University.

Correlation Between Body Image Dissatisfaction and Rates of Depression and Anxiety and Quality of Life in Overweight and Obese Pregnant Women: Findings from the LIMIT Randomized Trial

Andrewartha K[1], Newman A[2], Moran L[2], Grivell R [2], Dodd J[2]
[1] The Women's and Children's Hospital, Adelaide, South Australia; Women's and Babies Division: Department of Perinatal Medicine.
[2] The University of Adelaide, Adelaide, South Australia; The Robinson Institute, School of Paediatrics and Reproductive Health.

Introduction: Overweight and obesity are increasingly common, with estimates that 34% of Australian pregnant women have a BMI≥25 kg/m^2. The complications of overweight and obesity in pregnancy are well known but little is documented regarding the potential psychological impact. This study aims to report the correlation between body image dissatisfaction and rates of depression, anxiety and quality of life in overweight and obese pregnant women.

Methods: This prospective cohort study is nested within the LIMIT randomised trial. Women were eligible with BMI ≥ 25kg/m^2 and singleton pregnancy between 10+0 and 20+0 weeks gestation. Women were recruited from the three maternity hospitals in Adelaide, South Australia and were asked to complete questionnaires relating to depression (EPDS), anxiety (STAI), quality of life (SF-36) and body image satisfaction at the time of study entry. 236 women from the standard care group comprise the current cohort.

Results: On univariate analysis, weight and shape satisfaction correlated positively with anxiety (p= 0.017 and p<0.001) and inversely with quality of life mental overall component score (p= 0.013 and p=0.004) and physical overall component score (p=0.003 and p=0.004), indicating that increasing body dissatisfaction was associated with higher levels of anxiety and worsened quality of life. No significant correlation was documented between rates of depression with weight satisfaction (p=0.271) or shape satisfaction (p=0.173).

Conclusion: In women who are overweight or obese in pregnancy, weight and shape dissatisfaction is associated with higher levels of anxiety and worsened quality of life (both mental and physical components). No significant correlation was established between weight or shape satisfaction and levels of depression. This highlights the importance of a holistic approach towards overweight and obesity in pregnancy, with pregnancy care needing to target maternal psychological wellbeing in addition to the physical maternal and foetal complications.

Ethical compliance statement: The submitted abstract reports on research or clinical material from human participants or patients with approval from an Institutional Human Research Ethics Committee.

Distribution of Accidental Pregnancy in Contemporary Australia: A National Survey

Rowe H[1], Holton S[1], Kirkman M[1], Bayly C[2], Sinnott V[3], Jordan L[4], McNamee K[4], McBain J[5], Fisher J[1]
[1]Jean Hailes Research Unit, Monash University, Melbourne
[2]The Royal Women's Hospital, Melbourne
[3]Victorian Government Department of Health, Melbourne
[4]Family Planning Victoria, Melbourne
[5]Melbourne IVF, Melbourne

Objectives: Australia faces the contradictory problems of high rates of unintended pregnancy and of infertility. The objective of this study, funded in partnership by the Australian Research Council, the Royal Women's Hospital, The Victorian Government Department of Health, Family Planning Victoria and Melbourne IVF, was to investigate how Australians manage fertility. The aim of this paper is to describe contraceptive practices and correlates of unintended, mistimed, or unwanted pregnancies in an Australian national sample of women and men of reproductive age.

Design and methods: A population-based cross-sectional survey was conducted. The survey and a letter of invitation to participate were mailed to a random sample of people aged 18 to 50 extracted from the Australian Electoral Roll. Information was collected about sociodemographic factors and management of fertility across the life-course, including about contraceptive practices and the circumstances of any accidental pregnancies. Correlates of accidental pregnancy were assessed in a multivariable model.

Results: The survey was sent to 15,590 people (7795 women; 7795 men), yielding a nationally-representative sample (recruitment fraction 15%). Almost all had access to affordable, acceptable contraception, but few expressed willingness to use long-acting reversible contraceptives. At least one accidental pregnancy was reported by 25% of the respondents. Accidental pregnancy was independently associated with living in a rural location, being born overseas, social disadvantage and experience of forced sex.

Conclusions: Availability of acceptable contraception is insufficient to ensure that pregnancies are intended and not mistimed or unwanted. Four independent risks for accidental pregnancy were established; experience of forced sex confers the greatest (almost two-fold) risk. Prevention of accidental pregnancy should focus of rural health and social services, unmet needs of migrant groups, promotion of long-acting reversible contraceptives and prevention of violence against women. The results will inform targeted health service, public health, health promotion and sex education policy responses.

Approval to conduct the study was obtained from the Monash University Human Research Ethics Committee.

Vulval Disorders: An Overview

Dr Ann Olsson
[1] Vulval Disorders Clinic, Royal Adelaide Hospital
[2] Adelaide Women's Health Centre, Adelaide, South Australia

This presentation will outline the common vulval dermatoses encountered in clinical practice. Clues to diagnosis and management regimens will be presented. The presentation will also include multiple photographs of the conditions discussed.

Practitioners in this field also deal with vulval pain which occurs in many guises. Terminology of vulval pain and an approach to management will be discussed.

Vulval Disease in Indigenous Women
Dr Jane Thorn, NT

Vulval disease can be can be uncomfortable, embarrassing and potentially debilitating for women, especially when surgical treatment is required as is the case with pre-malignant and malignant conditions. Although such conditions are uncommon in the general Australian population (and indeed world-wide) there is a disproportionate burden of disease in the Indigenous population of the Top End of the NT. This disease presents both an epidemiological conundrum and unique clinical and psychosocial challenges in long-term management.

Barriers to Diagnosis and Treatment

Dr Jacqueline Boyle,VIC and Ms Marlene Liddle, NT

Vulvar cancer in women under 50 years of age in parts of the Top End NT is 70 times higher than the incidence in the total Australian population in the same age group. Whilst screening and surveillance of women at risk will not eradicate disease it is an important component of prevention and care.

Many factors affect the attendance of women for screening and treatment including: “shame” or embarrassment, fear, lack of trusted health care providers, lack of female health care providers and lack of awareness about the condition. A vulval cancer project has been ongoing for sometime assessing genetic contributions to disease, and barriers and enablers to seeking health care. The project has also developed culturally appropriate educational tools in language for educational purposes

Cultural Aspects of Birthing
Dr Terry Dunbar, NT

Notes:

Darwin Midwifery Group Practice – Working with Indigenous Women from Remote Communities

Desley Williams & Elizabeth Coombes
Top End Health Services, Darwin, NT

Women living in remote areas of the Northern Territory are encouraged to transfer to urban centres to give birth and this gives rise to many difficult situations for them. In order to address some of these issues the NT Department of Health established a caseload collaborative Midwifery Group Practice in Darwin in 2009 with funding from the NT Government Closing the Gap Initiative and the Australian Government's Indigenous Early Childhood Development National Partnership Agreement. The practice provides antenatal, birth and early post natal care for Indigenous women from nine Top End remote communities. Care is provided for all women and collaboration with a multidisciplinary team is coordinated for those with complex Obstetric and/or Medical need. This presentation will give an overview of the practice and provide examples of the social and emotional support provided to the women and their families

Impact of Social Determinants in Pregnancy in the Top End
Dr Christine Connors, NT

Aboriginal women living in remote areas of the Northern Territory experience some of the poorest social determinants in the country. This impacts across the life span influencing both physical and mental Wellbeing. High rates of smoking in the community, maternal malnutrition, poor diet, low levels of school graduation, and family violence all contribute to increased stress, low birth weight and poorer pregnancy outcomes. Childhood malnutrition, recurrent infection, poor school attendance, high rates of incarceration of men, early onset of chronic disease and premature death of family members continue this high level of stress and disadvantage throughout childhood and adolescence. Pregnant women come with significant disadvantage and high levels of stress contributing to poorer health status. Health services need to understand and recognise how this disadvantage impacts on women and their families. This provides opportunities for focusing on improved access, ensuring culturally safe and inclusive services, providing quality care whilst minimising stressful demands from the health system, and integration of social and emotional Wellbeing support into maternal health services. Health systems are not especially well developed to achieve these outcomes, so specific focus is required to change how individual clinicians practice and the how the health system as a whole functions.

Sexual Difficulties…The Communication Gap
Dr Susan Carr, VIC

In some indigenous communities there are high rates of sexual abuse, with all its consequent negative sequelae. In order to address these issues, they have to be communicated.

Discussing sexual issues, under any circumstances ,can be difficult for both health professionals and patients alike. There are many barriers to this discussion.

In minority groups, however, it can be particularly difficult, as there may be added factors inhibiting this discussion. These issues will be highlighted , and some strategies to help these interactions will be discussed.

The Passing on, of Sexual Health Knowledge in Rural and Remote Aboriginal Communities

Ms Susan Arwen and Kathy Edwards
SHine SA (Sexual Health Information networking and education South Australia), Adelaide

Discussing respectful relationships and sexual health is a difficult topic for many cultures. Building strong relationships based on respect, trust and collaboration with individuals and communities is essential and fundamental to the development of age and culturally appropriate programs and resources that address a range of relationships and sexual health issues with young Aboriginal people living in rural and remote communities.

Funded for a second three year cycle through SA Health to develop and deliver 'Sexual Health Education Programs Targeting Aboriginal Young People' in 17 rural and remote Aboriginal communities in South Australia, the Yarning On model builds on the strength and capabilities of schools and communities to pass on respectful relationship and sexual health knowledge through education both within and outside the school system. The program demonstrates collaborative community partnerships and throughout its development has used innovative engagement and feedback mechanisms to pass on culturally appropriate, relevant to the locality and life of the community and young people, relationship and sexual health information.

An external evaluation of the program in 2013 found that Yarning On is a sustainable model given time and one which has the potential to have long term health gains by contributing to the reduction of teenage pregnancy, sexually transmitted infections and family violence. Evaluation findings also found that both programs are building significant capacity among individuals, organisations and communities to promote sexual health, well-being and safety for young Aboriginal people.

Contraception Conundrums
Dr Meredith Frearson, SA

A conundrum may be defined as a confusing and difficult problem or question: How is it that with more options than ever available to them than Australian women continue to have the 3rd greatest rate of pregnancy termination in the world? How is it that we are not doing better at avoiding unwanted pregnancy and how can we easily improve education and clinical practice for Australian women? Trends overseas , recent research and suggestions for incorporating this information easily into clinical practice will be explored.

An overview of the National Indigenous Cervical Screening Project (NICSP)
Dr Suzanne Moore, QLD

Background: Cervical cancer has a much greater impact on Aboriginal and Torres Strait Islander women than other Australian women; incidence is 2.7 times and mortality 5.2 times higher for Indigenous compared to non-Indigenous women. Although national data are not available, local reports indicate that Indigenous women have lower participation in screening, are diagnosed later, and have lower survival rates from cervical cancer. Australia has had a nationally coordinated approach to cervical screening, the National Cervical Screening Program (NCSP), including Paptest registers, since the early 1990's, that provides data to monitor and evaluate cervical screening. However, the registers do not record Indigenous status and consequently no data on cervical screening for Indigenous women are available. This study will assess the effectiveness of the National Cervical Screening Program (NCSP) for Indigenous women compared with other Australian women, and investigate trends in cervical cancer incidence and survival for Indigenous women.

Design: This project utilizes the data linkage unit in each state and territory to conduct the linkage of Pap Test Registers, Cancer Registers and Hospital inpatient data and firstly ascertain Indigenous status. Rates of participation by Indigenous women in the NCSP and cervical cancer outcomes with respect to comorbidities, remoteness of residence and other health and diagnostic indicators, will then be analysed.

Results: This presentation will provide an overview of cervical cancer epidemiology in Indigenous women in Australia, methods used by NICSP and study progress to date.

Breast Cancer in Indigenous Women

Suzanne P Moore[1], Adèle C Green[2, 3], Gail Garvey[1], Michael Coory[4], Jennifer Martin[5,6], Patricia C Valery[1]

1. Menzies School of Health Research, Brisbane
2. QIMR Berghofer Medical Research Institute, Brisbane
3. University of Manchester, Manchester, UK
4. Murdoch Children's Research Institute, Victoria
5. School of Medicine University of Queensland Translational Research Institute, Brisbane
6. Monash University, Melbourne

Objectives: Indigenous Australians with cancer receive less treatment and have poorer outcomes than non-Indigenous Australians. Whilst some outcomes for Indigenous women with breast cancer have been reported, gaps remain in our understanding. We compared treatment, survival and presence of comorbidity in Indigenous and non-Indigenous women, and sought the views of Indigenous Health Workers (IHW) regarding barriers and enablers to treatment and survival.

Design: A matched-cohort study of Indigenous (n=110) and non-Indigenous women (n=105), diagnosed with breast cancer and treated in Queensland public hospitals during 1998-2004. We used Pearson's Chi-squared analysis to compare proportions and Cox proportional hazard models to assess survival differences. Using semi-structured dialogues, we conducted focus groups with IHW.

Results: Indigenous women were more likely to be socioeconomically disadvantaged ($p<0.01$), have serious comorbidity ($p<0.01$), and advanced disease than non-Indigenous women ($p=0.03$). More Indigenous women underwent a mastectomy (44% vs. 34%, $p=0.17$), were deceased by the end of the follow-up period (32% vs. 18%, $p= 0.01$) and were more likely to die of a non-cancer cause than non-Indigenous women. IHWs reported geographic remoteness from health services, specifically lack of transport and dislocation from community whilst undertaking treatment as barriers to treatment uptake. Systemic failures such as inadequate transfer of health data and treatment plans to patients themselves and primary health care providers, poor understanding of cancer and treatment by Indigenous people, and poorer general health were also identified. Treatment delays reportedly occur if people did not feel ill from their cancer or had competing health issues such as diabetes. The benefits of a cancer support person, to assist patients through their cancer journey, were identified.

Conclusion: In Queensland, Indigenous women with breast cancer generally received comparable treatment to their non-Indigenous counterparts in the public health system. However, poorer overall health, later stage at diagnosis, and issues with treatment access reinforce the need for early detection, improved management of co-existing disease and cultural and geographical support for Indigenous women with breast cancer.

Ethical approval

Ethical approval to conduct the study was obtained from Queensland Health and the Queensland Institute of Medical Research. An Indigenous Reference Group were established to advise on cultural and research transfer issues.

Fertility-Related Health Care Needs of Women Diagnosed With Breast Cancer While of Reproductive Age

Prof Jane Fisher[1]
[1]Jean Hailes Research Unit, School of Public Health and Preventive Medicine, Monash University, Melbourne

Breast cancer is the most commonly diagnosed cancer among women aged under 40 years in Australia. As the average age at which women give birth is increasing, women who experience breast cancer while of reproductive age may not yet be partnered, have had a child or have completed their families. While rare, some women experience breast cancer when pregnant. Breast cancer, fertility and reproductive health are inter-linked in diverse ways which have immediate and long-term consequences. They are challenged with decisions about survival, treatment and fertility, which can continue after the cessation of active treatment. All have heightened needs for health care in which cancer, its treatment, and implications for life meaning, including fertility can be considered together in the immediate and longer term. Few clinicians feel equipped to provide this comprehensive care, but women's accounts and reflections on their needs provide guidance. In-depth interviews with women in these predicaments reveal that fertility is significant, rarely enquired into and influences life after breast cancer treatment is complete. Women welcome clinical care at the time of diagnosis and treatment, and during long-term follow up, that is fertility-informed.

Dr Kate Andrewartha
Resident, Women's and Children's Hospital, Adelaide, South Australia
Kate studied at Adelaide University and graduated from MBBS in 2012. She completed her Internship at the Royal Adelaide Hospital before undertaking a year as a Resident at the Women's and Children's Hospital in Adelaide, South Australia. She has a passion for Obstetrics and Gynaecology and has travelled to Bali several times over the past few years to work with local hospitals in the aim of improving women's health in developing countries. She aims to enter RANZCOG training to further her career in Obstetrics and Gynaecology.

Ms Susan Arwen
Sue Arwen is the Manger of Clinical Services and Community Programs at SHine SA. Sue led the development and implementation of the Yarning On - Aboriginal Sexual Health program targeting rural and remote Aboriginal communities in South Australia.

Ms Emily Bariola
Emily Bariola is a Research Officer at The Australian Research Centre in Sex, Health and Society of La Trobe University and the project officer on the Work, Women and the Menopause study. Emily has a qualification in psychology and has worked in public health for the past four years. She has managed a number of national research projects examining health across the lifespan.

Dr Jacqueline Boyle
Jacqueline is an NHMRC research fellow and is the Head of the Indigenous and Refugee Women's Health research group at Monash Centre for Health Research and Implementation, School of Public Health and Preventive Medicine, Monash University. As an Obstetrician Gynaecologist with a Masters of Public Health and a PhD, she also provides clinical services in women's health in Melbourne and in remote communities in the Northern Territory through the specialist outreach service. Jacqueline is the Chair of the Indigenous Women's health committee at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and a co-lead on the National Indigenous Women's Health partnership on research and translation.

Dr Carly Brazel
Carly is an Intern at St Vincent's Hospital, Sydney. She has a passion for Aboriginal women's health, a topic she had the pleasure of presenting on at the United Nations 57th Commission on the Status of Women in 2013. Carly also has an interest in Obstetric Endocrinology, an area she aims to specialise in. Having grown up in rural Australia, in the future Carly hopes to combine her areas of interest with the aim of contributing to enhancing women's health outcomes in rural Australia.

Dr Susan Carr
Susan worked as Consultant in Sexual and Reproductive Healthcare in the NHS in Glasgow until 2009. where she set up clinics for 'women in marginalised populations '. Was Scottish training co-ordinator for the Institute of Psychosexual Medicine UK. Is past chair of the International Society for Sexuality and Cancer, and past president of Sexuality and Sexual Health Section of the Royal Society of Medicine, London.
Since moving to Melbourne in 2009 , as Head of Psychosexual Service The Royal Womens Hospital, she has developed a telephone clinical service in co-ordination with Cancer Council Victoria.
She teaches and writes about sexuality, with particular interest in sexuality and cancer, and communication about sex.
She is currently President elect of the Australian Society of Psychosomatic Obstetrics and Gynaecology (ASPOG).

Prof Tony Chung
Professor Tony Chung graduated from the University of Sydney in 1977 and after specialist training in Newcastle, Australia, joined the Chinese University of Hong Kong in 1989. He was Chairman of the Department of Obstetrics and Gynaecology from 2000 to 2013. He was also Chief of Service of Obstetrics and Gynaecology in the NTEC of the Hospital Authority of Hong Kong from 1999-2007. Currently, he is Associate Dean of the Faculty of Medicine at CUHK. His main research interest are in the psychological aspect of human reproduction and general gynaecology and he has published more than 200 papers in these and related areas. He is past president of the Hong Kong College of Obstetricians and Gynaecologists and an Honorary Professor of the Sydney Medical School, the University of Sydney.

Ms Elizabeth Coombes
Elizabeth Coombes is a Tiwi woman from Pirlangimpi, Melville Island. She is an experienced Aboriginal Health Practitioner who has worked at Pirlangimpi Health Centre, Danila Dilba Health Service in Darwin and for the last year, with the Darwin Midwifery Group Practice. She has a strong interest in Maternal & Newborn health and in the provision of pregnancy and birth support for Aboriginal women from remote communities.

Dr Caitlin Dallas
Caitlin is currently an Intern at the Western Hospital in Victoria. In the future she hopes to specialise in Obstetrics and Gynaecology. Last year Caitlin spoke at the United Nations 57th Commission on the Status of Women in New York, about the effect of trauma on women's healthcare outcomes, and also of the unique role of Doctors as advocates; an area that she is very passionate about. Caitlin's other passion is equality in healthcare, and she has undertaken electives in Obstetrics in both rural Australia and developing countries, with the aim to continue this work in the future.

Dr Christine Connors
Christine Connors (FAFPHM MPH DRACOG) is a public health physician and GP who has been working in the Northern Territory for over twenty five years, providing clinical and public health services. She is currently the General Manager Primary Health Care for the Top End Health Service. Christine has extensive experience in public health research with Menzies School of Health Research and the Cooperative Research Centre in Aboriginal and Torres Strait Islander Health. Her research interests include health systems approach to improving outcomes in chronic disease, models of care for diabetes in pregnancy and chronic kidney disease and population approaches to reducing childhood infectious diseases. She has had a major focus on improving research translation into practice using systems such as clinical guidelines, continuous quality improvement and key performance indicators to monitor practice changes. She currently chairs the NT CQI Committee for Aboriginal PHC services.

Ms Heather D'Antoine
Heather is an Aboriginal woman from the West Kimberley region of Western Australia. She trained as a registered nurse and a midwife. She moved into research 12 researchers where she became involved with a team doing research on Fetal Alcohol Spectrum Disorders. She is the Associate Director for Aboriginal Programs at the Menzies School of Health Research in Darwin.

Dr Liam Dunn
Liam Dunn is an Obstetrics and Gynaecology Principal House Officer at Mater Mothers' Hospital, Brisbane. Liam completed his medical training through the University of Queensland and incorporated two years of clinical training in addition to his internship at Toowoomba Hospital. Coming from a Queensland country town, Liam has a keen interest in regional and rural Australian women's health policy and practice. Utilising the robust research facilities and focus at the Mater Mothers' Hospital, Liam is pursuing higher research. Outside of work, Liam is a fitness enthusiast, particularly half marathon and amateur triathlon events.

Ms Kathy Edwards
Kathy Edwards is Aboriginal woman from Queensland. Kathy works in SHine SA as an educator in the field of sexual health and relationships, with Aboriginal workers and community members in rural and remote Aboriginal communities in South Australia.

Dr Elizabeth Farrell
Dr Farrell is the Head of the Menopause Unit at Monash Medical Centre, Adjunct Honorary Senior Lecturer in the Department of Obstetrics and Gynaecology, Monash University and a Director, Consultant Gynaecologist and Acting Senior Medical Officer with the Jean Hailes Foundation for Women's Health in Melbourne, Australia.
She is a Past President of the Australasian Menopause Society and also of the Asia Pacific Menopause Federation.
Dr Farrell has been actively involved in the management, education and research of the menopausal woman for more than twenty years.
In Australia she established the first Early Menopause Clinic in 2002, the first Adult Turner's Syndrome Long Term Care Clinic in 2004 and in 2009, the first Women and Cancer Clinic in Victoria at Monash Medical Centre. She also has an interest in general gynaecology and endometriosis. She has had her own private gynaecology practice since 1980
In January 2009 she was awarded an AM, Member in the General Division of the Order of Australia by the Australian Government and in May 2013 was awarded an Honorary Doctor of Laws from Monash University for her services to women's health.

Prof Jane Fisher
Jane Fisher is Professor of Women's Health and the Director of the Jean Hailes Research Unit in the School of Public Health and Preventive Medicine at Monash University. She is an academic Clinical and Health Psychologist with longstanding interests in public health perspectives on the links between women's reproductive health and mental health from adolescence to mid-life, in particular related to fertility, conception, pregnancy, birth, and the postpartum period. She worked in the multidisciplinary clinical team at the Breast Unit @ Mercy Private from 1998 – 2011.

Dr Meredith Frearson
Dr Meredith Frearson is a General Practitioner with extensive post graduate training and clinical experience in many aspects of Women's Health. She works in Adelaide as a GP and for over 15 years has provided monthly services via the RFDS Rural Women's GP service to small rural and remote communities in SA and NT, currently visiting either Canteen Creek and Epenarra or Lake Nash monthly. She also enjoys helping her colleagues to keep up to date in this field and is pleased to have this opportunity to speak about current issues in contraception.

Dr Helen Haines
Helen Haines is a lecturer at the Rural Health Academic Centre, The University of Melbourne based in Wangaratta Victoria and the Department of Women's and Children's Health, Obstetrics and Gynaecology, Uppsala University Sweden. She is also a Post Doctoral Research Fellow at the Department of Women's and Children's Health, Karolinska Institute, Sweden.

Ms Marlene Liddle
Marlene,born in Alice Springs who is now living in Darwin is a traditional owner for Alice Springs and is a proud Eastern Arrente woman of Central Australia.
Marlene is one of 10 children, has 3 children 13 grandchildren and 6 great grandchildren.
Marlene's vision is to gain more knowledge about her culture, to remain healthy, to be there to guide and offer guidance to her 3 children. Marlene describes herself as a quiet achiever, a caring person, values and respects Aboriginal Law and Culture, and loves working towards improving better health outcomes for Aboriginal people.
Marlene is a Co-Coordinator of the Northern Territory Governments Dept of Health's – Strong Women, Strong Babies, Strong Culture Program and has been in this role for 20 years.
The SWSBSC is a successful program has been going for 21 years this month (August) and has gained both National and International recognition over that time. Marlene has travelled to Lihir (PNG) and Perth to deliver a Strong Woman Training Package (which she developed) to enable the women to implement the program in their areas. Marlene has represented the Department of Health at many conferences throughout Australia promoting and sharing the work of SWSBSC program and its workers. In 2013 the SWSBSC program and it's workers received the Northern Territory's Administrator's award for Primary Health Care and also recognition from the Minister of Health for twenty years of valuable service. Marlene is very passionate about the SWSBSC program. In 2014 Marlene received an award at the Annual Chronic Disease Conference for her contributions towards Aboriginal Health and Leadership.
Marlene has seen many changes within the Department in her 36 years with the Health Department .

Dr Tonia Mezzini
Dr. Tonia Mezzini is the Director of Medical Services at SHine SA and works in private practice at North Adelaide Family Practice and Pelvic Pain SA. She is committee member for the Australian Society for Psychosocial Obstetrics and Gynaecology, and the Society for Australian Sexologists (South Australia).

Dr Suzanne Moore
Suzanne Moore is a Research Fellow at the Menzies School of Health Research, based in Brisbane, Australia. She has a background in nursing and public health, and has managed a number of community-based national research projects. Following completion of a Master of Public Health degree, Suzanne was the project manager of the Australian Cancer Study: the epidemiology of oesophageal and ovarian cancer, at the Queensland Institute of Medical Research (QIMR). In 2010 she completed a Doctorate in Public Health, in which she investigated cancer incidence, diagnosis, treatment and survival among Indigenous and non-Indigenous people in Queensland. In 2011 she commenced a Postdoctoral Fellowship at the International Agency for Research on Cancer (IARC), researching the burden of cancer among Indigenous peoples globally. She recently established an international network of Indigenous and non-Indigenous researchers to promote awareness and research with the aim of improving cancer outcomes for Indigenous people. She currently manages the National Indigenous Cervical Screening Project, a study of cervical screening participation and cancer outcomes of Indigenous Australian women.

Dr Ann Olsson
Dr Ann Olsson is a gynaecologist currently practising in South Australia. She graduated from the University of Adelaide in 1984 and completed specialist training in Obstetrics and Gynaecology in 1994. She works in both public and private practice in Adelaide and rural South Australia.
Hospital appointments include Senior Visiting Gynaecologist to the Vulval Disorders Clinic at the Royal Adelaide Hospital and Senior Consultant in the Colposcopy Clinic at Flinders Medical Centre.
She is currently Treasurer of the Australian Society for Psychosocial Obstetrics and Gynaecology and President of the Australian and New Zealand Vulvovaginal Society.

Ms Leeanne Pena
Leeanne has a Master of Indigenous Social Policy and a GradDipEd in secondary education. Predominantly her experience relates to Indigenous education and is passionate about the obvious links between education and health, consequently she has always used the opportunity and platform as an educator to deliver material on the concepts of health promotion and preventative care for Indigenous people. She has been enthusiastic about her current opportunity to work as a Project Officer between the Aboriginal Medical Services Alliance of the Northern Territory and Northern Territory General Practice Education. Leeanne has held this position for 2 years developing a more productive relationship and a model for future engagement for supporting the expansion of Indigenous Heath Training for General Practice Registrars in the Northern Territory Australia.

Dr Heather Rowe
Heather Rowe is Senior Research Fellow at Jean Hailes Research Unit, School of Public Health and Preventive Medicine at Monash University in Melbourne. Her background is in the biological and psychological sciences, and health promotion. She investigates women's reproductive and mental health in their social, economic, cultural and political contexts, including female gender disadvantage.
Heather is Immediate Past President of ASPOG and Secretary General of the International Society for Psychosomatic Obstetrics and Gynaecology.

Dr Jane Thorn
Dr Jane Thorn is a staff specialist Obstetrician and Gynaecologist at Royal Darwin Hospital. She has particular interests in both vulval disease and Indigenous Women's Health and has had a long association with Top End Communities.

Dr Cathy Watson
Cathy works as a women's health nurse practitioner at the Royal Women's Hospital in Melbourne. She recently completed a PhD looking at garlic and candida, in which she undertook a pilot study, a randomised control trial, a survey and mass spectrometry. Her paper reflects an interesting (and so far, unpublished) aspect of this research. She is hoping to undertake a post-doctoral fellowship in 2015 looking at a completely different subject which is slightly better suited to dinner party conversations: endometrial cancer.

Ms Desley Williams
Desley Williams is a registered Nurse/Midwife who came to the NT from Melbourne In 1989. She initially worked as the clinical manager of the Maternity Unit at Katherine Hospital. Since then she has worked as a Remote Outreach Midwife in the TE of the NT, on a Maternal & Child Health Program in PNG and since 2009, as the Co-coordinator of the Darwin Midwifery Group Practice

Jinko Yokota
Dr. Jinko Yokota obtained M.D. and Ph.D from Tokyo Women's Medical University (TWMU), and Master of Women's Health from Melbourne University. Currently she is a lecturer as well as an internist specializing in Cardiology, Gender-sensitive Medicine and Women's Health at the Student Health Care Centre and the Institute of Women's Health of TWMU. She is also a project member of the Gender Equality Promotion Office at TWMU, for undertaking faculty liaison on the issues of gender harassment and discrimination. Her research interest lies in Health of Young Women. Besides educating on Health Management at TWMU, she is active in the specialized formation for junior doctors.

Delegate List

Title	First Name	Last Name	Organisation	State/Country
Prof	Suzanne	Abraham	University of Sydney	NSW
Dr	Kate	Andrewartha	Women's & Children's Hospital	SA
Ms	Susan	Arwen	Shine SA	SA
Dr	Elinor	Atkinson	Flinders Medical Centre	SA
Ms	Emily	Bariola	La Trobe University	VIC
Ms	Caterina	Bortolot	The Women's Hospital	VIC
Dr	Catherine	Boyd	Royal Darwin Hospital	NT
Dr	Jacqueline	Boyle	Monash Centre for Health Research & Implementation	VIC
Dr	Carly	Brazel		SNW
Ms	Angela	Bull	Charles Darwin University	NT
Dr	Susan	Carr	Royal Women's Hospital	VIC
Prof	Tony	Chung		HONG KONG
Dr	Tamsin	Cockayne	NTGPE	NT
Mrs	Sue	Colquhoun	Health Development	NT
Prof	John	Condon	Repatriation Hospital	SA
Ms	Leonie	Conn	Top End Health Services	NT
Dr	Christine	Connors	Top End Health Services	NT
Dr	Rowena	Conway	Goyders Line Medical Practice	SA
Ms	Elizabeth	Coombes		NT
Ms	Barbara	Cox	N.T.G, Department of Health	NT
Dr	Robyn	Cross	Delmont Private Hospital	QLD
Ms	Dana	Dabrowska	Department of Health	NT
Dr	Caitlin	Dallas	Western Health	VIC
Ms	Heather	D'Antoine		VIC
Ms	Belinda	Davis		NT
Ms	Teresa	De Santis	AHP Management Team	NT
Dr	Rebecca	Deans		NSW
Miss	Kobie	Delaney	Royal Darwin Hospital	NT
Dr	Terry	Dunbar		NT
Dr	Catherine	Duncan		VIC
Dr	Liam	Dunn	Mater Mothers' Hospital	QLD
Ms	Theresa	Dunn	NT Department of Health	NT
Ms	Kathy	Edwards	Shine SA	SA
Dr	Charlotte	Elder	Royal Children's Hospital Melbourne	VIC
Dr	Jane	Elliott	North Adelaide Family Practice / AMS	SA
Dr	Elizabeth	Farrell	Monash Medical Centre	VIC
Prof	Jane	Fisher	Monash University	VIC
Ms	Jan	Franklin	Department of Health & Families	NT
Dr	Meredith	Frearson	Adelaide Health Care	SA
Ms	Margaret	Fuller	Royal Darwin Hospital	NT
Dr	Margaret	Gottlieb		NSW
Dr	Fiona	Haines	Healthy Women Medical Centre	QLD
Dr	Helen	Haines	University of Melbourne	VIC
Dr	Helen	Hankey		WA
Dr	Meredith	Hansen-Knarhoi		NT
Ms	Miriam	Heath	Department of Health NT	NT
Mrs	Josephine Michelle	Hogan		SA
Dr	Jonas	Ilocto	Top End Medical Centre	NT
Ms	Amie	Johns	Family Planning Welfare NT	NT
Dr	Elizabeth	Kenihan	Blackwood Clinic	SA
Ms	Marlene	Liddle	N.T.G, Department of Health	NT
Ms	Patricia	Magee	NT Health	NT
Ms	Leanne	March	Adelaide Women's Health Centre	SA
Ms	Sharon	Marchant	Department of Health	NT

Delegate List

Title	First Name	Last Name	Organisation	State/Country
Dr	Amanda	McBride	The University of Notre Dame	NSW
Dr	Moira	McCaul	Adelaide Health Care	SA
Dr	Belinda	McDonald	Ngaanyatjarra Health Service	NT
Ms	Sandra	McElligott	DOH	NT
Mrs	Iana	McLellan	Katherine Hospital	NT
Dr	Tonia	Mezzini	Shine SA	SA
Dr	Saman	Moeed	Royal Children's Hospital Melbourne	VIC
Dr	Suzanne	Moore	Menzies School of Health Research	QLD
Ms	Jennifer	Morrisey	Royal Hospital for Women Sydney	NSW
Ms	Kathleen	Mulders	Rose St Clinic	SA
Dr	Amanda	Nichols		SA
Ms	Irene	Ogilvie	AHP Management Team	NT
Dr	Ann	Olsson	Adelaide Women's Health Centre	SA
Ms	Monica	Ostigh	Remote Health, Julanimawu Health Centre	NT
Ms	Sharon	Overend	Department of Health	NT
Ms	Leeanne	Pena		NT
Dr	Judith	Reddrop	Women's Wellbeing	QLD
Dr	Esther	Richard	GP "Women's Wellbeing"	QLD
Dr	Heather	Rowe	Monash University	VIC
Ms	Esther-Rose	Seaton	Northern Territory Government	NT
Dr	Jo Ann	Silva	Guardian Medical	VIC
Dr	Jackie	Stacy	O & G	NSW
Dr	Phyo	Thandar	Northern Territory GP Education	NT
Dr	Christine	Thevathasan		VIC
Dr	Jenny	Thomas		SA
Mrs	Belinda	Van Hees	Queensland Health	QLD
Mrs	Bronwyn	Van Ras	Remote Health Top Ent	NT
Ms	Nancy	Vozoff	Santa Teresa Health Service	NT
Ms	Robyn	Wardle		NT
Dr	Cathy	Watson	Royal Women's Hospital / Melbourne University	VIC
Dr	Aruna	Wijayaratne	Palmerston Medical Clinic	NT
Dr	Bronwyn	Williams	Health on Kensington	SA
Ms	Desley	Williams	Darwin Midwifery Group Practice	NT
Dr	Jennifer	Wilton	Adelaide Women's Health Centre	SA
Dr	Regina	Wulf	Nighcliff Medical Centre	NT
Dr	Jinko	Yokota	Tokyo Women's Medical University	JAPAN