

O&G  
MAGAZINE



# SILENT EPIDEMIC

Vol. 19 No. 4 | Summer 2017

a RANZCOG publication



Vol. 19 No. 4 Summer 2017

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ISSN 1442-5319

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## **The College**

### **5 From the President**

Steve Robson

### **9 From the CEO**

Alana Killen

## **Silent epidemic**

### **11 Editorial**

Angela Jay

### **12 Tackling family violence: a system-wide approach**

Jane Hooker

### **14 Family violence in New Zealand**

Linda Haultain

### **16 Violence against women in Australia**

Brett Daniels

### **18 Insights into the migrant and refugee communities**

Carol Kaplanian

### **20 Routine enquiry for DFV in healthcare settings**

Kathleen Baird

### **23 The case against routine screening for DFV**

Deborah Walsh

### **26 Clinical assessment of sexual assault**

Miranda Howlett

### **29 Does FGM/C still matter in our clinical practice?**

Wemi Oyekanmi, Natalija Nesvadba and Bernadette White

### **31 Assisting women seeking refuge**

Margaret Bell and Alexandra Brown

### **33 Misogyny in reproductive health**

Helen Paterson

### **35 Sexual harassment in the workplace**

Gary Pinchen and Alyssandria Lim

## Women's health

- 37 **Q&A: Is NovaSure endometrial ablation the safest surgical treatment for heavy menstrual bleeding?**  
Prathima Chowdary, L Ellet and P Maher
- 40 **Case report – Ogilvie's syndrome with caecal perforation post caesarean section**  
Dennis Gong, Victor Chin, Josephine Woodman, B Bikshandi, R Wescombe and R Pegram
- 42 **Case report – Extraovarian endometriosis-associated neoplasms**  
Marilyn Boo and Nasser Shehata
- 46 **The leg-up**  
Nicole Woodrow and Vinay S Rane
- 48 **From the editor's desk**  
Caroline de Costa
- 50 **Journal Club**  
Brett Daniels
- 51 **How we talk about drinking alcohol during pregnancy**  
Susan Hickson

## The College

- 52 **Letters to the Editor**
- 54 **Winners of 2017 Liam & Frankie Davison Award**  
Delwyn Lawson
- 56 **New FGM module**  
Nesrin Varol and Angela Dawson
- 58 **Just another day in Jahun paradise?**  
Jared Watts
- 60 **Catalysts for change**  
Pushpa Nusair
- 63 **RANZCOG Women's Health Foundation: 2018 scholarships and fellowships**
- 64 **Notice of deceased Fellows**

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# From the President



**Prof Steve Robson**  
**President**

Summer is now with us, and I hope all of you will have the opportunity for some rest and relaxation over the festive season. I spent some time with the senior leadership of one of the large medical indemnity organisations recently and one of their messages was clear: rest and time away from clinical work are good for our patient care. Significant to the profile of a number of practitioners who are involved in medico-legal claims is overwork and lack of down time. So even the workaholics among us must take some time off to clear our heads, rest our bodies, and make sure we have the physical and mental resources to provide the level of care women deserve. So... take a break!

## Violence against women

This issue of *O&G Magazine* is devoted to the critically important issue of prevention of violence against women. It is easy for us to underestimate the enormous toll that violence against women takes in our communities. As we have become better at managing the deadly complications of pregnancy – bleeding, infection, hypertension, and thrombosis – violence against women remains a tremendous and deadly challenge we must face.

Many of you will remember the shocking attack against RANZCOG Trainee, Dr Angela Jay. The violence against Dr Jay made front-page news around the country and internationally. Dr Jay has come through the highly public and near-fatal attack with dignity and resilience, and has demonstrated an incredible determination to harness the emotion and publicity to benefit women everywhere. She has joined me in putting prevention of violence against women at the forefront of College advocacy. As the new MBS maternity item numbers support screening for violence, it has become a personal mission of mine – supported with incredible energy and focus by Dr Jay.



Video regarding changes to MBS obstetric item numbers available on the College website.

### Enmeshed...

Since my last column, I have had the 'pleasure' of appearing before the Senate Inquiry into transvaginal mesh. The College had made a detailed submission to the Inquiry, an effort driven by Chair of the Urogynaecology Subspecialty Committee, Dr Peta Higgs and her team. I am extremely grateful for her wisdom, experience and hard work in drawing together a sometimes diverse body of opinion in writing the submission.

Along with Urogynaecology Subspecialty Committee Deputy Chair A/Prof Chris Benness, and College CEO Ms Alana Killen, I appeared before the inquiry at Parliament House in Canberra. The appearance was very intimidating, as we knew that an enormous amount of unwarranted criticism had been levelled at the College and our handling of the issue. We spent a great deal of time preparing for the appearance, and I need to acknowledge Dr Agnes Wilson and Ms Jacqueline Maloney for the hard work they did behind the scenes. The report from the Senate Inquiry is due for release in November, and might well be out by the time you read this.



The College President and CEO, and A/Prof Christopher Benness appeared before the Senate Inquiry in September.

### Private practice in Australia

Many Fellows and GP obstetricians have a private practice component to their work, and in Australia private care is fundamental to both obstetrics and gynaecology practice. Almost one third of births occur in private hospitals, and the majority of gynaecological operations and procedures take place in private settings. In Australia, a healthy balance between the public and private systems seems fundamental to the provision of good care for women.

One of the key drivers of the uptake of private health insurance with hospital cover is maternity. Young couples commonly take out

private cover to start a family. The experience of private maternity care affects whether they continue with lifetime private health insurance, and even friends and family visiting them after birth get some sense of private care. The data tell us that many couples are relinquishing private cover, and this has the potential for a severe adverse downstream effect for the whole private health system.

In response to this, I have convened round-table meetings at College House with key figures and organisations from across the spectrum of private health in Australia. Participants come from the Anaesthetic College and Society, the AMA, NASOG, private health insurers and hospitals, Private Health Australia, indemnity providers, as well as Government and the opposition. Focus groups are being run in most Australian capital cities. I am hoping to provide a detailed report on recommendations and actions from these activities early in the new year.

### Going global...

It has always been a core College activity to support women's health for our Pacific neighbours. The largest Pacific country, Papua New Guinea (PNG), is a short flight from Australia, yet has some of the worst health outcomes for women in the world, owing to a combination of factors. PNG has a high-skilled and dedicated women's health workforce and the College is absolutely committed to supporting them. I had the privilege of attending the PNG Medical Symposium in September – along with the Presidents of RACS and ANZCA – and met with the Prime Minister and Health Minister of PNG, as well as senior officials from the Australian High Commission, to discuss access to safe care.

The College has just released a major overview of Pacific women's health that outlines key challenges and solutions, which can be found here: [www.ranzcog.edu.au/Womens-Health/global/What-we-do](http://www.ranzcog.edu.au/Womens-Health/global/What-we-do). While the College's resources are limited, we have an excellent ability to advocate for Pacific health and to partner with governments and NGOs. Ms Killen and I met with the Minister for Pacific Development to discuss opportunities to work together. Also, for the first time, RANZCOG has signed an historic letter of intent with the American College of Obstetricians and Gynecologists (ACOG) to work together on women's health issues in the Pacific.

### And the rest...

Before I became President – even when I was on the College Board – I had little idea about the enormous workload going on at College House. Some issues you will hear about next year are: the College House redevelopment; revalidation; Aboriginal and Torres Strait Islander women's health; rural workforce; responses to procedural training issues; a new National Maternity Framework; the cervical screening renewal and changes to C-QulP; the new College maternity app; the National Women's Health Summit... Since there is clearly a large workload ahead of us all next year, I prescribe a restful summer break for everyone.



Prof Robson speaking at the PNG Medical Symposium about the critical importance of resourcing women's health.



# From the CEO



**Alana Killen**  
CEO

## Supporting Respectful Workplaces – Update

Reports of bullying, harassment and discrimination in medicine have been the subject of much discussion over the past few years; across the entire spectrum from medical student to consultant.<sup>1-10</sup>

While the problem is widely acknowledged, effective strategies to address the situation have been difficult to identify. Medicine is a complex domain that involves 'a loose coalition of high-achieving, competitive individuals belonging to numerous workplaces and associations, each with its own internal hierarchies and cultures'.<sup>8</sup>

Within medicine, there exist multiple subcultures; each with its own set of values, beliefs and attitudes that influence the behaviours of its members. However, common themes have emerged from the research conducted over the past decade and these themes were reflected in RANZCOG's own survey into bullying and harassment conducted in 2016.

The survey was sent to 2149 Fellows and 701 trainees; of this number, 659 Fellows (approximately 30 per cent) and 265 trainees (approximately 40 per cent) responded. Of the total responses received, 60 per cent (522) indicated that they had been bullied in the O&G workplace – most often when in the role of a trainee, but with 34 per cent indicating that they had experienced this behaviour while working as a consultant.

Consistent with findings from other surveys, the reasons given for not reporting or challenging the behaviour were related to a fear of compromising career prospects or fear of making the situation worse. In terms of what form the bullying and harassment took, the common themes were humiliating and belittling behaviour generally perpetrated in the presence of others, including patients. What was not investigated at that time was the incidence of sexual discrimination in the workplace nor the gender of those who had experienced bullying.

## What is RANZCOG doing?

As a result of the survey and in acknowledgement of the growing need to provide greater support to our trainees (and supervisors), a new Training Support Unit has been established. This Unit was formally launched at the ASM in New Zealand and the Trainee Liaison Senior Coordinator has already commenced in her role and is quickly becoming familiar with the RANZCOG programs and processes. This role will be the primary point of contact for trainees (or supervisors) seeking support and assistance. The College will shortly finalise an agreement with Converge International



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([www.convergeinternational.com.au](http://www.convergeinternational.com.au)) who are experienced in the provision of expert advice and assistance. This organisation employs specialists in psychology, mental health and wellbeing and can provide confidential support over the phone or face-to-face to trainees in times of difficulty.

RANZCOG is also pleased to launch the Train-the-Trainer 'Supporting Respectful Workplaces' workshop, which is being run in a number of regions and will be progressively rolled out over the coming months. The workshop has been developed for trainees, SIMGs and Fellows involved in the RANZCOG training program and aims to develop and consolidate the skills and knowledge essential for safe and respectful practice in O&G and to help ensure training environments are free from bullying, harassment and discrimination.

### Mentoring

Medicine is a demanding profession, making the wellbeing and support of doctors, especially those in their first years of medicine, of significant importance. Trainees face a multitude of external pressures, including heavy workloads, shift work and long hours, as well as significant internal pressures, such as the ongoing drive to achieve career goals and finding work-life balance. SIMGs face even greater challenges as they attempt to balance not only career and training pressures, but also the challenges associated with navigating the Australian health workplace.

The 2013 beyondblue survey of medical students and doctors provided sobering insight into the health of the medical profession. Alarming findings included that 47.5 per cent of doctors aged 30 years and younger reported emotional exhaustion. These findings prompted the recommendation for increased support for younger doctors, including strengthened mentor and mentee relationships. To address this, the College has developed a mentoring workshop that will assist in developing supportive relationships and provide a formalised program for mentors to enhance and develop their skills. This mentoring program will also be open to trainees.

### What can I do?

Advanced trainees and Fellows who would like to take the lead in delivering these workshops are encouraged to attend a T3 workshop. The workshops are free of charge and attract CPD points. The T3 workshops include didactic and small group teaching methods as well as roleplay and simulation. Those who are interested should contact [trainee liaison@ranzcog.edu.au](mailto:trainee liaison@ranzcog.edu.au).

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# Editorial



**Dr Angela Jay**  
FRANZCOG trainee  
Royal North Shore Hospital

**'I tell my story, not because it is unique, but because it is not.'**

— Malala Yousafzai, Nobel Lecture 2014

On 3 November 2016, after a brief relationship ended, I was almost murdered and set on fire in my own home. During the assault, I was stabbed 11 times and doused in petrol before fleeing for my life.

In the weeks preceding the attack, I vividly remember my predominant emotions – fear and shame. I couldn't comprehend how a seemingly successful and intelligent person could possibly become a victim of domestic violence. Feeling embarrassed to find myself in such a vulnerable position, I found it impossible to open up to those around me. While I waited for the police to serve the Apprehended Violence Order I had applied for, I constantly felt nervous and sick. I was too afraid to sleep in my home, and considered sleeping in my car or the registrar room at work instead. Suspecting my perpetrator was stalking me, I was always on edge and looking over my shoulder to check whether I was being followed. Meanwhile, I continued to care for my patients, attended clinics and performed procedures – all with a forced smile.

On the afternoon I was attacked, I could see the knife and my brain started to comprehend that I was being stabbed. I fell to the ground and saw the wound on my left thigh, I could see the fat beneath my skin and it was bleeding heavily around my fingers even when I tried to apply pressure. I would later learn that there was in fact not one, but six stab wounds in that thigh, with one extending all the way into my femur. I'm sure only a few seconds had passed at this point and my mind was buzzing frantically. Yet I remember having one distinct thought – I was about to become one of the 1–2 women *per week* murdered by a current or ex-partner in Australia<sup>1</sup> – known ever more as a mere statistic.

I felt sinking despair as I realised that I would die then and there, all alone, and never get the chance to see my friends or family again. I think I even briefly accepted that fate. I eventually found the strength to pick myself off the ground, only to be met by a

shower of petrol. It ran down my face and through my hair, it burned my eyes and filled my ears, and I coughed as the fumes began to choke me. It was that moment of indescribable horror – waiting to be lit on fire – that my adrenaline kicked into overdrive and, somehow, I found the courage to run for my life.

Leading up to the one-year anniversary of the day my life almost ended, it has become a poignant reminder of the impact of silence. *One in three* women will experience sexual and/or physical violence during their adult lives.<sup>2</sup> In fact, intimate partner violence is the leading risk factor for preventable death, disability and illness burden in women aged 15 to 45 years; contributing even greater morbidity than smoking or obesity.<sup>3</sup> If you believe your friends, family, colleagues and patients are untouched by this tragedy, you are sadly misinformed. There are survivors and victims all around us. That is why ending the silence about such a taboo topic is vitally important.

As obstetrics and gynaecology doctors, we are uniquely well placed to identify and support our most vulnerable patients. We must rise to the challenge as leaders in women's health and become powerful advocates for change. Together, we can work toward a world in which all women, men and children can live in safety. I for one am so privileged to still have a voice, and I will never let it be silenced.

Written in memory of the 13<sup>\*</sup> New Zealand and 71 Australian women murdered in 2016 in acts of domestic violence.

*\*on average per year<sup>4</sup>*

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# Tackling family violence: a system-wide approach



**Jane Hooker**  
Registered nurse and program leader  
Prevention of Violence Against Women  
The Royal Women's Hospital, Melbourne, Victoria

There is much data, research and evidence on the detrimental effects of violence against women on physical, psychological and emotional health. The impact is significant, not only on patients, but also their families, healthcare workers and the broader community. It is a complex, pervasive issue that affects women across social and cultural divides and, according to research, is increasing in Australia and New Zealand.

The Royal Women's Hospital (the Women's), in Melbourne, commonly sees intimate partner violence and its consequences across all its services. The variety of physical health issues that are related to this type of violence can present in a multitude of ways. For example, women may present with higher rates of gynaecological issues, including vaginal and anal bleeding and infections, chronic pelvic disorders, urinary tract infections, fistulas, pain during sexual intercourse and sexual dysfunction. They may also present with reduced reproductive control, increased rates of sexually transmitted infections, pregnancy and complications, and requests for termination of pregnancy.

**"The psychological, sexual and controlling behaviours that are associated with intimate partner violence may be less obvious, but are just as significant to the health of women."**

Research shows that hospital and medical professionals are in a unique position to identify

and support people at risk of family violence and the Women's is working to ensure that all medical professionals involved in women's health understand their role in identifying and supporting women experiencing violence. A toolkit to support healthcare professionals and hospitals effectively deal with this issue has been developed for public use (Figure 1).

## The role of the Royal Women's Hospital

The Women's is taking a lead in addressing violence against women as a health issue and, as a specialist women's and maternity hospital, it is uniquely positioned for early intervention to assist women and their children to safety and recovery from violence.

As a state-wide leader in Victoria, the Women's is collaborating with other health services to build capacity across the whole health system in tackling family violence. It has fostered partnerships with government, academia, the community, other hospitals and the family violence sector. In addition, it is actively participating in, and promoting, research to strengthen the evidence base for clinical care and social support and improve services and programs within the family violence sector.

Tackling the complex and multifactorial challenge of reducing the effect of violence against women has been a priority for the Women's throughout its history, but never more so than over the past few years, as the focus on addressing violence against women in Victoria has increased following a number of violence-related incidents and deaths.

Since 2015, family violence has been a priority area for the Victorian Government, which has made significant investment in prevention. In February 2015, Victoria was the first state in Australia to hold a Royal Commission into Family Violence, which led to the commitment of \$1.91 billion towards addressing family violence in the 2017/18 Victorian budget. In July 2017, it established Victoria's first-ever agency dedicated solely to family violence reform: Family Safety Victoria.



**Figure 1.** Strengthening Hospital Responses to Family Violence project website with toolkit.  
<http://haveyoursay.thewomens.org.au/shrfv-project>.

The Women's, along with Bendigo Health, was one of the first hospitals in Victoria to develop family violence prevention and response services. The support following the Royal Commission has meant the Women's role as a leader in this area has now been formalised, enabling it to expand its model to foster greater coordinated activity across Victoria's public hospitals.

### The Strengthening Hospital Responses to Family Violence project

In 2014, the Victorian Government commenced funding the Strengthening Hospital Responses to Family Violence (SHRFV) project, led by the Women's in conjunction with Bendigo Health. This innovative work aims to develop and implement a framework for embedding within Victorian hospitals the practice of systematically identifying and responding to patients experiencing family violence.

The SHRFV project covers all elements of developing and supporting a whole-of-hospital approach to implementing a family violence program in any hospital setting in Victoria. Based on international best practice, the SHRFV model (Figure 2) has two overarching principles and five key implementation elements. It aims to deliver a whole-of-hospital response to violence and achieve better outcomes for women, children and families in Victoria.

Core to SHRFV is creating a safe and welcoming physical space for women and staff who might be experiencing violence, and providing the right training, tools, support and structures to enable hospital staff to identify and sensitively enquire about family violence.

Some of the practical aspects of the SHRFV program include the following:

- Training staff on how to have the confidence and skills to identify, respond to and refer on women experiencing or at risk of violence.
- Ensuring physical sites are safe and welcoming environments.
- Supporting and mentoring other hospitals to be able to identify and respond to family violence, particularly through the creation of a toolkit that contains a host of information, training programs, adaptable marketing material, and policy and procedures concerning the prevention of violence against women and the role of hospitals. This toolkit has been specifically developed to be adaptable to any hospital and applicable in any healthcare setting.

One of the key tenets of the SHRFV project is that healthcare professionals are not expected to become 'experts' in family violence prevention. Rather, it aims to encourage and give confidence to health workers so they feel able to sensitively enquire and support women experiencing, or at risk of, violence, and know where to refer them for further support.

### Beyond the SHRFV project

The Women's continues to contribute to the prevention of violence against women in other ways, such as by supporting staff who may be at risk of, or experiencing, violence; supporting managers; and undertaking research into family violence.

In 2016, it implemented a workplace support program for employees affected by family violence. The program includes training for colleagues and managers, human resources policies and procedures



Figure 2. SHRFV model.

to better support staff experiencing violence, and the introduction of family violence leave to help individuals to manage issues and appointments associated with family violence.

The hospital also established a Centre for Family Violence Prevention, a hub for researching interventions, including identification tools, early intervention and therapeutic responses, to assist women experiencing family violence. In 2016, Prof Kelsey Hegarty was appointed Australia's first chair of Family Violence Prevention, a joint appointment by the Women's and the University of Melbourne.

Early in 2017, the Women's CEO, Dr Sue Matthews, was appointed the hospital representative to Victoria's Family Violence Steering Committee, which provides specialist advice on the development and implementation of policies, strategies and programs that seek to address family violence in Victoria. The Women's has also recently been appointed as one of four Victorian hospitals to trial routine screening for family violence in an antenatal setting.

**"The Women's believes that prevention and intervention of violence against women should be core business to all health professionals."**

The goal for the next four years is to continue to develop and implement a sustainable, whole-of-hospital response to violence against women right across Victoria. This will be achieved by aligning and prioritising the safety and wellbeing of women exposed to violence professionally or personally and educating and supporting health professionals to enhance their capacity, capability and confidence to practice sensitive inquiry into violence and appropriately refer.

Family violence is a complex issue, but we encourage all healthcare professionals to take a look at the toolkit that has been developed by the Women's, Bendigo Health and other respected hospitals to provide practical support and tools.

# Family violence in New Zealand



**Dr Linda Haultain**  
PhD  
Allied Health Director  
Women and Childrens  
Social Work Professional Leader  
Allied Health Services

Family violence is the brutal reality for far too many New Zealanders, with evidence indicating some of the highest rates of domestic abuse in the developed world.<sup>1</sup> Increasingly, the connection is also being made between intimate partner violence and child maltreatment.<sup>2</sup> Giving expert evidence at the recent inquest regarding a child homicide, Judge Becroft, New Zealand's Children's Commissioner, maintained we have a 'dark side' to our country, reflected in the high rates of youth suicide, domestic violence, and child, drug and alcohol abuse.<sup>3</sup> Given these high rates of violence against women and children in New Zealand, what steps have been taken by health services in an effort to help address these disturbing figures?

## Policy and program development

Described as one of the Ministry of Health's flagship programs, the Violence Intervention Programme (VIP) as we know it today began in 2001. Selected District Health Boards (DHB) established pilot programs supported by the 2002 Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse.<sup>4</sup> Favouring a population health approach, the program now includes the provision of training for health professionals, public policy and education. Combined with information systems and regular evaluation, the program aims to help facilitate effective responses to those experiencing domestic violence.

In 2007 an extension to the program resourced a national VIP manager and family violence coordinators across all DHBs. Their role is to provide training, support and audit of the program in the clinical environment. The current iteration of this program is articulated in the updated Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence.<sup>5</sup> Published by the Ministry of Health in 2016, and implemented across all DHB at their core, is the premise that healthcare

providers are well placed to help victims of domestic violence, inclusive of child abuse.

This assertion is made on the basis that the provision of routine healthcare, such as during pregnancy, injury or illness, brings the majority of the population into contact with health providers. Given that those suffering the effects of family violence seek healthcare more often than those not suffering abuse, health professionals are potentially well positioned to provide timely identification, brief interventions, support and referral onwards to people affected by domestic abuse.

Similar to the 2002 expectations, the 2016 guideline aims to provide a workable tool to assist health professionals to intervene safely and effectively in support of those that have experienced violence. Founded on fundamental ethical principles that support all healthcare practice, such as beneficence (to do good), non-maleficence (to do no harm), autonomy and justice, the guideline describes the following six-step process:

1. Routine inquiry (identification)
2. Validation and support
3. Health and risk assessment
4. Safety planning
5. Referral and follow-up
6. Documentation

Emphasising the co-occurrence of partner abuse and child abuse, the guidelines promote an integrated response to addressing these issues. The overall aim of the program is to make sure that those people affected by family violence who are using health services obtain early support and that health professionals assess and intervene competently.

The foreword to the 2016 guideline persuasively argues that much has been learned during the years of program delivery and development, and that 'the clinical knowledge, health system support and referral source links we have built mean that it is no longer acceptable for us not to respond to an issue that is of fundamental importance to the health of New Zealanders.'<sup>5</sup> Given the program's aims, what does the available data tell us about the challenges New Zealand continues to face in relation to the silent epidemic?

## Data summary

Prevalence data published in June 2017 indicate the following: in 2016 there were 118,910 family violence investigations by New Zealand police, accounting for 41 per cent of a frontline police officers' time. One-in-three (35 per cent) of ever-partnered women in New Zealand describe having experienced physical and/or sexual intimate partner violence (IPV). When psychological abuse is included in the statistics, 55 per cent of women report having experienced IPV in their lifetime.<sup>6</sup>

The available data from June 2012 indicate that the New Zealand police made 78,915 referrals to New



Zealand's statutory child protection agency on the grounds of exposure to family violence. This was after a national policy change in 2004 requiring police to notify the agency when children are present at family violence callouts.<sup>2</sup>

Almost half of all homicides committed in New Zealand are by an offender who has been identified as a family member. In a four-year period (2009–2012) nine children, 13 women and 10 men were killed as a result of family violence.<sup>7</sup> Like other indigenous populations, Māori are disproportionately represented as both victims and perpetrators of family violence.<sup>8</sup>

### How are we doing?

Summarised in the six-step process above, the expectations for health professionals having attended an eight-hour training program, is to undertake a routine inquiry regarding their safety at home for all women aged over 16 years. If a positive disclosure is made, the brief intervention follows. The referral pathway is likely to include either a DHB health social worker or a local specialist domestic violence service. How many of us are meeting this basic obligation?

There are positive signs of progress, (95 per cent of DHBs do have systems in place to support an efficient and safe response to domestic violence); however, the most recent internal DHB audit identifies only 45 per cent of eligible women receiving the routine enquiry mentioned above.<sup>10</sup> A number of organisational, clinical and public perceptions are worthy of reflection when we consider this figure.

Firstly, the sustained investment by the Ministry of Health and the provision of clear professional guidelines that makes clear our obligations. More than two decades of research that demonstrate the damaging affects of exposure to domestic violence for children and poor health outcomes for women.<sup>1</sup> In the women's health context, there is an established link between IPV and increased spontaneous abortion and termination of pregnancy.<sup>9</sup> Despite this compelling contextual background, more than half the time health professionals continue to shy away from our clearly articulated responsibility in relation to domestic violence.<sup>10</sup> The final part of this article explores why this may be the case.

### Asking ourselves the questions

Why is this? Is it because we don't understand the part we must play? Do we think this is someone else's job? Do we perceive we are too busy? Are we afraid of ripping the scab off a wound that we feel ill equipped to respond to? Do we have a lack of confidence in the program intended to respond to domestic violence? Do we fear causing offence, or scaring the patient off? Are we uncertain about to whom and how to refer? I invite all health professionals to ask ourselves these questions, and then to take active steps to attend to the specific barriers we identify that are preventing our more active engagement with this critical area of healthcare practice.

Local literature suggests that women are supportive of the questions being asked in a health context and have an expectation that health professionals will engage in a non-directive, non-judgmental way, appreciating the complexity of the situation women face, and the need to provide an individually tailored response. Across all health sectors we must develop our capability to respond effectively to those who are at risk. This will require us to step forward, to actively seek out opportunities to increase our capacity, and to more fully take up our share of the responsibility to help to address the silent epidemic.

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# Violence against women in Australia



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Violence against women is a worldwide phenomenon affecting millions of people each year. A 2013 systematic review by WHO reported that 35 per cent of women had experienced physical and/or sexual violence from a partner or non-partner.<sup>1</sup>

In Australia, recent reliable estimates of the prevalence of violence against women can be obtained from the Australian Bureau of Statistics' 2012 Personal Safety Survey (PSS), conducted from February to December 2012. This survey interviewed 17,050 randomly selected members of Australian households. Interviews were conducted privately,

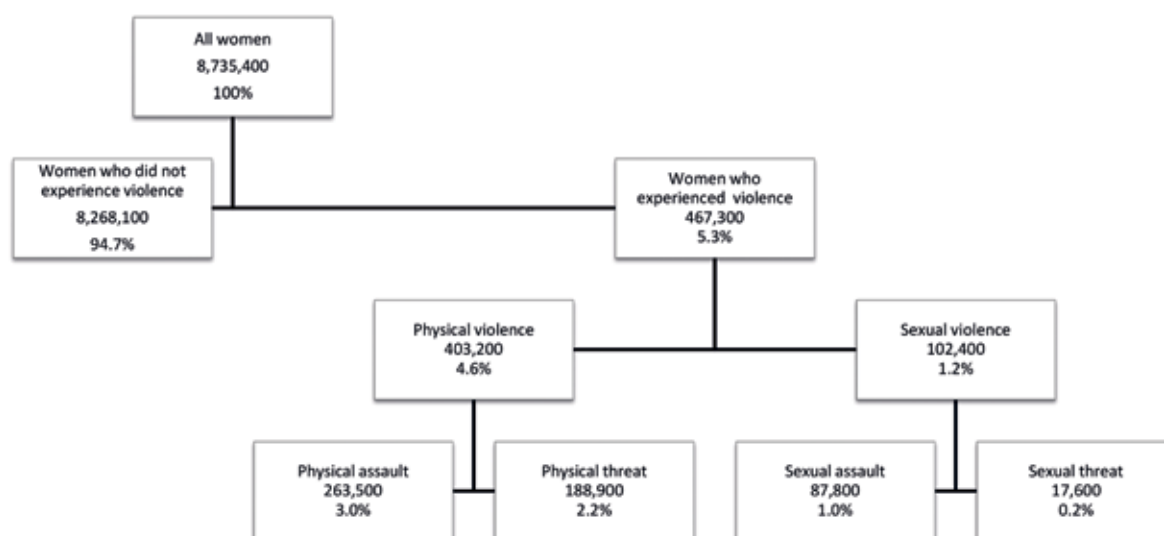
with interviewers trained specifically for what had the potential to be sensitive and traumatic disclosures. The results from this survey are expressed as estimates of the percentages and total numbers of women aged greater than 18 at the time of the survey. Data were collected both in terms of experiencing violence in the past 12 months, or at any time since the age of 15.

## Women's experience of violence in the past year

Figure 1 reproduces a flowchart summarising the prevalence estimate results of the PSS. The 2012 PSS data indicate that in the 12 months prior to the survey, 5.3 per cent of Australian women aged greater than 18 reported experiencing violence, 4.6 per cent experienced physical violence and 1.2 per cent experienced sexual violence.

## Changes in prevalence of violence

The 2012 PSS results compared the prevalence of violence with results from previous surveys in 1996 and 2005. While there was a statistically significant decrease from 1996 to 2005 in the proportion of women aged 18 years and over who had experienced violence in the 12 months prior to the survey (from 7.1 per cent in 1996 to 5.8 per cent in 2005)<sup>2</sup>, there was no statistically significant change from 2005 to 2012 in the proportion of women who had experienced violence in the 12 months prior to the survey. In 2005, an estimated 5.8 per cent of all women had experienced violence in the 12 months prior to interview, compared to 5.3 per cent in 2012.<sup>2</sup>



**Figure 1.** Women's experience of violence during the last 12 months, from ABS Personal Safety Survey, 2012.<sup>2</sup>



**Table 1.** Estimated prevalence of women experiencing physical or sexual violence since the age of 15, extracted from ABS Personal Safety Survey, 2012.<sup>2</sup>

Whether experienced violence since the age of 15	Females	
	'000	%
Did not experience violence since the age of 15	5,174.8	59.2
Experienced violence since the age of 15	3,560.6	40.8
Physical assault	2,606.8	29.8
Physical threat	1,118.4	12.8
Total	3,006.1	34.4
Sexual assault	1,494.0	17.1
Sexual threat	386.9	4.4
Total	1,696.1	19.4

#### Experience of violence by women any time since the age of 15

The PSS 2012 results estimated that 41 per cent of Australian women aged 18 and over (3,560,000 women in 2012) had experienced physical and/or sexual violence since the age of 15. Physical violence was experienced by 30 per cent of women (2,608,000) while 17 per cent (1,494,000) had been the victim of sexual assault since the age of 15.

#### Relationship to perpetrator of violence

Women who reported experiencing either sexual or physical violence since the age of 15 were much more likely to be assaulted by a person known to them than by a stranger. In the case of the 19.4 per cent of women who had experienced sexual violence, the perpetrator was known to the victim in 16.4 per cent of women and a stranger in 5.3 per cent. Current (4.9 per cent) or previous (4.4 per cent) partners, or boyfriend/girlfriend or date (5.9 per cent) were the highest reported relationships while 3.7 per cent reported being sexually assaulted by an acquaintance or neighbour and 1.6 per cent by a work colleague.

In the case of physical violence, of the 34.4 per cent of women who reported experiencing physical violence since the age of 15, in 8.4 per cent the perpetrator was a stranger and 29.6 per cent the perpetrator was known to them. Current (2.6 per cent) or previous (13.3 per cent) partners, or boyfriend/girlfriend or date (6.8 per cent) were again the highest reported relationships. 3.9 per cent reported being physically assaulted by an acquaintance or neighbour and 0.8 per cent by a work colleague.

#### Violence in pregnancy in Australia

A further analysis of the PSS data in 2015 reported that approximately 180,000 women experienced violence by a current partner and were pregnant

at some time in that relationship. Of these women, 21.7 per cent reported experiencing violence while they were pregnant, and of these women, 61 per cent experienced violence for the first time during pregnancy.<sup>3</sup>

The same paper also reported data on 768,000 women who experienced violence during relationships with previous cohabiting partners, and were also pregnant at some time in that relationship. Of these women, 53.9 per cent reported experiencing violence while they were pregnant in these previous relationships, with 47 per cent of these women reporting that they experienced violence for the first time while they were pregnant.

#### Time off work

The 2012 PSS reported the number of women who took time off work in the 12 months following their most recent experience of domestic violence. Of the women who reported experiencing sexual assault by a male perpetrator since the age of 15, 10.9 per cent took time off work in the 12 months following their most recent assault, while 29.6 per cent did not work at all in that time, although that could not necessarily be attributed to the violent incident/s. The standard error in the data regarding sexual assaults on women by women was considered too large to be reliable. In the case of women experiencing physical assault since the age of 15 by a male perpetrator, 19 per cent took time off paid work in the 12 months following the most recent assault and 29.6 per cent did not work at all. In the case of females experiencing physical violence by female perpetrators the corresponding numbers were 5.1 per cent and 34.2 per cent respectively.<sup>2</sup>

#### Conclusion

While the prevalence of violence against women in Australia is impossible to precisely ascertain, the data presented in this summary highlight the high rates of violence against women, with 40 per cent of women reporting experiencing violence since the age of 15. Perpetrators of violence against women are far more likely to be known to them than be strangers, with a substantial number of women being the victim of violence while they were pregnant and missing work because of it. These data should alert readers to be vigilant to the possibility of violence occurring to the women they have contact with in their personal and professional lives.

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# Insights into the migrant and refugee communities



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In the last few years, an overwhelming amount of literature and research has been conducted on the issue of family and domestic violence (FDV). It can be acknowledged that FDV is a global issue that spans culture, religion, ethnicity, skin colour and migration status. However, as professionals, we often forget that our perception and understanding of what FDV is can be very different to those we work with. In this case, I am specifically referring to the culturally and linguistically diverse community (CaLD). What we do know is that domestic violence occurs at the same rate, if not higher, in the CaLD community.<sup>1</sup> In 2015, ANROWS published a study on FDV in the immigrant community. They acknowledged that there are notably few studies that specifically examine the prevalence of family violence against immigrant and refugee women, with very little to no evidence available. Furthermore, Morgan and Chadwick reiterate that information on the prevalence of family and domestic violence in the CaLD community is minimised and very limited.<sup>2</sup> This article will examine why information is so limited, and further examine the notion surrounding perception and knowledge on what FDV is. We simply cannot ignore the fact that culture plays an integral role in shifting and/or stagnating people's perception around certain world views, including violence. We also cannot ignore that intimate partner violence is still the leading cause of death, disability and illness in women aged 15–44 in Australia.<sup>3</sup> Understanding such complex concepts, which encapsulate the perception of violence, will enable us to provide a more culturally sensitive response to our clients and patients.

Widening our understanding of culture in relation to FDV is pivotal. Sokoloff and Dupont adopt a macro view of culture by stressing that we cannot deny the 'real differences among battered women from diverse cultures'. They further stress that 'culture is crucial to understanding and combating domestic violence, we cannot rest on simplistic notions of culture. Rather, we must address how different communities' cultural experiences of violence are mediated through structural forms of oppression, such as racism, colonialism, economic exploitation, heterosexism, and the like'.<sup>4</sup> One can therefore argue that cultural beliefs play an integral role in shaping a woman's experience of abuse and what that abuse may mean to her. Gill et al<sup>5</sup> however, take on a more micro view of this issue by arguing that much of the cause of domestic violence creates barriers to help-seeking by CaLD women, resting upon patriarchal values, predominantly about the status of women in some communities. From an enculturated sense, one can further argue that structural forms of oppression emerge from the everyday language and relationships between women and their intimate partners, extended family or others of influence, such as community and religious leaders, who in turn reinforce patriarchal values about the status of women, and ultimately judge women's responses to FDV. This is one of the core differences between a Western understanding of violence to that of a different culture.

In many cultures around the world, FDV is not seen in the same light as we perceive it here in Australia. In 2009, Fisher noted that there is reluctance among immigrant and refugee women to conceptualise family violence in ways that emphasise aggression.<sup>6</sup> In many cultures, family violence may only be perceived as physical, without encapsulating any other forms of abuse. For example, in research undertaken with West African women now living in Australia, Ogunsi et al reported participants' descriptions of family violence focused mainly on physical abuse.<sup>7</sup> Controlling behaviours, financial and verbal abuse were not recognised as family violence, with sexual violence in an intimate partner relationship not mentioned at all. Additionally, in her research, Fisher illustrated that according to some women from the African community, 'discipline' was viewed as men's duty towards children, and in some cases, their wives as well.<sup>8</sup> Furthermore, Tonsing argues that studies among Asian and Middle Eastern immigrant communities in the United States have observed that it is culturally acceptable for men to use physical abuse as one form of discipline of women should they deviate from what is seen as their prescribed roles.<sup>9</sup> Rees and Pease allude that while culture and patriarchal values act as causes of FDV, it is the structurally based inequalities, social dissonance and psychological stress that predominantly contribute to FDV.<sup>10</sup> The cause of what constitutes FDV in Western society is also often

attributed to structural inequalities between men and women. This is the case for most societies around the world; however, for the CaLD community, perception about ingrained gender roles strongly differs. Araj and Carlson support this argument by extrapolating that 'a society's culture determines how supportive it will be of family violence and who it considers the appropriate administrators and recipients of abuse, most known societies are patriarchal, wherein men are given greater power, privilege, and control of women and children. In these societies, parents are also awarded authority over children'.<sup>11</sup>

Another pivotal point to note is the effect culture has on developing our sense of identity. In many migrant communities, individuals identify with a collective sense of identity as opposed to an individual one. Abu Odeh succinctly elucidates that 'through an elaborate system of commands and prohibitions, girls "learn" their performance at a very young age. The culture guards itself against possible violations by devising sanctions less violent than death that are meant to preclude it, such as physical abuse, spatial entrapment, segregation, the institution of gossip and reputation, "because you are a girl, people will talk if you do this", is rhetorically how women come to acquire their gendered subjectivity'.<sup>12</sup> It can then be stated that migrant and refugee women may and will experience family violence from multiple perpetrators due to the collective notion of identity. This can include in-laws or community members. This is often the case for women from communities where wives are considered responsible for maintaining the family unity, or where norms of collectivism or subordination of the individual to the demands of the family or the head of the family is seen as normal.<sup>1,13</sup> These factors have a consequential impact on CaLD women's interpretation of what FDV means and is linked to women's unique context of culture and patriarchal attitudes in a collective society. In turn, these factors provide a critical barrier for women to seek help, as they themselves do not categorise the violence that they are being subjected to as FDV. This is due to their cultural and social perception of what constitutes violence. If women only perceive physical violence as a form of domestic violence, they may be enduring other types of violence in a normalised manner as a result of their collective notion of identity.

As practitioners working with women from all walks of life, it can be difficult to understand someone else's world view, as our perception may not support that of the patient. This can also be compounded by the fact that many women hold a sense of obligation to stay in a relationship/marriage due to religious and traditional beliefs as attitudes that were ingrained from an early age.<sup>14</sup> In such clashes of cultural understanding, practitioners report not knowing how to respond to women from CaLD backgrounds who are experiencing violence. This is due to the practitioner's desire to maintain cultural sensitivity.<sup>15</sup>

To effectively work with women from different cultures, it is important to understand their world view. It is equally important to note that factors such as their immigration status, employment and financial independence, their family and community ties, their limited level of knowledge of the law and their own rights are all barriers that hinder them from seeking support. Additionally, women highly value their honour, status and reputation in a way that is tied to their family due to their collective notion of

identity. Taking all of the above into consideration will enable us to sensitively and effectively work with women from different cultural backgrounds.

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# Routine enquiry for DFV in healthcare settings



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Domestic violence and abuse against women is a global public health issue; it is embedded in society and pervades all socio-economic, gender and cultural groups, having a devastating effect on the lives of survivors.<sup>1</sup> In most situations, domestic violence occurs within the context of a relationship of a cohabiting couple and includes physical, sexual and emotional abuse, as well as controlling behaviours. Indisputably, experiencing domestic violence and abuse can lead to negative consequences in many spheres of life, including educational achievement and economic opportunities, increased uptake of risky health behaviours and reduced capacity to parent.<sup>1</sup>

## The nature of domestic violence

Domestic violence is a broad concept that affects the health and wellbeing of women, young girls and children.<sup>2</sup> It can lead to severe injury, disability and death, as well as indirect health consequences; for example, psychological disorders such as post-traumatic stress disorder, depression, sleep disorders, suicide, social withdrawal and eating disorders, self-harm and substance abuse. In comparison to non-abused women, those in abusive relationships report higher rates of sexually transmitted infections, including HIV, as well as unintended pregnancies, repeated abortions and gynaecological problems.<sup>3-5</sup>

## Domestic violence during pregnancy

Experiencing domestic violence at any time in a woman's life can result in a multitude of harmful health problems. However, domestic violence during pregnancy should be of special concern as the violence not only poses a threat to the woman, but also to her unborn fetus. It is associated with placental abruption, premature rupture of membranes, premature birth, low birthweight, postnatal depression and maternal and perinatal death.<sup>6</sup> The high rates of domestic violence and its known detrimental effects has resulted in health

policy developments in many countries, including the UK, USA, Canada and Australia, where screening for domestic violence during and following pregnancy is endorsed.

## Current debate around the effectiveness of routine enquiry for domestic violence

Those experiencing domestic violence are much more likely to seek healthcare than those who are not.<sup>1</sup> However, engaging healthcare professionals in supporting women experiencing domestic violence has proved to be a challenge. Indeed, until very recently, health services have focused their energy and resources on dealing with the consequences of domestic violence.<sup>7</sup> Proactive identification within healthcare settings and among health professionals has been poor for a variety of reasons, such as believing that domestic violence enquiry is not within their professional remit, fear of offending the woman, anxiety and nervousness about dealing with a positive disclosure and, most of all, a lack of training and education. In contrast, women experiencing domestic abuse consistently identify healthcare professionals as a potential source of support.<sup>7,8</sup> Yet, unless women are asked directly about a history of violence, they are reluctant to disclose for fear of not being believed, being judged and stigmatised, having their children removed, or simply because they think nothing useful can be done about their situation.<sup>7</sup>

Conducting routine enquiry for domestic violence in all healthcare settings is keenly contested and several systematic reviews indicate that while there is evidence that screening increases identification, there is limited evidence to date that it increases referrals, reduces abuse or improves women's health or safety.<sup>9-12</sup> However, perhaps when assessing the effectiveness of interventions for women experiencing domestic violence, intermediate primary outcomes such as disclosure, validation of their experience and increased safety planning discussions may be more achievable and may even be a more meaningful measure than trying to measure an overall reduction in abuse.

## What do women find helpful from health professionals?

Women who experience domestic violence will frequently access health services as they seek help for their injuries. In response, many professional health organisations have issued clinical guidelines on how to identify and respond appropriately to women and children who have or are experiencing domestic violence and abuse.<sup>1</sup> As mentioned previously, women find routine enquiry in certain health settings acceptable, providing that the health professional is caring, sensitive and non-judgemental. They want their experiences of violence to be believed and validated. It is important to acknowledge that routine enquiry for domestic violence may not be appropriate in all health settings, but maternity and women's health services provide an ideal setting to communicate with women who



are experiencing domestic violence. Though, to be able to do this safely and effectively, it is essential that healthcare professionals receive specialist education to be able to ask the question in a sensitive manner and to be able to respond appropriately to a disclosure from a woman. Healthcare professionals must be educated and supported to provide appropriate and accurate advice and help to women and children. It is important that they are aware of their professional responsibilities and be familiar with appropriate referral pathways, while acknowledging the limitations of their role. (Table 1)

Routine enquiry for domestic violence and abuse can reach many women who previously have not been provided with an opportunity to disclose their history of violence. Most importantly, a visible healthcare response will not only promote disclosures of violence from women, but also communicate a strong message to society; that domestic violence and abuse in any form is no longer acceptable.<sup>13</sup>

### Key messages

- The healthcare system has a significant role to play in a multisectoral response to violence against women
- A supportive response could be the catalyst to safety and recovery for women and children experiencing domestic violence
- All women disclosing domestic violence should be reassured that their information will be shared in a safe and appropriate manner
- All health organisations should have robust domestic violence policies and guidelines.

- Health services should provide support and ongoing domestic violence education and training
- Healthcare professionals who provide care to women and children should be aware of local support agencies and the services they can provide
- Routine enquiry/screening in this article refers to asking all adult women a set of standardised questions about a history of domestic violence at nominated health services such as maternity, mental health, drug and alcohol services, accident and emergency departments, sexual assault services and well women clinics, including gynaecology.

Domestic Violence Helpline  
1800 RESPECT – 1800 737 732 (Australia) 24 hours, 7 days a week.

The AMA and Law Council of Victoria have developed Supporting Patients Experiencing Family Violence: a resource for medical practitioners, available here: [ama.com.au/article/ama-family-violence-resource](http://ama.com.au/article/ama-family-violence-resource).

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**Table 1.** Five simple steps to assist healthcare professionals to ask about domestic and family violence and respond appropriately.

Asking about and responding to a positive disclosure to domestic and family violence	
1	<b>Asking about domestic violence</b> It is important to ask women about domestic violence in a confident and professional manner. The question should be framed in a way that does not pose judgement and should only be asked in a safe and private environment. The question should not be asked in front of the partner or a child who is able to repeat the conversation to another person.
2	<b>Responding to a positive disclosure</b> Healthcare professionals must be aware of health guidelines and protocols as well as safe and appropriate referral pathways to women's community organisations. If a woman discloses domestic violence, follow these five simple steps: <ol style="list-style-type: none"> <li>1. Thank her for telling you</li> <li>2. Tell her you believe her</li> <li>3. Ask her what she would like you to do</li> <li>4. Provide her with the option to talk to a community domestic violence agency</li> <li>5. Perform a risk assessment to assess her level of safety</li> </ol>
3	<b>Safe and accurate documentation</b> Accurate and contemporaneous record keeping of a domestic violence disclosure is imperative. Safe storage of any information pertaining to a positive disclosure is critical and should never be in hand-held notes or any notes that are visible to the perpetrator. It is also important to acknowledge the limitation to confidentiality, and a clear explanation provided in regard to any information that a health professional may be legally obliged to share. Information sharing should be carried out safely to minimise the risk to the woman and her family.
4	<b>Risk assessment and safety planning</b> An important consideration following a disclosure is the immediate and long-term safety obligations for both the woman and her children. Risk assessments should ensure that the emotional needs as well as the physical risks of women and children are considered. Women from different communities may have unique needs because of language difficulties and isolation. Women should never be encouraged to leave a violent relationship until a full risk assessment has been performed and a robust safety plan put in place to protect both her and her children.
5	<b>Referral and working in collaboration</b> Responding to domestic violence should never be a one-agency response. Working with other agencies in a safe and appropriate manner is an essential component of being able to support the woman and her children. <sup>7</sup>

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# The case against routine screening for DFV



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International estimates by the World Health Organization<sup>1</sup> indicate that approximately one-in-three women have experienced violence, with much of the violence perpetrated by an intimate male partner in a domestic setting. While there may be one-in-three women who are victimised, that does not mean there are one-in-three men who are violent. The majority of men are not violent, but those who are often have multiple partners.

When the health impact is measured, it has been found to cause a global disease burden of 30 per cent for women.<sup>1</sup> In addition, as many as 38 per cent of homicides of women worldwide are committed by a male intimate partner<sup>1</sup> and approximately one woman per week is murdered by a domestic partner in Australia,<sup>2</sup> demonstrating the potential catastrophic consequences for women victims. Considering the gravity of domestic and family violence (DFV) an attempt to intervene early in these situations was introduced by various health services, and routine screening for DFV was born. This article will argue that help seeking is complex behaviour and while routine screening may detect DFV in healthcare populations, disclosure does not equal help seeking nor does it mean women's safety and health outcomes will improve. Therefore, I will be arguing the case against screening.

In the 1980s and 90s, as prevalence data emerged about DFV, recommendations in favour of routinely screening women for domestic violence, particularly in antenatal care, became commonplace.<sup>3-5</sup> In the US the Preventive Services Taskforce recommended screening and counselling in all healthcare settings for women of childbearing age.<sup>6</sup> As a result, many nursing and health researchers went on to produce volumes of research data on standardising different screening tools.<sup>7-9</sup> Many argued to acknowledge awareness of DFV affecting women was important and healthcare would be seen to be doing something to break the cycle of violence and improve women's safety.<sup>4,5</sup>

As screening became popular, there were some who were cautious about its implementation in Australia. As an example, Taft cautioned against the use of screening tools as she felt these were problematic strategies attempting to address complex psychosocial issues such as DFV.<sup>10</sup>

There were advocates who argued that routine screening was an effective and efficient way to acknowledge the gravity of violence and reassure patients that it was not acceptable behaviour.<sup>11,12</sup> While I believe the motives behind screening are well meaning, I will argue here they are based on two false assumptions: one, that disclosure equals help seeking and with support the woman will leave her partner thus reducing exposure to violence and, two, as a result of leaving there will be improvements in the woman's safety.

## Disclosure does not equal help seeking

Several studies have explored the results of DFV screening programs and have consistently found that screening increases disclosures of violence.<sup>13-15</sup> However, it appears that there is little evidence to show a corresponding increase in help seeking once identified.<sup>16-18</sup> Irwin and Waugh, reporting on a screening program in NSW, found that of the 11 per cent who screened positive for DFV only 30 per cent agreed to some sort of assistance.<sup>13</sup>

When exploring the barriers to help seeking, Fugate et al found that women felt the violence they were experiencing was not serious enough, they didn't think any help would be useful, it was nobody's business, they feared reprisal, they were embarrassed or they feared being judged or criticised. In addition, women felt that if they disclosed there would be an expectation that they would have to leave the partner and end the relationship and so they felt they needed to protect the partner to preserve the relationship.<sup>19</sup>

In my own practice of some 20 years working in the field of DFV, women frequently stated that they loved the partner and didn't want to leave, but they wanted the violence and abuse to stop. I have found that help seeking is a complex process that takes time and will occur when women have exhausted all their own resources to end the abuse and fix the relationship. Or, alternatively, if the physical violence is escalating or is severe, then women will leave, particularly if they fear for the children. Fugate et al<sup>19</sup> and Meyer<sup>20</sup> found that if a woman's tolerance threshold has not been reached or they were not prepared to end the relationship, then women will not seek help. So, while DFV screening may increase the numbers of women who identify violence, it does not mean they will actively help seek. So why screen?

Feder et al describe that a key element in justifying screening programs is that there will be an effective intervention available.<sup>17</sup> Despite the claims that early intervention will eliminate violence and improve women's lives,<sup>21</sup> there is no evidence of any effective interventions that will improve women's

health and increase women's safety once screening has detected DFV. Two systematic reviews have concluded that there is insufficient evidence to support DFV screening programs either in health services generally or in specific clinical settings<sup>17,18</sup> as they found no robust evidence that DFV screening reduces violence or improves health outcomes for victimised women.

In addition to the research findings above, my (yet untested) concern is that routinely asking women about violence that relies on questions about physical assault, sexual violence and fear has the potential to reinforce the notion that DFV is about black eyes and broken bones, negating other damaging forms of coercive controlling behaviours. Women victims already minimise and deny their experiences of violence and, in my view, screening for DFV has the potential to reinforce their silence or the feeling that the violence is not that bad. It is my view that there are far more compelling arguments against screening than there are for screening because when we do detect violence the only option we can offer the victim is support services to help her to leave and that is a problem as the next section will show – leaving DFV does not mean an increase in safety.

### Leaving DFV does not equal safety

It is a common myth that DFV ends when the victim leaves the relationship, but even a cursory glance at domestic violence service websites highlights the danger involved when leaving a violent partner. Numerous studies have found that violence escalates if the woman leaves the relationship, with separation being a risk factor in the domestic homicide of women.<sup>22-24</sup> McKenzie et al<sup>25</sup> note that:

Contrary to common perceptions, non-physical forms of violence can be 'red flag' indicators of high risk. These include controlling behaviour, obsessive jealousy, stalking, and sexual assault, as well as threats to kill the victim, children or pets, trying to choke the victim, and abuse during pregnancy... Separation is a relationship factor that is consistently found to be associated with higher risk of lethal violence.

The key factor for the increase in risk at separation and during the first 12 months post-separation is the violent partner has lost control of their partner and the violent response may be severe, life threatening or fatal.<sup>26</sup> In my experience running behaviour change intervention programs, men report that they first try to be nice and promise to change or to go to counselling and if that doesn't work the violence escalates. If that fails to get the partner back they frequently resort to punishing her for leaving in any way possible. Research undertaken with men who kill found that they describe experiences of losing control, suspicions of infidelity, involuntary separation, jealousy and rage.<sup>27-29</sup>

Women who separate from violent partners and share biological children find that ongoing victimisation frequently occurs at child handover, exposing the children to ongoing abuse and violence.<sup>25,30,31</sup> While for some women the experience of abuse post-separation may decrease over time, for others the violence never ends, even after the violent man re-partners.

In summary, routine screening in health settings is based on two assumptions that have been challenged. One, that screening will identify victims who will then help seek and, two, that support to leave the violence will improve health outcomes and reduce violence.

With the current responses to DFV in Australia, staying with the partner or separating are the only options for women. The decision to separate frequently comes at the end of a long process. Women will have exhausted all other options, have reached their tolerance threshold and are prepared to end the relationship before they engage in help seeking. Professionals who respond to cues, ask about what is happening at home, are prepared to listen and believe without judgment are in fact providing a valuable intervention. Respecting her timing in terms of disclosure and listening to the experience will help her to come to terms with the fact her partner may not change no matter what she does or does not do. To have up-to-date community resources available is critical to ensure that when women are ready to seek help, links to those resources can be made.

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# Clinical assessment of sexual assault

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Sexual assault is broadly defined as any sexual act carried out against the will of a person through the use of violence, coercion or intimidation.<sup>1</sup> Legally, the term sexual assault refers to those cases that involve sexual penetration of the mouth, vagina or anus.<sup>2</sup> Sexual assault is very common in Australia. The Australian Bureau of Statistics' personal safety review in 2012 estimated that one-in-six women and one-in-25 men over the age of 18 have experienced a sexual assault since age 15.<sup>3</sup> Rather alarmingly, the incidence of sexual assault in Australia is currently rising, with 2016 data revealing a seven-year high.<sup>1</sup>

Contrary to popular belief, the majority of perpetrators of sexual assault are known to their victims and a high proportion of perpetrators are current or ex-partners. Stranger assaults only make up approximately 15 per cent of sexual assault cases.<sup>3</sup>

Given its prevalence, it is important for all clinicians to be confident responding to a disclosure of sexual assault. In most circumstances a clinician will be able to refer such cases to their local Sexual Assault Resource Centre (SARC) for definitive management.

## Taking a history

The sexual assault victim may present to you openly and disclose that they have been assaulted. They also

might present indirectly. It is important to consider sexual assault when a patient presents with injuries, sexual or mental health problems (Table 1).

Many victims of sexual assault experience self-blame and fear that they will not be believed. Thus, the way in which you respond to a disclosure of sexual assault will not only influence how much distress the patient feels, it will also help determine whether they will report to the police and proceed through the criminal justice system.

Ideally, take the history in a private area and do not rush the patient. Take the time to explain confidentiality and its limits, so that the patient is aware that the assault will not be discussed with the police or their family without their consent. One limit to confidentiality is mandatory reporting and it is important to discuss this with the patient prior to assessment. Mandatory reporting laws vary from state to state. In Western Australia, we must report all cases of sexual assault that occur to a person under the age of 18 must be reported.

A good history will gather the information detailed in Table 2. After the history is taken, it is important to discuss the options available to the patient. Some clinicians falsely believe that it is the victim's responsibility to report to police in order to prevent the perpetrator from committing another assault. However, many patients will not want to report to the police and their choice should be respected.

## Assessment and management

There are three key areas to consider: medical, psychosocial and forensic.

### 1a. Medical issues – contraception

Medical concerns always take priority over a forensic examination. A common concern following female sexual assault victims is that of unwanted pregnancy. It is important to determine if the woman is using reliable contraception and, if not, to offer her appropriate emergency contraception. We predominantly use levonorgestrel; however, ulipristal is now an option to consider, especially for those women presenting more than 72 hours post sexual assault or with a raised BMI.<sup>4</sup>

### 1b. Medical issues – STIs

One of the most common concerns following a sexual assault is the risk of acquiring an STI. In the case of a digital assault, we can easily reassure the patient. For the remaining patients, we must provide information about their risk of acquiring an STI; assess the need for prophylaxis and arrange STI screening, taking window periods into account.

I conducted an audit on STI detection at our SARC and found that chlamydia is the most common infection diagnosed. It is not always clear if the infection predated, or was acquired from, the sexual assault. Azithromycin can be offered prophylactically

**Table 1. Common medical presentations following sexual assault.**

Common medical presentations following sexual assault
Requesting emergency contraception or STI screen
Unwanted pregnancy
Pelvic pain, sexual dysfunction
Reluctance for Pap smears
Injury, domestic violence
Memory loss
Psychiatric presentations, self-harm, suicide attempts
Drug or alcohol abuse
Deterioration in work or school performance



**Table 2. Important features on history.**

Important features on history
Time and date of assault
Brief description of assault (what went where)
Condom used
Details of assailant: Stranger? Number? Ethnicity? IV drug user? Incarcerated?
Violence (particularly attempted strangulation)
Injuries or anogenital bleeding
Preceding drug or alcohol use
Current contraception
Risk assessment for patient and any children (from self or perpetrator)
Identifying patient's concerns (pregnancy? STIs? safety?)
Accommodation issues
Mental health history

to all victims of sexual assault; however, some clinicians prefer to reserve prophylactic treatment to those patients who are at high risk or unlikely to return for follow up.

We offer prophylaxis against gonorrhoea for cases where we deem the assailant to be high risk. Knowing your local rates of, and risk factors for, gonorrhoea will assist you in deciding whether to provide prophylaxis to your patients.

It is uncommon to contract HIV after a sexual assault in Australia. This is because HIV is not easily transmitted through unprotected vaginal sex and because the overall seroprevalence of HIV in Australia is low (0.14 per cent). The risk of HIV transmission after receptive penile-vaginal sex with an HIV-positive male (who is not on antiretroviral treatment) is 1/1250 versus 1/70 after receptive penile-anal sex.<sup>5</sup> We offer post-exposure prophylaxis to those patients who present within 72 hours of exposure and either the assailant or the type of assault is deemed to be high risk (Table 3).

Unlike HIV, hepatitis B can easily be transmitted through unprotected penile-vaginal and penile-anal penetration. There is not a great deal of literature regarding post-exposure prophylaxis against hepatitis B. If the patient has been vaccinated against or previously infected with hepatitis B, then they should be immune. We offer a hepatitis B vaccine to anyone who is unlikely to be immune and who presents within two weeks of exposure. Hepatitis B immunoglobulin is reserved for those cases assessed as high risk for hepatitis B transmission (Table 3).<sup>6</sup>

STI screening is performed at the time of initial presentation and at one month and three months after. Baseline screening is for chlamydia, gonorrhoea, hepatitis B, hepatitis C, HIV and syphilis. If a patient reports a penile-oral or penile-anal assault, one should collect swabs from the oropharynx or rectum. At the one-month follow up we test for chlamydia and gonorrhoea. We can also

give the second hepatitis B vaccine if the course was started at the initial presentation. The three-month follow up involves repeating serology and completing the course of hepatitis B vaccination.

### 1c. Medical issues – injuries

Medical safety of the patient takes priority over any forensic investigation, so it is imperative that you take a history and examine the patient to exclude any significant injuries that need to be managed prior to transfer to SARC. Examples of injuries that need medical review prior to SARC review include head injuries, attempted strangulation, suspected fractures and heavy anogenital bleeding.

### 2. Psychosocial issues

Following a sexual assault, many people experience suicidal ideation, sleep disturbance, depression, anxiety and post-traumatic stress disorder. It is important to perform a risk assessment on all patients following a sexual assault and refer for counselling. Our Perth SARC is happy to offer one-off or regular counselling to people who have experienced a sexual assault.<sup>7</sup>

Given that many sexual assaults are carried out by a partner, it is important to assess if the patient is safe to return to their accommodation and if the Department of Child Protection needs to be involved to ensure the safety of any children.

### 3. Forensic issues

The forensic assessment involves documentation of any injuries and collection of specimens to detect DNA and trace evidence. The chance of finding DNA lessens as the time to examination increases so the first clinician to see the patient should collect an early evidence kit (EEK). EEKs are tailored to the type of assault, but may include an oral rinse, first void urine or a gauze wipe of the vulval, penile or peri-anal regions. EEKs are very effective, with a WA SARC study demonstrating that spermatozoa were detected in 35 per cent of EEKs versus 42 per cent of full forensic examinations.<sup>8</sup> The clothes worn at the time of the assault should also be collected, with each item in a separate bag. Clothing should still be collected even if it has been washed because DNA may still be obtained. Blood and urine samples should be collected for toxicology assessment if drug facilitated sexual assault is suspected.

A top-to-toe examination should be carried out to look for any general body injuries. It is important

**Table 3. Risk factors associated with higher rates of HIV and hepatitis B transmission following sexual assault.**

Risk factors associated with higher rates of HIV and hepatitis B transmission following sexual assault
<b>Assailant features</b> <ul style="list-style-type: none"> <li>From a high-risk country (SE Asia or Africa)</li> <li>Multiple assailants</li> <li>Men who have sex with men</li> <li>IV drug use</li> <li>Incarceration</li> </ul>
<b>Assault features</b> <ul style="list-style-type: none"> <li>Receptive anal penetration</li> <li>Breach in the oral/vaginal/anal mucosa</li> <li>Concurrent STI, particularly gonorrhoea</li> </ul>

to use the correct terminology to document any injuries, namely, bruises, abrasions, lacerations or incised wounds.<sup>9</sup> A useful mnemonic to use when documenting injuries is SPICS: site, position, injury type, colour and size. Nearly one-third of patients will have no general body injuries on examination. Approximately one-in-five women have moderate or severe injuries and intimate partners are the most likely perpetrators in these cases (30.4%).<sup>10</sup>

In Perth, we use naked-eye examination to look for anogenital injuries. An analysis of our database showed that genital injury occurs in 24 per cent of cases of completed vaginal penetration. This is consistent with published data worldwide. Genital injury is more likely if there are multiple penetrants, general body injury is present and if there is no prior history of sexual intercourse (up to 52 per cent). It is less likely to be seen if the victim reports sedation or amnesia or if examination is delayed (most injuries heal within 72 hours).<sup>11</sup> Of course genital injuries can also occur during consensual vaginal penetration; however, there is limited published data and the rates tend to be lower.<sup>9</sup>

A forensic assessment is not a therapeutic examination and hence there are specific consent requirements. It is important to note that in obtaining consent for a forensic examination, duty of care and the mature minor principle do not apply. Assessment of a recent sexual assault is complex, so please do not hesitate to contact your local SARC before commencing a forensic assessment. For Perth clinicians, the WA SARC runs a 24-hour service and we can be contacted on 6458 1828.

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**The Royal Australian  
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College of Obstetricians  
and Gynaecologists**  
*Excellence in Women's Health*

# Sexual Assault module

**'Better knowledge and enlightened attitudes amongst healthcare staff can have a significant impact on the management of sexual assault and influence the likelihood of victims presenting for treatment.'**

Williams L, Forster G, Petrak J. Rape attitudes amongst British medical students. *MedEduc*. 1999;33(1):24-7.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) coordinated the development of this educational module under the auspice of the Sexual and Reproductive Health Special Interest Group in collaboration with other experts in this field.

This module is designed as a resource to assist RANZCOG Trainees, Fellows and Diplomates in understanding the prevalence of sexual assault and the importance of providing appropriate care to survivors of sexual assault. It has seven topics; you may navigate through each in order, or access the topics on a needs basis.

Topics covered:

1. An introduction
2. Sexual assault and the law
3. The impact of sexual assault on its victims/survivors
4. Childhood sexual assault
5. Medical responses to sexual assault
6. Forensic examination
7. Working with victims survivors of sexual assault



# Does FGM/C still matter in our clinical practice?

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A growing number of migrants and refugees who come from countries that practice female genital mutilation/cutting (FGM/C) have settled in Australia over the last few decades. This has been an ongoing area of interest (and occasional controversy) in the obstetrics and gynaecology fields. This article provides a general overview of FGM/C and offers some practical suggestions on how to appropriately engage with women and girls affected by FGM/C.

## An overview

According to the World Health Organization (2016) FGM/C 'comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons. The procedure has no known health benefits.'

It is estimated that 200 million women and girls worldwide have undergone the practice (WHO, 2016). FGM/C is prevalent in 30 countries in Africa and a few countries in Asia (such as, some communities in India, Indonesia, Malaysia and Pakistan) and the Middle East. The age at which it is performed varies according to countries, tribes and circumstances. Through international migration, women and girls affected by FGM/C now live in many countries, including Australia and New Zealand. Therefore, all healthcare providers have a responsibility to provide quality, accessible, culturally safe care to those affected.

Reasons for the practice are complex, arising from a belief system based on cultural and social traditions that impinge on the woman's social acceptance and marriageability within her community. While some people believe FGM/C to be part of religious requirements, this is in fact not the case.

## Types of FGM/C

FGM/C is classified into four types, depending on the severity:

- **Type 1:** excision of all or part of the clitoris
- **Type 2:** partial or total removal of the clitoris and the labia minora
- **Type 3:** removal of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
- **Type 4:** pricking, piercing of clitoris or labia. Scraping of vaginal tissue, or introduction of substances into the vagina to cause bleeding, or any other procedure that falls within the above definition

## Health consequences

As previously stated, FGM/C has no known health benefits. Women and girls affected by FGM/C are at a risk of suffering from various complications throughout their lives. Immediate complications can include severe pain, shock, haemorrhage, tetanus, sepsis, urine retention, open sores in the genital region and injury to nearby genital tissue.

Long-term consequences can include dysuria, implantation cysts, dyspareunia, recurrent UTIs and vaginal infections, dysmenorrhoea, pelvic inflammatory disease, infertility, difficulties during pregnancy and childbirth and mental health issues. FGM/C may also have long-term effects on the psychosexual and psychological health of those who have undergone the procedure

It is critical for health professionals to be aware of the negative health consequences that FGM/C can bring and to ensure early identification and appropriate treatment. At the same time, it is also important to consider the women's health history and not immediately subscribe that all health issues are a result of her FGM/C experience. This can be a difficult balancing act.

## Box 1. The use of the term FGM/C.

### A special note on terminology

The term mutilation is used to reinforce that the practice is a violation of girls' and women's human rights. Mutilation emphasises the physical, social and psychological consequences of the act and promotes advocacy to eliminate the practice. However, at the community level, this term can be problematic. The use of the term 'female genital mutilation' in a clinical encounter may have the potential to be counterproductive to forming an effective professional relationship with the patient and hence detrimental to the provision of ongoing care for what is a sensitive issue. Different communities use different terms, so we suggest that you explore with each individual what terminology they use for the practice. If unsure, accepted forms of description are traditional female cutting or female circumcision. For this reason, throughout this article we use the term FGM/C.

### The current state

Concentrated efforts have been made to eradicate or abandon the practice in some affected communities in the countries of origin as well as host migrant countries. Despite some improvements, FGM/C persists in some communities.

After decades of work in this field, in 2016, WHO published the first Guidelines on the management of health complication from female genital mutilation with an aim to 'provide up-to-date, evidence-informed recommendations on the management of health complications from FGM.'

In Australia and New Zealand today, there are a number of FGM/C specific support services (see useful resources for more information). Health professionals can also access many of these services for training and secondary consultations. For example, the Department of Health and Human Services in Victoria funds the Family and Reproductive Rights Education Program (FARREP). Mercy Hospital for Women in Melbourne is one of the FARREP service providers aiming to support women affected by FGM/C, as well as building the capacity of health professionals in this area.

### Providing culturally safe care

In 2014, we conducted a small qualitative study supporting young women who have experienced FGM/C. Our aim was to explore experiences of young women (18–25 years old) from FGM/C affected communities to determine ways to develop, improve and deliver support services that are culturally and age appropriate. A culturally and generationally appropriate worker was employed to conduct semi-structured interviews and focus groups with 12 young women and three key stakeholders who work with the target group.

Thematic data analysis identified the following:

- The young women who participated in the project experienced a lack of awareness and understanding of services that may be available to them.
- They expressed an expectation that GPs and other health professionals will offer support when required

- Access to appropriate, relevant information about FGM/C and supports available was noted by participants as a challenge. They recommended delivering information in a variety of modes, including online and through information sessions.

They also identified a number of features that would be important to them if they were to access services and support. Apart from practical, features such as hours of operation and location, the participants highlighted the need for person-centred, culturally responsive care; access to bi-cultural workers; and emphasis on privacy, confidentiality and trust. While this is not a new finding, our experience tells us that this is not consistently practised.

'Better understanding is important; sometimes it is difficult for professionals to understand you. It is also important to be treated like an individual rather than being put in a group because you are from a particular community. We all don't have the same experiences or facing the same issues so it's important to me to be treated like an individual with her own needs and issues rather than for professionals to assume that I have the same experience or facing the same issues to that of my community.' (Participant #4)

Participants in this project have lived in Australia for a significant part of their life. They report that they can speak and write English very well and have been educated in Australia. However, it appears that their help-seeking behaviours and health literacy are largely shaped by cultural and family values and traditions.

#### Further reading

WHO fact sheet on FGM. Available from: [www.who.int/mediacentre/factsheets/fs241/en](http://www.who.int/mediacentre/factsheets/fs241/en).

WHO guidelines on the management of health complications from female genital mutilation. 2016. Available from: [www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en](http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en).

The National Education Toolkit for FGM/C in Australia (NETFA). 2015. Available from: [www.netfa.com.au](http://www.netfa.com.au).

Mercy Public Hospitals Inc. Supporting young women who have experienced FGM/C. 2014. Melbourne, Australia.

FGM information for health and child protection professionals in New Zealand <http://fgm.co.nz>

### Box 2. Further suggestions to assist in providing appropriate care.

#### Tips that may assist in providing better care to women affected by FGM/C

Communication:

- Consider health literacy. For example, use plain English, avoid medical jargon, check for understanding
- Engage appropriately qualified female interpreters, if required
- Provide information in the woman's first language, where available

Engagement and referrals:

- Remind the woman of confidentiality and privacy
- Other significant people may need to be involved in consultations. Always check with a woman if and who they would like to be present
- Provide female health professionals where possible. Alternatively, explain why it may be necessary to see a male health professional. In this case, consider offering a female chaperone
- Build a relationship with your local FGM/C support service
- Refer women who require de-infibulation to hospitals that have established services to support women for this procedure
- For pregnant women, explain options for accessing either antenatal or intrapartum de-infibulation
- If child born is female, remind patient that FGM/C is illegal in Australia
- Alter your approach. For example, women affected by FGM/C may avoid Pap tests. Engage and explain how you can assist, such as by using different sizes of instruments

# Assisting women seeking refuge



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At the time of writing, over half a million people have fled violence in Myanmar to seek refuge in Bangladesh in a dramatic exodus that is yet to abate.

Their 'refuge' is precarious indeed. Predominantly women and children are trapped in conditions that continue to threaten their safety and health due to the makeshift settlements, insufficient sanitation, severe food shortages and poor security overall. There are calls for resettlement options in wealthier countries.

In these chaotic circumstances, medical-humanitarian organisation Médecins Sans Frontières (MSF) has seen patients with severe dehydration, physical trauma and, in line with reports by other organisations, growing numbers of women showing signs of sexual violence.<sup>1</sup> Our colleague Kate White, emergency coordinator in Bangladesh, has said 'this is a fraction of the cases that are likely to be out there,' and we know she's right.<sup>2</sup>

So what can be done for such victims of sexual violence; what kind of care can we provide? What do we need to know about the hazards the women have faced? How can we adapt our care for the best outcomes in the context where we are providing it?

## The global burden

In terms of global averages, an estimated 30 per cent of women with experience of a relationship have suffered intimate partner violence, while 7.2 per cent of women have been victims of sexual violence at the hands of a non-partner.<sup>3,4</sup> The numbers are inexact and, very likely, underestimates, for various reasons. Poor or non-existent data collection and the 'normalisation' of violence in many contexts can be added to the many well-documented individual and structural barriers to receiving care, including shame, stigma and fear of repercussion, and lack of accessible, appropriate services.<sup>3,4</sup> Of note, the evidence gap is even greater for men than women.

Non-partner violence can be exacerbated by a number of factors. Displacement and its push factors – especially conflict – can be the cause of a traumatic experience that the victim then carries for years.<sup>3,5</sup> If recognised for resettlement as a refugee, they may carry it all the way to Australia.<sup>6</sup>

## Defining sexual violence

The World Health Organization defines sexual violence as:

'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'<sup>3</sup>

This definition is important to MSF and other humanitarian organisations, because in some countries where we work, the legal definition of sexual violence means rape only.

## MSF's response to sexual violence

MSF's core model for sexual violence care combines medical and psychological care as a priority in the first consultation. This patient-centred care is offered for free, in strict confidentiality. Our impetus is: 'What can we do for this person that's appropriate for them and is going to make their life a little bit better?'

Over 90 per cent of our sexual violence patients are women and children. Our care comprises treatment of physical injuries; prevention, treatment and vaccination against infections such as HIV and STIs and prevention and management of unwanted pregnancy, if appropriate; and a large component is psychological support, which can include referral if needed and available. We also provide the patient with a medical certificate.

Beyond the first consultation, when we have the capacity or are in a context to provide further care by ourselves or with others, we do. Networking is key to comprehensive care and assistance for the individual, and to influencing a holistic response across multiple sectors.<sup>7</sup>

## A violent journey

Most of the victims of sexual violence in our emergency programs have been forced to flee due to high levels of conflict and instability. In these situations, people often have limited access to food, safety, shelter or basic healthcare. This makes them vulnerable to sexual exploitation – you may have heard of the term ‘survival sex’ and coercion such as, ‘I’ll give you food for your children if you agree to have sex with me’. More sinisterly, in high-conflict areas, sexual violence is also a military strategy for destabilisation of communities. It can be deployed on a very large scale, reverberating through the family and the whole community.<sup>5</sup>

Since mid-2016, more than one million South Sudanese refugees have fled to Uganda, into the northwest. Initially MSF responded with large-scale water and sanitation services and inpatient and outpatient care. By December 2016, the settlement known as Bidi Bidi had reached capacity, spurring the opening of a new settlement, Imvepi.

Care for victims of sexual violence still lags behind other sexual and reproductive health services at the onset of a humanitarian crisis, such as conflict or natural disaster, and MSF (not the only responder) commenced care in both Ugandan settlements in 2017.

Between April and May 2017, a reported 86 per cent of arrivals were women and children. Typically, women with children and/or hiding along the way have endured a slower journey. The testimonies of MSF’s patients confirmed their collective vulnerability. They had suffered sexual violence, often rape, mostly en route, including at the border. Armed soldiers were the most implicated; the women were attacked in groups rather than as individuals, and many were not able to reach care until days or weeks after the attack, missing the deadlines for effective prevention of HIV or unwanted pregnancy.

## Establishing a dedicated program

Employing mostly Ugandan staff, we developed our program with an emphasis on raising awareness and ensuring that our services were accessible and appropriate. We created community outreach teams to talk about sexual violence and how care was available. Witness to other violence as well, victims can be traumatised, scared and desensitised to violence, which often impedes their ability to seek help. People needed to know that there was a safe and confidential place where they could be listened to, supported and followed up if necessary.

We also undertook sensitisation training with our staff. In contexts where violence is the ‘norm’ or common, it is important to educate staff in all issues associated with sexual violence. This then allows them to be empathetic to the victims and provide the most appropriate care. Our staff’s positive embrace of this role was crucial to helping us expand our provision of care.

We set up fixed, semi-fixed and mobile clinics to reach the dispersed population. We would travel

with our staff, our tents with moveable partitions for privacy and confidentiality, and all relevant equipment and medicine needed to set up afresh each day. Through coordination with other organisations, we have also been able to continue to identify other pockets of people that are likely to have suffered sexual violence but are yet to receive care, as well as secure referral pathways for them.

## Other pathways to care

Meanwhile in the northern hemisphere on Lesbos, a Greek island and hot spot for crossing the Mediterranean, there was a huge surge in arrivals between April and June. At the same time, healthcare and other services for them were severely cut, increasing their vulnerability. MSF identified victims of violence via mental health assessments, but predominantly in our women’s health clinics. This included approximately half of the women seen for a gynaecological check-up: one-third assaulted before they left their country, the other two-thirds en route.<sup>8</sup> For many, their disclosure to MSF was their first ever. For weeks and months, they had completely lacked the medical or psychological care that could help them recover.

## Never too late

There are many frustrations and barriers in providing sexual violence care, especially in contexts of conflict and displacement. Being able to identify victims and provide timely care to resolve pressing medical and psychosocial needs is one of the greatest challenges. Ensuring appropriate care, based on age, gender or culture, is not possible without careful planning and implementation. Yet, however many weeks, months or years later it may be, as healthcare providers we can offer the support that allows a victim to share their long-held story and assist them in starting their journey to recovery.

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# Misogyny in reproductive health



**Helen Paterson**  
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While giving a talk recently on contraception, I asked what people thought the most reliable contraceptive is. 'Abstinence' said a senior O&G consultant. My response to this seemed to stun; 'well, as one-in-three women are raped in their life, abstinence is not really an effective solution.'

But is this misogyny? Yes – both the rape and the subtle judgement that if girls didn't have sex they wouldn't get pregnant. Misogyny is the dislike of, contempt for, or ingrained prejudice against women. This is an example of ingrained prejudice by the consultant, and it is more common in O&G than we would like to think. Often the perpetrator would be appalled to be called a misogynist. It is worth noting though, that women can be misogynistic much in the way men can be feminists. Other O&G examples include the proposed farcical Victorian and Tasmanian 2016 ASM debate on whether the Mirena should be compulsory for O&G trainees,<sup>1</sup> at least I assume they weren't proposing them for men in some way, so I assume misogyny was at work there too.

Rape of women is obviously misogynous. Global estimates published by WHO indicate that about one-in-three (35 per cent) women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.<sup>2</sup> We all accept that rape is 'bad'; however, it is pervasive in society. If you watch *The Hunting Ground*, a documentary about the incidence of sexual assault on college campuses in the US,<sup>3</sup> the complexity of the support systems become clear; who is more important to the university? The star football player or the raped woman? But I imagine you think 'that is just the US'. Don't be so sure. The University of Otago, to date, has no sexual assault policy.

The National Report on Sexual Assault and Sexual Harassment at Australian Universities reported that

51 per cent of students experienced sexual harassment, with women almost twice as likely as men to have been sexually harassed.<sup>4</sup> Of those surveyed, 10 per cent of women experienced sexual assault over a two-year period. The report identified that 'attitudes towards women contribute to sexual assault and sexual harassment at university'.<sup>4</sup> This institutional misogyny sets women on their way into the workforce with the implicit understanding that consent is a perception viewed from the eyes of the establishment or 'boss'. Just how much sexual harassment should you experience before you risk your career by reporting it? Often it is easier to play along and, ultimately, if you are not careful, become complicit in the misogynistic environment yourself.

After the Royal College of Surgeons was exposed by a whistleblower<sup>1</sup> there was a rash of interest in the extent of bullying and sexual harassment in medicine in Australia and New Zealand. In 2016, RANZCOG reported 12 per cent of respondents to a harassment and bullying survey had experienced sexual harassment, the majority of those (76.8 per cent) from a senior O&G consultant.<sup>5</sup> But I imagine a few people thinking 'is that really a problem?' Yes, it is. Just over 100 people respondents confirmed that they had been sexually harassed by their boss. How many had actually reported this bullying and sexual harassment? Only 24 per cent.<sup>5</sup>

David Grimes is an American O&G who travels the world talking about misogyny, which he identifies as including disdain, apathy, neglect, abuse, rape and femicide. He spoke in 2009 at the RANZCOG ASM on the topic and inspired me, and on his return in 2017 he described mourning the death of his country with the loss of reproductive rights as a result of the election. We should never assume that the rights civil society has fought so hard to achieve cannot be lost.

'Highly restrictive abortion laws are not associated with lower abortion rates. When countries are grouped according to the grounds under which the procedure is legal, the rate is 37 abortions per 1000 women of childbearing age where it is prohibited altogether or allowed only to save a woman's life, compared with 34 per 1000 where it is available on request, a non-significant difference'.<sup>6</sup> Why is this misogyny? The issue is that the rate of unsafe abortion increases where abortion access is illegal and with that the rate of complications and death. Complications from unsafe abortion are responsible for the deaths of 47,000 women each year.<sup>7</sup> Clearly this is not respecting the life of women.

We like to think New Zealand is progressive, the first country to get the vote for women; but in fact, women there still don't have fundamental human rights. Family size is based on the Contraception, Sterilisation, and Abortion Act 1977,<sup>8</sup> contraception is not fully funded and abortion is, at best, a challenge of jumping through ever-moving hoops and, at worst, outright illegal. Most women who have an abortion are determined to be 'mentally ill'. Caesarean rates in Australia and New Zealand sit at



25–35 per cent,<sup>9,10</sup> but despite the fact that abortion is safer than term birth, New Zealand women can't choose not to carry a pregnancy to term. That is, I would argue, contempt for the value of women's lives. Why do we trust a woman and her doctor to make decisions together on all other aspects of reproductive health, but not abortion?

Maternal and perinatal mortality statistics in Australia and New Zealand show higher rates in ethnic minorities.<sup>11</sup> No doubt this is due to a number of complex issues, but I challenge that misogyny may well be playing a part and when attempting to optimise care for all, we should consider how this factors into the mix.

I have limited this article to the topic of misogyny in reproductive health. There is a whole world outside of these issues where misogyny flourishes. Hopefully, we can at least reduce it in women's reproductive healthcare. So, what do I want you to take from this piece? Firstly, think: am I a misogynist? Do I support other's misogynistic behaviour? Add then: can I fight misogyny, or can I change someone else's misogynistic behaviour?

If you are a Fellow, member or trainee of the College and want to make a complaint about bullying, discrimination or harassment at work, please contact Paula Fernandez, Senior Coordinator, Trainee Liaison on 61 3 9412 2918 or via email [trainee Liaison@ranzcog.edu.au](mailto:trainee Liaison@ranzcog.edu.au).

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# Sexual harassment in the workplace



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Sexual harassment continues to be a prevalent issue that is experienced all too frequently in the workplace, especially by women. A poll conducted by the Australian Human Rights Commission in 2003 revealed that 28 per cent of women, along with 7 per cent of men, experienced sexual harassment in the workplace.<sup>1</sup> It is therefore critical that employers, along with employees, take proactive action to prevent harassment in the workplace.

## What exactly is sexual harassment?

Sexual harassment is conventionally known as any unwanted or unwelcome sexual behaviour that makes someone feel offended or humiliated. While this definition appears comprehensive, sexual harassment can come in a variety of forms and consequently goes unrecognised. Unsolicited kissing and caressing would undoubtedly be categorised as harassment. However, can a hand around the waist or a hand around the shoulder fall under the category of sexual harassment? Yes. The test is that such actions must be unsolicited.

## Who sexually harasses?

While it is the case that sexual harassment occurs among employees, the perpetrators of harassment

are often those at higher levels. These individuals are small business owners, dentists, bar managers, surgeons – all situations where the distinction between a person in authority and their employee is clearly delineated. In such circumstances, it is also clearer to these victims the precarious situation their employment is in, such as if they do so much as to protest when a hand is placed on their thigh.

## Sexual harassment in the medical field

In a field that continues to be increasingly competitive, and relentlessly demanding, it is not uncommon for sexual harassment to occur. The profession is one in which long, tireless hours are the norm, and yet complaints are not as commonplace.

There is a culture that this profession has allegedly cultivated – that if you make any complaints, you are effectively staining your career. Take Dr Caroline Tan, who excelled in medical school and was mentored by a surgeon. What began as requests to stay back for additional tutelage escalated to sexual assault, prompting Dr Tan to make a complaint of sexual harassment with a tribunal. While she did effectively win this case, her medical career was ruined; Dr Tan's applications to hospitals were cast aside due to a lack of ability, despite her outstanding references and results. The perpetrator on the other hand, Mr Xenos, was given a formal warning.<sup>2</sup> Dr Tan's case is an example of the appalling culture in the field, and the need to fight back, whether it is by ensuring all staff undergo the appropriate training or to simply raise awareness.

## Why does it continue to go unreported?

If sexual harassment and inequality is such a prominent issue, why does it continue to be unreported? Unfortunately, the stark reality that burdens many of these victims is that financial security and job stability takes precedence over their wellbeing and safety. Particularly in the medical profession, which is already competitive as it is, the fear of jeopardising a long, hard-earned career is terrifying. This is often the case for many single parents – while they are troubled by the stress and anguish of having to tolerate this unjust treatment, the burden of an exponentially growing debt, or the knowledge that their family needs food on the table, is more important.

### Box 1. How work is affected by issues at home.

#### Issues at home, impact on work

The issues that occur behind closed doors at home can often manifest in the workplace. Domestic violence does not only create issues at home, but also in the workplace. Women who must battle abuse at home often must do so while at work, whether it is at the hands of their employers, or fellow colleagues. Additionally, having to deal with a host of issues at home may cause fatigue and impede work performance, which in turn may instigate impatience and frustration from unsympathetic employers. It does not assist the situation when employers continually reinforce the notion that issues at home are meant to be left at home. It is important to maintain professionalism at work, but if an employee requires time off to see a therapist, or take stress leave, the employer should accommodate this. A failure to understand perpetuates the cycle of inequality against victims of domestic violence.

### Failure of employers

All too often, employers fail in properly fulfilling their responsibility to take the appropriate action to prevent discrimination, harassment and inequality in the workplace. When complaints are brought to the attention of employers, it is their duty to conduct a thorough investigation and to ensure that measures are put in place to prevent further harassment and vilification.

However, if no complaints are raised, it does not mean that the employers can turn a blind eye to harassment or inequality that is occurring in their workplace. It is obviously the duty of the employer to ensure their staff undergo the appropriate training and are aware of the strict policies and procedures that are in place. It is also the duty of employers to recognise that certain forms of banter are inappropriate, and any incidents of uninvited touching should be addressed.

### What to do if you feel like you're being sexually harassed or being treated unfairly

It is important to raise your concerns with your employer as soon as you have experienced sexual

harassment or unfair treatment. If your company has a human resources department, address your complaints to them. It is then the duty of human resources to investigate these complaints in a prompt manner, while maintaining confidentiality. Alternatively, you may seek to consult a manager, or someone who can direct your complaints and have the matter properly addressed. If your company fails to appropriately address your concerns, or if they fail to enforce any preventative measures to ensure the harassment or discrimination does not continue, you may reach out to the Human Rights Commission ([www.humanrights.gov.au](http://www.humanrights.gov.au)).

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## Q&amp;A

**For the broader O&G Magazine readership, balanced answers to those curly-yet-common questions in obstetrics and gynaecology.**

Q

## Is NovaSure endometrial ablation the safest surgical treatment for heavy menstrual bleeding or is it just a delayed difficult hysterectomy?

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A

Heavy menstrual bleeding (HMB) is one of the most common gynaecological symptoms for which women seek medical care.<sup>1,2</sup> One in 20 women suffer from HMB.<sup>3,4</sup> Several endometrial techniques are available for treatment, provided that intracavity abnormalities are absent. Modern endometrial ablation devices are effective in the treatment of HMB with high patient satisfaction rates.<sup>5</sup>

### What is the difference between different generations of endometrial ablation devices?

Endometrial ablation (EA) refers to a series of blind techniques originating in the 19th century, which used various sources to achieve thermal destruction of the endometrium. The late 20th century brought an important paradigm shift when a rod lens hysteroscope was used together with an energy source permitting EA under direct visualisation. However, the early hysteroscopic resectoscopic techniques required training owing to their complexity and more user-friendly techniques with reported improved safety are now available.<sup>6</sup>

### How does NovaSure ablation work?

The NovaSure system comprises of a disposable ablation device, a radiofrequency generator (RF), a suction line desiccant and a carbon dioxide canister.<sup>7</sup> The ablation device is a conformable, bipolar electrode array housed within a protective sheath and mounted on an expandable frame (Figure 1). It also contains an intrauterine measuring system that determines the uterine cavity width (cornua–cornua distance). When the ablation device is seated correctly within the cavity, the sheath is withdrawn into the endocervical canal to protect the endocervix from thermal injury.<sup>7</sup> Using the uterine width and length, the RF controller calculates the appropriate power output to ensure complete ablation of the endometrium. During ablation,

the tissue impedance is continuously monitored and the procedure terminates once a level of 50 ohms is achieved. Actual treatment may vary up to 120 seconds to accommodate different uterine dimensions and endometrial thickness. Carbon dioxide is delivered into the uterine cavity at a safe flow rate and pressure through the central lumen of the ablation device. When 50mmHg is achieved for four seconds, uterine integrity is confirmed. If this intrauterine pressure is not achieved due to a perforation or a leak through the cervix, the procedure cannot be performed.<sup>7</sup> A vacuum pump in the RF controller brings the endometrial lining into contact with the electrode array and simultaneously removes byproducts of ablation from the uterine cavity. Compared to other ablation techniques, NovaSure procedure has the shortest treatment time, requires no uterine pretreatment and can be performed at any time during the menstrual cycle.<sup>8</sup>

### What are the success rates?

Satisfaction rates for NovaSure ablation are high, ranging from 77–96 per cent, amenorrhoea occurs in 14–70 per cent and quality of life (including pleasure and discomfort) scores from women with HMB are substantially improved.<sup>9,10,22</sup> Treatment failure is defined as; hysterectomy for any benign indication, repeat ablation within 36 months of the procedure, synechiolysis or treatment with gonadotrophin-releasing hormone for post-ablation pain or bleeding.



Figure 1. NovaSure ablation device.

### Pre-operative predictors

A paper published in 2014 demonstrated that women with a history of tubal ligation were more likely to experience treatment failure compared to women without a history of tubal ligation (16.4 per cent compared with 9.0 per cent,  $P=0.0008$ ).<sup>11</sup> Women with preoperative dysmenorrhoea, pelvic pain or obesity were more likely to experience treatment failure after ablation (21.8 per cent compared with 10.7 per cent,  $P=0.002$  and 16.7 per cent compared with 9.8 per cent  $P=0.003$  respectively).<sup>11</sup> Tubal ligation is a well-recognised risk factor for hysterectomy after endometrial ablation, secondary to post-ablation syndrome, which has an incidence of 6–8 per cent and usually develops 2–3 years after endometrial ablation. Other predictors of failure are age younger than 45 years, adjusted hazard ratio (aHR) 2.6,  $P=0.008$  and parity  $>5$  aHR 1.3 – 6.0,  $P<0.001$  and finally, ultrasound features suggestive of adenomyosis aHR 1.5.  $P=.003$ .<sup>12</sup>

### Intraoperative predictors

Intraoperative predictors of failure are uterine sounding length  $>10.5$ cm (aHR 2.58), uterine cavity length  $>6$ cm (aHR 2.06), uterine width  $>4.5$ cm (aHR 2.06) and procedure time  $<93$  seconds (aHR 2.61).<sup>13</sup> Of interest, previous caesarean section is not a pre-operative or intra-operative predictor for failure of ablation. The risk of bowel injury at the time of NovaSure ablation is 1:5000.<sup>14</sup>

### What are the short- and long-term complications?

#### Pregnancy-related complications

Endometrial ablation is not considered a form of contraception. Pregnancy has been reported to occur in 0.7 per cent of women who have undergone a tubal ligation.<sup>15</sup> Pregnancy has been reported as early as five weeks and as late as 12 years postoperatively. The chances of pregnancy occurring after endometrial ablation and tubal ligation is estimated to be at 0.002 per cent or one in 50,000. Pregnancy has also been reported in amenorrhoeic women.<sup>16</sup> There is no significant increase over the baseline miscarriage rate; however, the risk of ectopic pregnancy is approximately 2 per cent.<sup>17</sup>

#### Pain-related obstructed menses

When energy is applied to the endometrium, tissue necrosis and inflammation can result in uterine contracture and intrauterine scarring. This has been demonstrated with both resectoscopic endometrial ablation and the newer devices, such as NovaSure ablation.<sup>17</sup> Persistent endometrium after endometrial ablation is common as evidenced by clinical, imaging, and histologic studies. Randomised clinical studies have shown that amenorrhoea rates are generally less than 50 per cent, suggesting persistent endometrial glands after endometrial ablation. Contracture and scarring at the fundus can lead to obstructed degrees of menses. This can manifest as haematometra within the body of the uterine cavity (central haematometra) or at the cornual region. In cases of post-ablation tubal sterilisation syndrome, symptom relief has been reported after removal of the tubes.<sup>13</sup> Central haematometra is most likely to occur when the cervical canal is damaged at the time of endometrial ablation and has an incidence of 1–3 per cent.<sup>18</sup> Central haematometra can usually be treated with cervical dilatation; however, in some cases, hysteroscopic adhesiolysis may be required.

### Failure to control menses

A discussion centred around patient expectations is an important aspect of pre-operative counselling. Most women who undergo endometrial ablation will not experience amenorrhoea, yet 85 per cent will be satisfied at the one-year mark.<sup>19</sup> The evidence for long-term failure of endometrial ablation may be examined by a 4–5 year re-operation rate of 18–38 per cent.<sup>12</sup> For patients who are not satisfied with endometrial ablation, most case series report hysterectomy as the next step. Repeat endometrial ablation was not evaluated as part of the FDA for NovaSure ablation and should be considered off-label use.

### What if she has symptoms?

#### Evaluating the uterine cavity and cancer risk after NovaSure ablation

The risk of endometrial cancer increases by approximately 2–3-fold between ages 50 and 70 years; it is possible that women who have undergone endometrial ablation in the last two decades are now entering the age group at risk for endometrial cancer.<sup>20</sup> These patients should be evaluated with caution when abnormal uterine bleeding occurs and a diagnosis of endometrial cancer should be taken into consideration. Patients with bleeding after an endometrial ablation create a diagnostic dilemma because the basic tools for evaluation may fail to yield substantial results. In addition, the anatomical distortion can alter features at ultrasonography, making a noninvasive diagnosis challenging.<sup>21</sup> However, a systematic review found that even though endometrial sampling and investigation of abnormal uterine bleeding may be difficult to perform, it remains feasible.<sup>20</sup> In only two cases (11.8 per cent) a preoperative diagnosis of endometrial biopsy was not successful at presentation because of cervical stenosis and intrauterine adhesions.<sup>20</sup> Therefore, in most cases, preoperative diagnosis of endometrial cancer or hyperplasia is possible. This is contrary to concerns that diagnosis may be delayed or difficult to achieve. If unable to perform pipelle because of cervical stenosis, hysteroscopy should be attempted given that evidence shows that it is feasible. Using a smaller hysteroscope, such as a 3mm scope, with vaginal estrogen for a few weeks prior to procedure (for postmenopausal patients with vaginal atrophy) and 400µg buccal misoprostol 30 minutes pre-operatively has been found to be helpful at our endosurgery unit.

Endometrial ablation is not a treatment for endometrial hyperplasia or cancer and may interfere with subsequent evaluation of the endometrium. The safety of endometrial ablation has not been well studied in women who are at increased risk of developing endometrial cancer. These risks include nulliparity, chronic anovulation, obesity, diabetes mellitus, tamoxifen therapy and hereditary nonpolyposis colorectal cancer.<sup>17</sup> An early concern about the safety of endometrial ablation was the fear that it may delay the diagnosis of a subsequent endometrial carcinoma. However, it appears that in most instances the intrauterine cavity is not completely destroyed, thus allowing degrees of bleeding from the retained endometrium. A systematic review, published in 2011, examining endometrial cancers diagnosed five years after NovaSure ablation, confirmed that most women with post-ablation endometrial cancer present with abnormal uterine bleeding and pain.<sup>20</sup> Over 75 per cent of the women with post-ablation endometrial cancer were diagnosed with stage I



endometrial cancer. This is in keeping with the typical presentation of endometrial cancer in women without a history of endometrial ablation. Furthermore, most women with endometrial cancer post ablation remained able to have the endometrium sampled by pipelle or hysteroscopy.<sup>20</sup>

### Conclusion

In the 13 years since the NovaSure procedure was approved by the FDA, significant data has been generated that provides a good safety profile, low re-intervention rates and high patient satisfaction rates.

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## Case reports

# Ogilvie's syndrome with caecal perforation post-caesarean section

**Dr Dennis Gong**  
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**Dr Josephine Woodman**  
**B Bikshandi**  
**R Wescombe**  
**R Pegram**

This case report highlights a rather uncommon, yet important, complication of caesarean section: Ogilvie's syndrome (OS). This syndrome describes the phenomenon of an acute colonic pseudo-obstruction, often without an obvious mechanical cause. The obstruction can then lead to bowel perforation or ischemia.

OS carries the name of the British surgeon Sir William Heneage Ogilvie who first reported it in 1948, following observation of two of his patients with metastatic cancer.<sup>1</sup> He describes the clinical scenario of acute massive dilatation of the colon with no mechanical obstruction of the distal colon.

OS remains an under-recognised condition. Its true incidence is a mystery; partly as mild cases tend to resolve spontaneously. Furthermore, there is no reliable national or international data to suggest its frequency.<sup>2</sup> However, delays in diagnosis have a significant direct correlation with mortality rates. It has been suggested that there is a 15 per cent mortality rate in healthy patients who receive early intervention with no complications compared to 36–50 per cent mortality rate in cases where there is a perforation or ischemic bowel.<sup>3</sup>

OS does not have any age predilection, although it is observed more often in elderly patients as well as those with multiple comorbidities. It has a male-to-female ratio of 1.5:1.<sup>4</sup> In the obstetrics setting, caesarean section is noted to be the most common procedure associated with OS, although it has also been reported to occur following vaginal birth and forceps-assisted delivery.<sup>4–6</sup> The UK Confidential Enquiry into Maternal and Child Health 2000–2002 report mentioned four deaths from OS, all following caesarean section.<sup>7</sup>

Despite the rising rate of caesarean sections being performed worldwide, OS remains a relatively rare condition that requires prompt recognition. Clinically, it is rather challenging to differentiate between OS and paralytic ileus in the initial stage.

### Case report

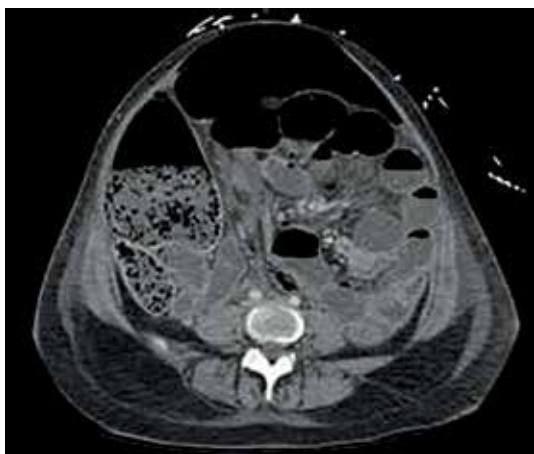
We present the case of a 19-year-old G1P0 with an uncomplicated singleton pregnancy. She was admitted for induction of labour due to post-dates at 41 weeks and was induced with 1mg of Prostin gel followed the next day by artificial rupture of membranes, which showed the presence of light meconium-stained liquor. Her labour was augmented with Syntocinon and routine labour monitoring was commenced with no abnormal recordings throughout labour. Of note, she was positive for Group B Streptococcus and had asymptomatic sinus tachycardia.

Following 12 hours of active labour with good progress initially, she had secondary arrest at 8cm of cervical dilatation with a reactive cardiotocograph and the baby was found to be in direct occiput-posterior position. Subsequently, a category 2 emergency caesarean section for failure to progress was called.

Caesarean section went smoothly, with abdomen entered via Joel Cohen technique; peritoneal cavity and pelvic organs appeared normal. No electrocoagulation instruments were used during the procedure. The baby was delivered via Wrigley's forceps, weighing 4.5kg. The Apgar score was 9 at one minute and 9 at five minutes. The estimated blood loss was 500ml. No bowel or bladder injury was observed intra-operatively.

Post-operatively, her recovery was slow and she experienced abdominal distension and mild pain on the second post-operative day, but was tolerating a normal diet by the third day. Although bowel sound and distended abdomen were documented on days 3 and 4, she had opened her bowels on day 3, so no further investigations were carried out. She requested to be discharged home on day 4.

She presented to the emergency department on Day 6 with recurrent vomiting, pyrexia, generalised abdominal pain, significant distension and also specifically mentioned bilateral shoulder tip pain. She also mentioned that she did open her bowel, but it was different from her normal routine and her abdomen was so distended that she felt that



**Figure 1.** Multiple air fluid level seen with possible faecal loading.

she was 'pregnant again at 40 weeks'. Despite these symptoms, she had been breastfeeding and bonding well with baby.

Her blood results came back with markedly elevated CRP of 612 and white cell count of  $12.1 \times 10^9/L$ . Abdominal x-ray showed distended loop of small and large bowel with positive Rigler's sign, suggestive of perforation. This was confirmed on CT scan, which showed distended ileum with free intra-abdominal fluid and gas collections.

An emergency laparotomy was performed through the previous Pfannenstiel incision; however, a midline laparotomy was necessary due to the extent of faeculent soiling of the peritoneal cavity. A perforated caecum was found and a right hemicolectomy with ileostomy was performed. Approximately five litres of faecal-purulent fluid was drained and the abdominal wound was left open with a negative pressure (VAC) dressing and a further washout and full closure was performed the next day. Histology of the resected colonic segment showed full thickness necrosis, perforation and findings consistent with caecal pseudo-obstruction.

She was admitted to the intensive care unit (ICU) after her initial operation. A few days later, she underwent a repeat laparotomy for recurrent sepsis. A VAC dressing was applied over the open abdomen. She was returned to ICU mechanically ventilated, requiring vasopressor therapy. The next day, the Pfannenstiel incision was re-opened due to purulent discharge and superficial dehiscence. After further abdominal washout, the abdominal fascia was closed with a VAC dressing. Three days later, a further wound debridement and full closure were performed.

A transvaginal ultrasound examination and hysteroscopy with dilatation and curettage ruled out endometritis as a cause of ongoing septic shock. No specific organisms were grown on blood or wound cultures so empirical, broad-spectrum antibiotics were administered in consultation with infectious diseases specialists. She remained intubated and mechanically ventilated for a total of nine days, during which time she developed anaemia of critical illness requiring blood transfusions, reactive thrombocytosis and reactive pleural effusions that required drainage.

She was discharged to the surgical ward after 15 days in the ICU, but was readmitted to the ICU twice for recurrence of septic features. Discrete abdominal collections were found on a further CT scan, which were treated conservatively considering

the relatively inaccessible locations and associated risks of drainage. A segmental pulmonary embolism occurred despite being on mechanical and medication thromboprophylaxis. She was discharged home after 35 days in the hospital with surgical and obstetric follow up. Her progress has been positive since discharge.

### Discussion

The hallmark symptom of OS is marked abdominal distension developing over a short timeframe.<sup>2</sup> Often this is associated with abdominal pain, nausea and vomiting. The woman is typically 2–12 days post caesarean section.<sup>4</sup> The signs and symptoms may initially mimic paralytic ileus, but bowel sounds are often reported to be higher pitched and hyperactive.<sup>9</sup> In addition, patients may still be able to pass small amounts of fecal fluid and flatus. Abdominal pain in OS usually manifests as a dull, crampy sensation with no specific localisation, typical of hollow viscus distension. This may then progress to localise over the right iliac fossa, indicating impending rupture of caecum.<sup>9</sup>

Patient is usually tachycardic, afebrile (pyrexia might indicate sepsis) and may be hypotensive. Laboratory results may not be helpful in the first instance. In the acute setting, a plain erect abdominal x-ray is most helpful in terms of narrowing down the list of differential diagnosis. This may show a typical picture of large bowel dilatation, especially the caecum with or without pneumoperitoneum. A CT scan can then be requested to confirm the diagnosis of OS and, more importantly, to measure the caecal diameter, which will aid in the management and outcome of patient.

The exact aetiology of OS is still poorly understood; however, the current consensus is that there is an imbalance of sympathetic and parasympathetic innervation of the colon.<sup>4</sup> Physiologically, the parasympathetic system increases the motility of the colon while the sympathetic system does the exact opposite. In a large analysis of 400 cases of OS, it was suggested that there is a temporary neuropraxia of the sacral parasympathetic outflow (S2–S4).<sup>10</sup> This finding may help to explain OS post caesarean section, but this is yet to be confirmed.

The caecum is the part of the colon with the thinnest wall and largest diameter, which makes it especially vulnerable to perforation. This can be explained by the Law of Laplace, which states that the tension in the wall of a hollow viscus is directly proportional to its radius and intraluminal pressure.<sup>11</sup>

Management of OS has been classically divided into conservative/medical and surgical. These options are dependent upon the caecal diameter, which in turn is dependent on early recognition of the condition. In general, caecal dilatation of less than 10cm can be managed conservatively, provided there are no signs of perforation.<sup>4</sup> This involves the patient being given nil by mouth and the use of nasogastric decompression. Any narcotic analgesics and anti-cholinergic drugs should be stopped.

Medical therapy involves the use of neostigmine, which promotes colon motility by inhibiting acetylcholinesterase. A small trial done in 1999 showed that 50 per cent of patients had an immediate response (within 30 minutes; passing of flatus and reduced abdominal distension) and 73 per cent had a sustained response (lasted over three hours; reduced caecal diameter).<sup>12</sup> Neostigmine

is given intravenously at 2.5mg over 3–5 minutes. Colonoscopic decompression can be used next if treatment with neostigmine fails. This, however, has a variable success rate (61–78 per cent), with a recurrence rate of 40 per cent.<sup>13–14</sup> Any signs of bowel perforation warrant surgical management. This usually entails laparotomy with bowel resection and formation of a stoma.

It is important to maintain a high index of suspicion in the post-caesarean patient presenting with progressive abdominal distension, despite the presence of falsely reassuring bowel sounds and passage of flatus. It cannot be stressed enough the importance of early diagnosis and intervention in preventing a catastrophic outcome to an otherwise young, healthy woman in her reproductive years.

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# Extraovarian endometriosis-associated neoplasms

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It is estimated that 1 per cent of women with endometriosis will develop endometriosis-associated malignancies. These neoplasms most commonly arise in the ovary.<sup>1,2</sup> Published cases of extraovarian endometriosis-associated neoplasms are rare. Here we present three cases arising from various extraovarian sites.

#### Case 1

A 75-year-old woman (G4P3), presented with a 4cm firm mass in the right iliac fossa region that she reported had been present since her hysterotomy for a mid-trimester termination 42 years ago. Her surgical history also included a vaginal hysterectomy for pelvic organ prolapse, and histology of the uterus revealed external endometrial glands and stroma consistent with pelvic endometriosis.

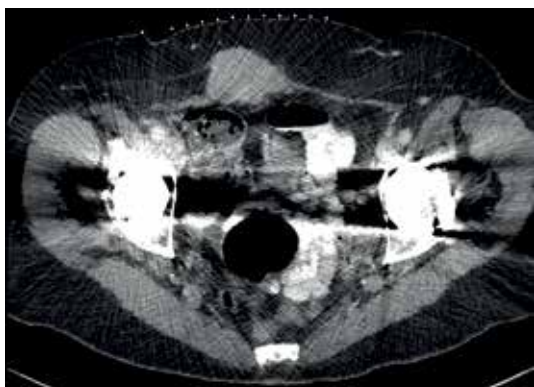
A CT scan of her abdomen and pelvis revealed an enhancing mass measuring 5.8cm in transverse diameter by 3.6cm in AP diameter arising from the anterior abdominal wall musculature extending into the subcutaneous fat, which was suggestive of a tumour. (Figure 1)

A core biopsy of the mass confirmed a moderately differentiated adenocarcinoma consistent with a primary from the gynaecological tract; endometriosis was noted within the specimen. To complete the staging process, a CT scan of her chest showed no evidence of metastatic disease. Her CA-125, CEA and CA19-9 were within normal range.

She underwent a wide local excision of the mass, including bilateral salpingo-oophorectomy and omentectomy. A moderately differentiated endometrioid adenocarcinoma in abdominal wall endometriosis was confirmed. Given full resection of this mass and no definitive sign of metastatic disease, adjuvant treatment was not recommended.

#### Case 2

A 52-year-old nulliparous woman presented with severe pelvic pain and vaginal bleeding. On examination, a 5cm smooth, firm posterior vaginal



**Figure 1.** CT scan of abdomen. Enhancing mass arising from the anterior abdominal wall extending into the subcutaneous fat, which has appearances suggestive of a tumour.

wall mass was found. A rigid sigmoidoscopy was performed up to 18cm, which found no rectal masses.

An MRI revealed an ovoid 12x11x9cm midline pelvic mass, displacing the bladder anteriorly and rectosigmoid posteriorly. Her CT scan showed a cystic mass posterior to the bladder with enhancing solid peripheral tissue, which displaced the rectum posteriorly and intimately associated with the distal sigmoid. There was no evidence of metastatic disease. She also had an elevated CEA and CA19-9.

Previous history showed a total abdominal hysterectomy with bilateral salpingo-oophorectomy six years previously for heavy menstrual bleeding and dysmenorrhea. Histology showed fibroid uterus with serosal endometriosis and surface endometriosis on both ovaries.

Three months after her initial presentation, a pelvic posterior exenteration and anterior resection of pelvic mass was performed. A hypervascular mass invading the terminal ileal loop, rectum and vaginal vault was seen during the surgery. Histology revealed a malignant mixed Müllerian tumour arising from endometriosis involving loop of colon. She underwent pelvic adjuvant radiation therapy and adjuvant chemotherapy (paclitaxel and carboplatin). She remains free of recurrence and metastases four years after her index surgery with normal tumour markers.

### Case 3

A 58-year-old woman (G3P1) presented with post-menopausal bleeding. She had a BMI of 32 and a background of hypertension that contraindicated use of HRT. Her uterus felt enlarged at 20 weeks in size on examination, no adnexal masses found.

A pelvic ultrasound revealed a 13.2x11.6x7.4cm heterogenous mixed solid/cystic mass seen in the right adnexa with areas of vascularity seen inside the septae (Figure 2). Uterus revealed an endometrial thickness of 0.3cm in fundus and 0.9x1.7x1.7cm heterogeneous lesion posteriorly in the endometrium (Figure 3). An MRI of her abdomen and pelvis showed complex cystic mass measuring 14x13x8cm with a well-defined border arising from the right ovary. This mass contained numerous septations within a well-encapsulated lesion, which contained several solid nodular areas. Her staging CT scan was normal and so were her CA-125 and CEA.



**Figure 2.** A 0.9x1.7x1.7cm heterogeneous lesion seen posteriorly in the endometrium, suspicious for endometrial tumour or possibly may represent a submucosal fibroid.

She was scheduled for a total abdominal hysterectomy, bilateral salpingo-oophorectomy, removal of pelvic abdominal mass, lymph node dissection and partial omentectomy. A mass adherent to the anterior surface and mesentery of the recto-sigmoid colon was seen. However, it did not appear to arise from either ovary or fallopian tubes. Histology revealed a grade 1 proliferative endometrioid adenofibroma with focal adenocarcinoma arising from ectopic ovarian tissue.

Adjuvant chemotherapy or radiotherapy was considered, although felt to be unbeneficial given no evidence of metastatic disease and ill-defined tumour origin.

### Discussion

Endometriosis is diagnosed when there is a presence of endometrial glands and stroma outside of the uterine cavity.<sup>1-3</sup> The majority of endometriosis-associated neoplasms are of ovarian origin and only 25 per cent involve extraovarian sites; mainly the bowel, but rarely, the abdominal wall.<sup>1-6</sup>

### Aetiology

Unfortunately, at present, no clear causal relationship has been identified. One theory is the association between hyperoestrogenism and development of malignancy from endometriosis. The proposed theory involves a shared origin



**Figure 3.** A 13.2x11.6x7.4 cm solid/cystic mass seen in the right adnexal region.



between endometriotic deposits and endometrial tissues, therefore both responding in a similar fashion when exposed to hormonal stimulation.<sup>1,2,7</sup> A case series by Modesitt et al included 21 patients with extraovarian cancers arising in endometriosis and reported an association between HRT use and extraovarian cancers, with 62 per cent receiving HRT versus 10 per cent in the other groups.<sup>7</sup> Apart from one case involving a nulliparous patient, our other two cases had no past history of excess oestrogen exposure. All of our patients had BMIs between 25 and 30.

Other speculated links between endometriosis and malignancy include the use of carcinogenic products, such as dioxin and polychlorinated biphenyls. Dioxin is a by-product of the chlorine bleaching process used in manufacturing tampons. It is a potent inhibitor of T lymphocyte function and has immunosuppressive properties.<sup>2,3</sup> Genetic anomalies such as the loss of heterozygosity of chromosome 5q is reported to play a role in 25 per cent of endometriotic sites affected by carcinoma compared to 6 per cent without.<sup>2,3</sup> However, since most endometriosis remains benign, it is worth considering the theory that some endometriotic cells might undergo somatic mutation involving oncogenes or tumour suppressor genes, such as p53, which has been reported to be elevated in cases with malignant transformation.<sup>2,8</sup> This is specific to endometriosis co-existing with ovarian clear cell carcinoma.<sup>8</sup>

### Location

More than 50 per cent of extraovarian neoplastic changes of endometriosis occur in the colon, rectovaginal septum and vagina. Of the 40 cases of endometriosis-associated intestinal tumours (EAIT) documented in the literature, 65 per cent involve the rectosigmoid colon, an area of the bowel having the highest incidence of endometriosis.<sup>9,10</sup> One of our discussed cases revealed a neoplastic mass adherent to the anterior surface of the rectosigmoid colon deriving its blood supply, while the other involved a mass invading the terminal ileum, rectum and vagina. Malignant transformation of abdominal wall endometriosis is rare in the literature, often presenting at the previous abdominal incision site 6–20 years after initial abdominal surgery.<sup>3</sup>

### Histology

The most common histological subtypes of extraovarian endometriosis malignancy include endometroid adenocarcinoma (69.1 per cent), sarcoma (25 per cent) and clear cell carcinoma (4.5 per cent).<sup>2,10</sup> In contrast, clear cell carcinoma accounts for the majority of malignant abdominal wall endometriosis, followed by endometroid carcinoma as reported in a case review of 10 cases currently in the literature of malignant tumours in endometriosis of the abdominal wall.<sup>3</sup>

The majority of EAIT cases reported in the literature are endometroid carcinoma.<sup>2,9</sup> As these often occur in the rectosigmoid colon, it can be difficult to distinguish high-grade endometroid carcinoma from poorly differentiated colonic carcinoma. There are three histologic characteristics that may assist in distinguishing the two. Firstly, the bulk of EAIT occur in the outer walls of the bowel. Secondly, the neoplastic endometroid cells form tubular glands lacking in intracellular mucin. Thirdly, and finally, the use of immunohistochemistry is helpful in determining the origin of tumour and, therefore, distinguishing the two.<sup>9,10</sup>

Sarcomas and carcinosarcomas, also referred to as mixed Müllerian malignant tumours, are best known as uterine tumours. Their association with endometriosis is rare and, if present, frequently involves the ovaries, but in the extragonadal setting often arises from the vagina or rectovaginal septum.<sup>2,6,10</sup> Booth et al describe a homologous carcinosarcomatous mass closely associated with endometriosis in a patient with presenting complaint and history of a previous hysterectomy and bilateral salpingo-oophorectomy for benign reasons, similar to our patient in case two. This mass, however, was found in the retroperitoneal compartment encasing the left ureter. This is perhaps the most recently documented extragonadal carcinosarcoma arising in endometriosis.<sup>6</sup>

### Treatment

The first-line treatment for extraovarian endometriosis-associated malignancy is complete surgical resection of the offending pelvic tumour to obtain a histological diagnosis. Staging of the disease can be performed with pelvic and para-aortic lymph node dissections, omentectomy, multiple peritoneal biopsies and, sometimes, bilateral salpingo-oophorectomy.<sup>1,2</sup>

Depending on the histology and staging, chemotherapy and/or radiation therapy can be considered. However, it is difficult to establish the most appropriate approach to adjuvant treatments due to the rarity of this disease in extragonadal sites.

A review of the scarce literature on this topic reports limited effectiveness for postoperative radiation and chemotherapy in endometriosis-associated neoplasms. Peritoneal and ovarian cancers are chemosensitive, but chemotherapy in those with endometrial cancers has limited efficacy.<sup>1–3,11</sup> Modesitt's series of 21 cases described factors associated with survival in women with endometriosis-associated cancers. All patients underwent surgery and 71 per cent received adjuvant chemotherapy; 74 per cent were then disease free after completion of initial adjuvant therapy. Using a multivariate analysis, the type of chemotherapy was not significantly associated with survival.<sup>7</sup> No adjuvant chemotherapy was prescribed in two out of our three cases as there was no evidence of metastatic disease. In a review by Dilsilvestro et al, chemotherapy was recommended to all patients who, at the time of surgical exploration, were found to have widespread intraperitoneal disease.<sup>1</sup> This often consists of paclitaxel and one of the platinum agents (cisplatin or carboplatin).<sup>1</sup>

The use of radiation therapy was described for malignancy arising in endometriosis when disease is localised to the pelvis.<sup>1</sup> In 2003, Booth described a retroperitoneal localised Müllerian carcinosarcoma receiving adjuvant external beam radiation therapy to the pelvis, similar to our patient in case two.<sup>6</sup> The patient remained disease free after eight months of follow up. There has not been recent literature on the role of radiotherapy nor has there been literature on the combined use of chemotherapy and radiotherapy.

### Conclusion

The diagnosis of malignant transformation of endometriosis, especially in extraovarian sites, is uncommon and not well understood. Such neoplasms should be considered in women presenting with a pelvic mass, even in those with a previous hysterectomy and bilateral



salpingoophorectomy. Primary management is by surgical resection. More research in the role of adjuvant treatment is needed.

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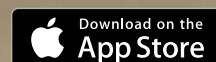
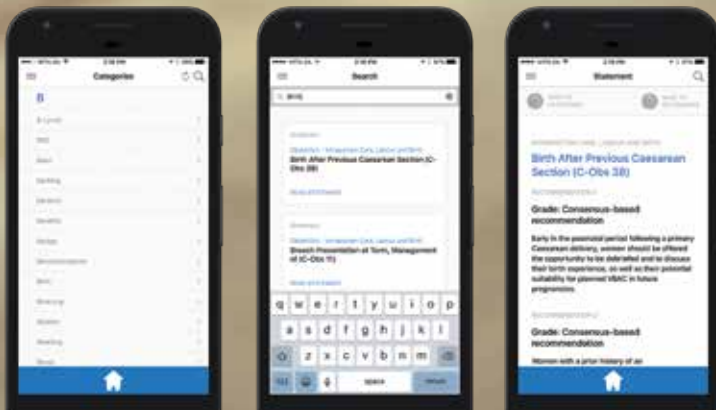
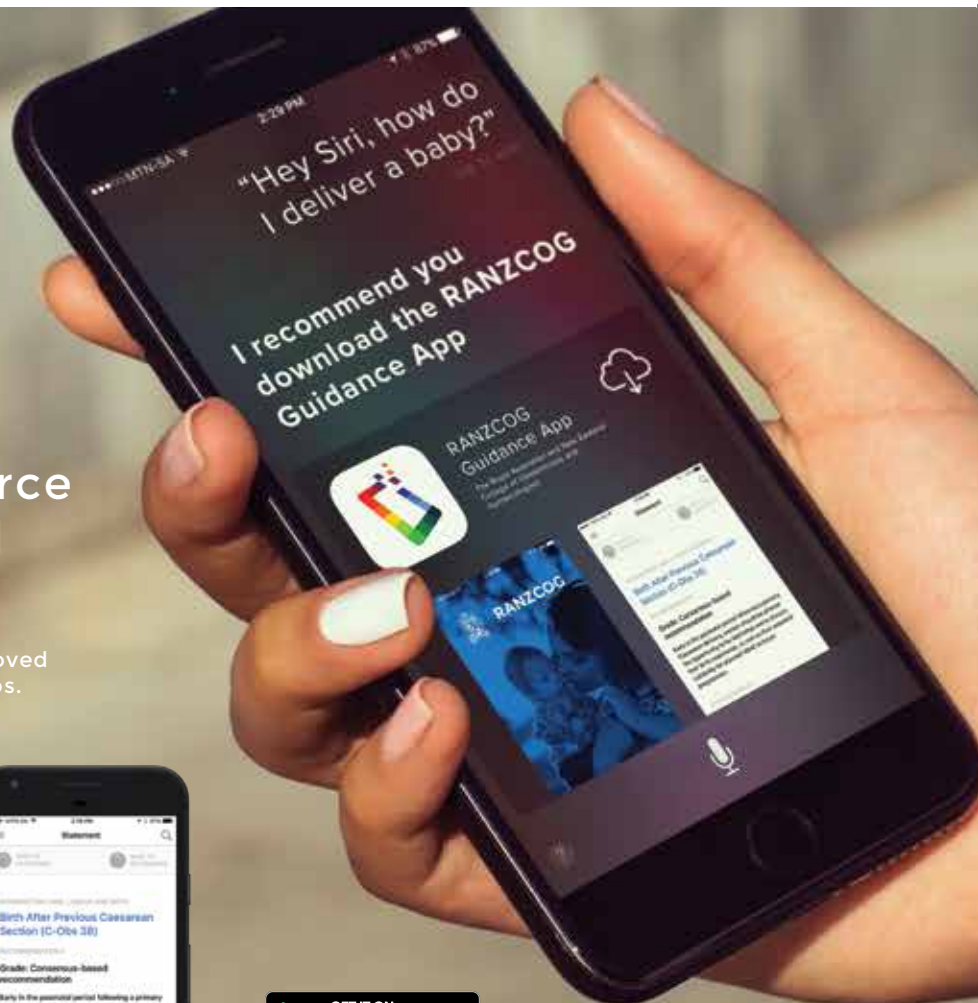
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# The leg-up



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## Legal solutions to domestic violence: mandatory reporting

In response to high rates of family and domestic violence in Northern Territory, it became the only Australian legal jurisdiction to introduce mandatory reporting laws.

Since March 2009, the Domestic and Family Violence Act requires that every adult in Northern Territory must report to police, if they believe on reasonable grounds either or both of the following:

1. 'Another person has caused or is likely to cause serious physical harm to someone else, with whom the other person is in a domestic relationship.'
2. '...the life and safety of another person is under serious or imminent threat because domestic violence has been, is being or is about to be, committed.'

The Criminal Code defines 'physical harm' to include 'unconsciousness, pain, disfigurement, infection with a disease and any physical contact with a person that a person might reasonably object to in circumstances...'

## Your regular legal update to keep you informed on current medicolegal issues in the practice of obstetrics and gynaecology

Failure to make a report is a criminal offence and can therefore result in a wide range of persons – including professionals and family members who have not themselves committed family violence – entering into the criminal justice system. ALRC Report 144 asserts that it is unlikely that any prosecutions or formal offences have ever been made for this offence.

On the whole, healthcare workers have been positive about the laws, seeing it as a strong commitment and response to a community problem. 'Mandatory reporting is sending a message to the community, to our friends and neighbours, that abuse will no longer be ignored; that we, the community, will no longer remain silent.'

Since instituted, the positives have included that women become quickly connected to support services, funding has increased for hospital and refuge services, police have increased the number of intervention orders on women's behalf and there is a pathway to increase prosecutions for violent criminal behaviour. Furthermore, health professionals are encouraged to view domestic violence as a health issue rather than a private social matter outside their scope of clinical practice.

Opposition to mandatory reporting has been voiced on the grounds:

- there is no evidence that it improves safety for the victims
- a significant number of victims are opposed to it
- victims might be deterred or prevented from seeking medical treatment
- women worry about custodial sentences for perpetrators, fear of children being removed by child protection and violent retribution for disclosing abuse
- police do not have the capacity or willingness to investigate all reported cases
- migrant and refugee women are particularly vulnerable to mandatory police involvement with real fears of deportation

Criticism has been made that mandatory reporting threatens women's dignity and takes away their power; that she is uniquely aware of her personal circumstances and should be empowered to make her own choices with the help of a supportive professional. Mandatory reporting of adult women remains deeply problematic with our ethical underpinnings in respect for autonomy and confidentiality.

## Cerebral palsy claims: we can read CTGs, but the system can't

In 2016/2017, clinical negligence for maternity care cost 1.7 billion pounds and the most expensive claims were for avoidable cerebral palsy (CP). Incidence over the past decade within the NHS has remained static, despite our best efforts.

It is recognised that the majority of CP cases are not attributable to medical error, but in the rare event where this is the case, lessons may be learned.

Recent evidence has given rise to the 'two-hit theory'. This suggests that in the development of CP, a 'hostile intrauterine environment' is coupled with a second intrapartum (chorioamnionitis, placental abruption and birth asphyxia) or neonatal event (interventricular haemorrhage, periventricular malacia and sepsis).<sup>1</sup>

The UK NHS Resolution, a litigation authority, has recently released a thematic review of CP legal claims that occurred between 2012 and 2016.<sup>2</sup> Using claims data, they reviewed the root cause analyses (RCAs) and secondly, analysed areas of clinical practice common to the claims.

Errors with fetal heart monitoring were the most common clinical practice theme in the claims (64 per cent) with almost all involving cardiocotographs (CTGs). Errors using CTGs included:

- misinterpretation
- not started when it should have
- false reassurance with an uninterpretable trace assumed to be 'loss of contact'
- too slow to act once a CTG was identified as pathological
- monitoring of the maternal HR

However, the underlying causes were more often related to systemic factors rather than individual misinterpretation. RCAs were found to be consistently deficient by focusing blame on individuals rather than looking at the environmental and organisational factors responsible for allowing the error to occur. The recurring theme in errors using CTGs was in recommending or reminding staff to follow current guidelines and policies. Individuals were advised to follow policies without an examination as to why they were not followed in the first place.

An example of ignoring cultural factors in an RCA included an instance where a midwife was blamed for misinterpreting a CTG without escalating obstetric review. The subsequent analysis by NHS Resolution showed that there were missed opportunities to act – 'the CTG was abnormal for 3.5 hours with no "fresh eyes" assessments, no review by a second midwife despite hospital policy requirements, the labour coordinator was in the room twice but did not review the CTG and there was no obstetric review despite this being a high-risk pregnancy'. These fail-safes were not even mentioned in the RCA. It seemed more palatable to appoint individual blame.

Despite, the universality of obstetric authorities (RANZCOG, ACOG, RCOG) to advocate CTG use in high risk women or low risk women who subsequently develop risk factors to prevent poor obstetric outcomes; there is poor evidence for reduction of CP risk. CTG training improves CTG interpretation, gives higher inter-observer agreement and better intrapartum management. This, however, does not confer an improvement in neonatal outcomes. No significant improvement in individual fetal outcomes has arisen from research on ST Segment Analysis (STAN) or the use of a computerised CTG decision support tool (INFANT study).

The issues for prevention of CP risk with CTG use are proposed to be dependent on many factors and thus hard to measure and therefore remedy. The

errors are likely to involve cultural factors related to risk: errors in risk stratification, lack of situational awareness, delays in decision-making and escalation, and performing CTG interpretation in isolation while ignoring maternal and fetal risk factors. In summary, CTG interpretation should not occur in isolation. A holistic approach should be implemented, incorporating risk stratification and the timely escalation of concerns.

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## Breech births overrepresented in cerebral palsy claims

'I can't understand why if they're saying this generation of doctors is unskilled, why are we not up-skilling them?' said a patient who gave birth with the hospital's breech clinic earlier this year. 'We up-skill in all other fields of our work as medicine develops, so why is it any different? It's not like breech births are new.' 7 August 2017, The Age Newspaper, Melbourne.

In the 2016/2017 NHS Resolution data of cerebral palsy claims, breech births were significantly overrepresented at 12 per cent compared to the national average (variously reported as 0.4–2.7 per cent). Four of the breech births were term with two at 34 weeks gestation. All were born out-of-hours and 85 per cent were undiagnosed in labour. Most were delivered by an obstetric registrar, without a consultant present. All were an attempted vaginal delivery with half later being converted to an emergency caesarean section.

Since the Term Breech Trial was published in 2000, demonstrating improved outcomes for breech babies delivered by caesarean section, the trend has been for fewer breech vaginal births. The result in the NHS (and likely Australia) has ironically meant that trainees with the least experience are performing the most deliveries, since most are undiagnosed and occur in an emergency situation. This is wholly inadequate since the evidence is irrefutable that having an experienced practitioner present is a primary criterion for safer delivery.

In an undiagnosed vaginal breech scenario, RCOG recommends 'individualisation of delivery based on stage of labour, whether there are any additional risk factors, such as an extended fetal neck, and availability of skilled supervision'. Therein lies the rub – it needs to be recognised that a lack of experience has led to a loss of skills for all obstetricians, and the trend is for a continuing reduction.

With respect to the up-skilling of practitioners for 'an attempt at vaginal breech delivery', efforts need to concentrate on decreasing the number of undiagnosed breech presentations and counselling women to ensure a proper understanding of the absolute and relative risks regarding mode of delivery.

ANZJOG

# From the editor's desk



Prof Caroline de Costa  
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The August issue of *ANZJOG* commences with a fascinating invited editorial from Prof Rod Baber, entitled 'Sex hormones, receptors and modulators', in which he first explores the known history of sex hormones – apparently these were around for millions of years 'before sex became interesting'!<sup>1</sup> Rod goes on to describe the great increase in understanding of reproductive endocrinology that occurred from the early 20th century onwards, culminating in the recent development of selective oestrogen and progesterone receptor modulators

(SERMs and SPRMs) that can be used in clinical practice. His editorial is a stimulating introduction to the important review it complements later in this issue, from Rozenberg et al, on the use of SPRMs and, in particular, ulipristal in gynaecology and women's health.<sup>2</sup> I believe this review will be of great interest to many of our readers.

Two papers among the original articles in gynaecology deal with the topic of abnormal cytology and detection of cervical cancer in women



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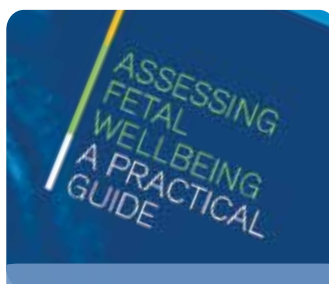
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aged under 25. A paper from Morgan et al concludes that there is a very low incidence of cervical cancer in women under 25, irrespective of the age of commencing screening or the length of intervals between screening; the authors state that their findings lend 'some support' to the forthcoming changes in cervical screening guidelines in Australia.<sup>5</sup> In the second paper, from Taghavi et al, the authors conclude that careful observation of CIN2 in women under 25 does not result in decreased 'health-related quality of life' or in undue psychological stress.<sup>4</sup>

Also in this issue, Harris et al review 525 cases of chronic vulval pain, reporting that the majority of these had a dermatological disease as the cause while a small proportion had neuromuscular conditions; both groups, the authors point out, are treatable. Other gynaecology original articles deal with endometriosis education,<sup>5</sup> management of low-risk trophoblastic neoplasia<sup>6</sup> and varying levels of anti-Müllerian hormone in infertile women.<sup>7</sup>

Among the obstetrics original articles, Waller et al report on multiple pregnancies conceived with overseas fertility treatments and subsequently managed in the sole tertiary maternity unit in WA; these constituted a third of all multiple pregnancies conceived with ART and managed over a two-year period in the hospital.<sup>8</sup> The authors note a significant cost to the health system of what is now termed 'cross-border reproductive care.' In other papers, Hughes et al report from their dedicated high-risk Melbourne clinic on a decreased rate of preterm labour over a ten-year period, and examine the reasons for this;<sup>9</sup> and Dunn et al from Brisbane find that although advanced maternal age doubles the risk of caesarean delivery in both nulliparous and multiparous women, the majority of older women nevertheless do have vaginal births.<sup>10</sup>

The October issue of *ANZJOG* will also be published by the time you read this. Prof Michael Permezel has contributed an incisive editorial on current O&G training,<sup>11</sup> in conjunction with two articles looking at RANZCOG trainees' working hours and reported fatigue levels that appear later in this issue.<sup>12,13</sup> The editorial examines the shortcomings of the present system and makes some strong recommendations for change. Still on the topic of training, Bhoopatkar et al have reported an interesting study of the experiences of medical students in South Australia and New Zealand in learning pelvic examination; they detail both the opportunities available to students, and the obstacles they encountered in their attempts to gain sufficient experience in the techniques of intimate examinations.<sup>14</sup>

In an important Clinical Perspective, Hammond et al give an excellent account of the changes to the Australian National Cervical Screening Program that will be implemented from 1 December this year. The authors clearly address many of the concerns that have been expressed by some health professionals in regard to these changes; the article should be essential reading for all practitioners involved in women's reproductive health.<sup>15</sup> Also of great interest is the review article by Nicklin on robotic-assisted laparoscopic surgery and its role, present and future, in gynaecological surgery.<sup>16</sup>

In the area of obstetrics, *ANZJOG* is pleased to publish the executive summary of the SOMANZ guidelines for the investigation and management of sepsis in pregnancy; a comprehensive guide to the causes, diagnosis and management of all types of sepsis in pregnant women that will be invaluable for all obstetricians.<sup>17</sup> Finally, in the Opinion section of the October issue, Tremellen and others argue against limitations to the access of obese women to assisted fertility treatments,<sup>18</sup> while Robson and Norman strongly defend the ethical and clinical reasons for withholding assisted reproductive treatments from women with a high BMI.<sup>19</sup>

I wish you all enjoyable reading of these two issues.

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# WOMEN'S HEALTH

## Journal Club



Had time to read the latest journals? Catch up on some recent research by reading these mini-reviews by Dr Brett Daniels.

### Links between suicide and domestic violence

In Australia, more than 2000 people die by suicide each year and it is the most common cause of death for men and women under 44 years of age. The causes of suicide are often multifactorial and associations are seen with predisposing factors including mental illness, drug and alcohol issues, regional location, ethnicity and race and the presence of domestic violence. In many cases, people who suicide may have more than a single risk factor, making it difficult to determine causality.

MacIsaac et al<sup>1</sup> reported a systematic review of the relationship between interpersonal violence (IPV) and suicide in both men and women as both perpetrators and victims. The authors searched eight medical, social science, public health and criminology databases, including Medline, PsycINFO, EMBASE, CINAHL, Scopus, Web of Science, Cochrane Library and Criminal Justice Abstracts. Databases were searched from their inception to March 2015. Search terms used encompassed a wide range of descriptors of self harm and suicide, physical and sexual violence, death and injury. After search and elimination of duplicates and examination of the 5216 titles and abstracts and 320 full-text articles, a final 38 articles were included in the analysis. The included articles were published between 1981 and 2014 and 18 studies included only women. Study types included retrospective record audits, cohort studies, psychological autopsy and two articles reviewing media reports.

Thirty-six of the studies reported on the strength of the relationship between being the victim of interpersonal violence and death by suicide. The reported lifetime prevalence of exposure to violence in women dying from suicide ranged from 3.5 per cent to 62.5 per cent. Alternatively, two studies reported that being the victim of violence conferred a 17–40-fold increase in risk of death by suicide. These results were not consistent across all studies. One study showed that after controlling for confounders such as mental illness, there was no significant relationship between interpersonal violence and death by suicide. In that study, 85 per cent of women dying of suicide with a history of domestic violence also had a history of depression or other mental illness. This association between violence, mental illness and suicide highlights the difficulty in determining causality.

As this review considered studies from across the world there were a number of studies in which suicide and domestic violence had specific cultural contexts. In countries with a dowry system, such as India, Pakistan, Bangladesh and Iran, if the requirements for the dowry are not met by the bride's family the husband's family may subject the woman to physical and mental abuse. In this case, some women may see suicide as their only means of escape. Such cultural considerations are relevant in other countries, especially with consideration of violence in immigrant communities.

As the authors state, at the time of writing, theirs was the only systematic review of IPV and suicide among women. Despite this, they acknowledge its limitations. The study had very broad inclusion criteria in terms of the search terms, geographical location, inclusion of studies of perpetrators of violence and no limitations on type of study methodology. Limitations were that only English language studies were included and that the authors excluded some studies where gender was not reported. They also excluded studies of murder-suicide. While these cases may almost always include evidence of domestic violence, the authors decided that they were more likely to accurately involve the psychology of homicide rather than suicide and that the perpetrators were generally men, rather than women, who were the focus of this study.

In conclusion, this review highlights the difficulties in studying the relationship between domestic violence and suicide, but finds there is definitely an association between domestic violence and suicide in women. In many cases this association may be mediated via mechanisms such as mental illness and depression, social isolation or cultural practices. While this makes research more difficult, it does provide avenues for providing methods to women who are the victims of domestic violence, before suicide becomes their final option. Provision of prompt and easily available mental health services to these women may be an important factor in reducing the suicide rate in this population.

#### Reference

1. MacIsaac MB, Bugeja LC, Jelinek G A. The association between exposure to interpersonal violence and suicide among women: a systematic review. *Australian and New Zealand Journal of Public Health*. 2017;41:61-9.

# How we talk about drinking alcohol during pregnancy

**Susan Hickson**  
**Health Promotion Officer**  
**Foundation for Alcohol Research and Education**

Rebecca has been referred by her GP because she is a 36-year-old in her first pregnancy. She and her partner are busy professionals. Rebecca has no significant past or family history and is in good health at 18 weeks gestation. She admits to often feeling stressed and says she has cut down on alcohol since the pregnancy was confirmed at 10 weeks, but is still having a glass of wine daily to help her wind down. Following history taking, review of test results and physical examination, you determine that Rebecca's pregnancy is progressing well.

## Rebecca's dilemma

Drinking alcohol helps Rebecca relax. She is not sure she can give up without help. She's received mixed messages about the risks of having the occasional glass of wine now she's pregnant. She feels reluctant to raise this with you, and hopes that you will raise alcohol consumption as part of the routine consultation.

## Your dilemma

You need to have a conversation with Rebecca about her drinking, but don't want to offend or alarm her. You're not sure how to approach this. You need to assess her level of risk and provide her with the appropriate advice, support or referral. This will all take time, and you already have a full waiting room.

## Rebecca's story is not uncommon

In Australia, one-in-four pregnant women consume alcohol after knowledge of their pregnancy.<sup>1</sup> Surprising to some is the fact that older, more educated and better-off women are those more likely to continue to drink during pregnancy.

Rebecca is consuming alcohol at a level that increases her risk of miscarriage and stillbirth, and puts her baby at risk of premature birth, low birthweight and fetal alcohol spectrum disorder (FASD) conditions.

## Australian Alcohol Guidelines and level of risk

The National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol state that for women who are pregnant, planning pregnancy or breastfeeding, not drinking alcohol is the safest option.<sup>2</sup>

Alcohol is a teratogen and heavy or binge drinking can cause damage to the developing fetus. It is not currently known if there is an amount of alcohol that can be consumed without damage to the fetus, hence, the recommendation to not drink.

## Women Want to Know – alcohol and pregnancy

You can solve dilemmas such as the ones outlined here by:

- having the conversation about alcohol consumption that women want
- providing clear advice about alcohol, based on the Australian Alcohol Guidelines
- offering support and referral if needed

## RANZCOG eLearning course

This course provides you with the information and skills to confidently tackle the above dilemmas. Completion of the comprehensive course attracts CPD points, but more importantly, you will be able to help women to achieve alcohol-free pregnancies by delivering clear and evidenced-based advice about the risks of alcohol during pregnancy.

## References

1. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: detailed findings. 2017. Available from [www.aihw.gov.au/reports/illegal-use-of-drugs/ndshs-2016-detailed](http://www.aihw.gov.au/reports/illegal-use-of-drugs/ndshs-2016-detailed).
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## WOMEN WANT TO KNOW COMPANION RESOURCES

Targeted resources aimed at health professionals who see women who are pregnant, planning a pregnancy or breastfeeding.





The Royal Australian and New Zealand College of Obstetricians and Gynaecologists  
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CLIMATE e-learning

[climate.edu.au](http://climate.edu.au)

# Letters to the Editor

**Dr Mary Schramm**  
FRCOG, FRANZCOG(Hon)

The article, Dysmenorrhoea in adolescents, published in *O&G Magazine* Vol.19;No.3:p.36, proposes a high level of medicalisation of a common condition, affecting 60–70 per cent of all adolescents, and 15 per cent to a level of serious discomfort and inconvenience.

Although the theoretical basis of ovulation suppression by combined oral contraceptive pills (COCP) may be sound, I consider it to be inappropriate as first-line therapy, especially in young adolescents. COCP should be reserved for those whose symptoms do not respond to simple analgesics and/or prostaglandin suppression by NSAIDs. If a young adolescent is sexually active, she needs barrier contraception, but is less likely to use if already taking 'the pill'.

Mefenamic acid is ideally taken from day minus 2 or 3, but can still be effective if taken as soon as the girl, like Lady of Shalott, realises that 'the curse is upon me'. Many early adolescents will find this easier and

more natural than a daily pill regimen. We should not forget that, for more than five decades, many women have discontinued COCP and sought alternative contraception because of side effects.

As a note of history, in the 1950s and 60s, dexamphetamine was combined with a small dose of sodium amytal in a pill that gave me, some friends and my patients rapid relief from cramping dysmenorrhoea. When I moved, as one did in those days, to the UK in 1968 these pills were being put to other uses, and were known as 'purple hearts'. I learned this rather late, when my consultant received an urgent call from a scandalised GP about his new registrar's prescribing sins – another good remedy wiped off the slate by external forces. Something like Debendox! (Debendox was an antiemetic; highly effective in early pregnancy with virtually no side effects. It was driven off that market around 1980 by 'research' that linked it, fraudulently, to heightened risk of fetal anomalies).

**Prof Judith Goh AO**  
FRANZCOG, PhD, CU

Re: Obstetric fistula: a public health issue, *O&G Magazine* Vol 19;No 3:p 60.

For over 20 years, I have spent much time in Africa and Asia treating women with obstetric fistula (OF), and have just returned from remote far western Uganda as a medical volunteer. I have lived in Ethiopia for over a year, spending most of my time there at the Addis Ababa Fistula Hospital, working as a fistula surgeon.

The paragraph on 'future directions of OF detection' is objectionable. At present, we can detect 100 per cent of fistulas from the urethra/bladder to the vagina (and recto-vaginal fistula) by clinical assessment alone. Imaging is useful in ureteric fistulas. In many parts of Africa, ultrasound is not available. It is too expensive, there is no training in ultrasound use and electricity is unreliable, with power surges damaging equipment. There is also a paucity of biomedical engineers to service or repair equipment.

At the hospital in remote western Uganda, the x-ray tube is many decades old with no funding for another, let alone an ultrasound. There is no blood for transfusion and very basic blood tests (that is, only haemoglobin, test for malaria, HIV and extremely difficult to obtain basic electrolytes).

In many low-income countries in Africa and Asia, healthcare is not free. Every visit and every investigation adds to the cost. Many cannot afford to come to the clinic, let alone pay for investigations.

For a woman with a fistula, history and examination +/- dye test is all that is required. A dye test is not required for the majority as the fistula is large and therefore easily palpable or seen on examination. Clinical hands-on examination also allows the clinician to inspect the vagina for other pathology, other fistulas (rectovaginal or more than one genito-urinary fistula) and vaginal scarring. It also allows the clinician to assess and plan for the route of surgery – vaginal repair or abdominal. This is very important in many low-income countries as spinal anaesthesia is safer and preferable to general.

For the 'pinhole' fistula, a dye test will allow the clinician to locate the fistula and, again, vaginal examination enables assessment of the vagina/rectum. The dye test is low cost, available anywhere, requires little training and extremely accurate in diagnosing a fistula. It does not add to the burden of healthcare costs.

The article quotes Nolsoe<sup>1</sup> who discusses perianal fistula, which is completely different (with different aetiology) to the obstetric fistula. This reference also admits that 'gold standard' for diagnosis of the obstetric fistula was surgery, in other words, clinical examination. Thus, an ultrasound scan is of little benefit and only adds to the cost of healthcare.

Therefore, as an experienced fistula surgeon, I disagree that ultrasound is required to detect obstetric fistulas and advocacy for expensive equipment with little scope for training or servicing of equipment is not helpful in low-income areas.

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**Dr David J Browning**  
**FRCOG, FRANZCOG, OAM**

The article by Madeline King that appeared in *O&G Magazine* Vol 19;No 3:p 60, Obstetric fistula: a public health issue, reminds us of the tragedy affecting about two million women in developing countries. The majority of fistula sufferers live in isolation in the rural areas of Sub-Saharan Africa. Commonly, they have co-morbidities such as renal disease, anaemia and lower limb palsies.

Unrelieved obstructed labour is the cause of obstetric fistula formation. About 5 per cent of all labours become obstructed and the problem is solved in the developed world by assisted delivery. But where there are no obstetric services, obstructed labour usually resolves with fetal death and delivery of a stillborn with reduced diameters.

Although a narrow pelvis undoubtedly contributes to obstructed labour, the basic cause is malposition of the baby's head, inadequate flexion, occipito-posterior position and deep transverse arrest. More than 90 per cent of women deliver at home in the rural areas of huge swathes of Sub-Saharan Africa, so assistance for obstructed labour is lacking.

Madeline King points to early marriage and childbearing with a narrower pelvis as the prime cause of obstetric fistula. However, experienced fistula surgeons dispute this. For example, Dr Andrew Browning, who has operated on 6500 fistula sufferers and seen 10,000, states 'It is a commonly held assumption that early marriage is a risk factor for obstetric fistula formation. The link seems to follow common sense as it is known that pelvic maturity is reached some two years after menarche.' Hence, the thought is that pregnancy at an early age leads to a higher chance of obstructed labour and fistula formation. However, this has not been proven in the field and it is hard to find an established fistula surgeon who would agree. For example, of an unpublished series of 2500 consecutive fistula patients in the Amhara region of Ethiopia, where marriage before menarche is the norm, only 45 per cent of fistula patients got their injury during their first labour, that is, when their pelvis was immature. A recently published paper by Browning<sup>1</sup> showed that of those fistula sufferers who become pregnant 'early' or 'late', the obstructed labour occurs in their first labour in equal proportions, hinting that regardless of pelvic maturity, obstructed labour occurs in the first pregnancy in equal rates.

Northern Nigeria has one of the busiest fistula services in the world, in an area where early marriage is not the cultural norm. There are many arguments against early marriage, but obstetric fistula is not one of them. Eradicating early marriage will have a minor, if any, impact on the rates of obstetric fistula formation. The only way that obstetric fistula will be eradicated is the same way that it was in the West, by ensuring that all women have access to safe and timely obstetric services such as is provided by Maternity Africa [www.barbaramayfoundation.com](http://www.barbaramayfoundation.com).

The author also proposes that ultrasound would be valuable in the diagnosis of an obstetric fistula. This is not the case. A fistula is simple to diagnose, as the average size of an obstetric fistula is 3x2.8cm. All you need is a gloved hand. If that is not available, inserting a gauze or tissue in the vagina and removing after an hour or so will see that it is soaked with urine, indicating a fistula. Or there is the traditional dye test – a low-technology and widely available investigation rendering an ultrasound superfluous. Neither FIGO nor WHO guidelines nor any obstetric fistula text lists ultrasound as a diagnostic test.

**Reference**

1. Browning A, Mbise F, Foden P. The effect of early pregnancy on the formation of obstetric fistula. *Int J Gynaecol Obstet.* 2017;138(3):288-92.

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# Winners of 2017 Liam & Frankie Davison Award

**Delwyn Lawson**  
**RANZCOG Women's Health**  
**Foundation Coordinator**

The Liam and Frankie Davison Award for excellence in literary writing on an issue in women's health was offered by the College for the fourth consecutive year in 2017, and once again attracted an impressive selection of applications from students across Australia and New Zealand.

Applications closed on 30 April 2017 and 20 eligible submissions were received on topics including endometriosis, body image concerns, postpartum depression, abortion, gender inequality and polycystic ovarian syndrome.

The award was judged by an Award Committee comprising RANZCOG Fellows from Australia and New Zealand as well as the College's CEO and Director of Practice and Advocacy. The judges were most impressed by the topics selected and the quality of the entries, with the top scores being higher than in any of the previous years.

Coming in at the top of this competitive field with their exceptional submissions were Gaia Bahaar of Melbourne Girls' Grammar School, Victoria, with her submission, 'Gag Trumps Women's Rights', and Angus McGregor of St Kevin's College, Victoria, for his submission, 'Early exposure to the internet has influenced my generation's view of "normal" women'.

The recipients were each presented with their awards and \$1000 prize money in front of the RANZCOG Board and Committee members at a presentation held at College House in Melbourne during this year's Council Week in July.

Gaia entered the award because of her passion for writing and chose to write about the Mexico City policy because she says, 'I was already really interested in the circumstances surrounding abortion and the government's stance on it, so thought it would be great to be able to look deeper into that by way of the award.' Angus' interest stemmed from a personal connection as his mother is a midwife and he intends to pursue a career in medicine himself.

The award provides a valuable learning experience for students and allows them to explore, in-depth,



Prof Robson presenting awards to Gaia Bahaar and Angus McGregor.

an issue related to women's health that they are interested in. Recipient Gaia Bahaar says, 'I had a few preconceived opinions about my topic before researching so it was incredibly enlightening to see the evidence against the gag rule and strengthen my own view, but also, considering the sensitivity of the topic, often shocking to see what is really going on in some areas due to the Mexico City policy. The award was an amazing way to look beyond the surface of a subject that I am very interested in and I think it is important when you do undertake research like this, that it is on a topic that can surprise you and that you can really learn from.'

The recipients were both deeply grateful to the College for their awards, with Angus McGregor saying, 'It was a great honour to receive this award and acknowledgment of my interest in this area from an organisation that has an impact on every woman and family in Australia and New Zealand.'

The winning submissions are available to download from the RANZCOG Women's Health Foundation section of the College website: [www.ranzcog.edu.au/about/foundation/Liam-and-Frankie-Davison-Award](http://www.ranzcog.edu.au/about/foundation/Liam-and-Frankie-Davison-Award).

Applications for next year's award will open on 31 January and close on 30 April 2018.

## About the award

Open to students in their final three years of secondary school in Australia and New Zealand, the award was introduced in 2014 to increase awareness within the education sector below tertiary level of the role and work of RANZCOG. The name was changed from the RANZCOG Senior Secondary Students Women's Health Award to the Liam and Frankie Davison Award following the tragic loss of Liam Davison and his wife, Frankie, in the MH17 disaster. Liam Davison was a valued member of staff at RANZCOG, responsible for eLearning, and Frankie a teacher at Toorak College for many years. The award was named in recognition of Liam and Frankie's shared passion for nurturing and encouraging young writers, teaching and good literature, and in the hope that this will be a meaningful legacy for Liam and Frankie. The award is intended to be of relevance not only to students intending to study medicine at tertiary level, but also those with an interest in a variety of subject areas from science and health, to law and politics. The award is administered by the RANZCOG Women's Health Foundation Coordinator and further information is available on the website: [www.ranzcog.edu.au/about/foundation/Liam-and-Frankie-Davison-Award](http://www.ranzcog.edu.au/about/foundation/Liam-and-Frankie-Davison-Award) or by contacting Delwyn Lawson on +61 3 9412 2993 or [lfaward@ranzcog.edu.au](mailto:lfaward@ranzcog.edu.au).



# New FGM module

**A/Prof Nesrin Varol**  
**PhD, MIPH, FRANZCOG, MBBS**  
**Sydney Medical School, University of Sydney**  
**Director**  
**Sydney Gynaecology and Endometriosis Centre**

**A/Prof Angela Dawson**  
**BA(Hons), MA, PhD, PGDipHEd, PGDipPubHlth**  
**Australian Centre for Public & Population Health**  
**University of Technology Sydney**

RANZCOG's FGM module was recently presented at an international symposium on FGM management and prevention at the Geneva University Hospitals, Switzerland. The symposium was sponsored by the World Health Organization's Human Reproduction Programme and the Universities of Geneva, Montreal and Brussels. Leading researchers, clinicians and program implementers from Europe, Africa and Australasia came together to share experiences and data concerning healthcare and prevention, evidence and consensus gaps and healthcare professional training and curricula. A/Profs Angela Dawson (University of Technology) and Nesrin Varol (University of Sydney), key members of the committee that developed RANZCOG's FGM modules, represented Australia. Nesrin Varol presented the results of a recently published paper on the obstetric outcomes of women at an Australian hospital and Angela Dawson presented the results of two systematic reviews on health professional education and training on FGM and showcased RANZCOG's education module.

The online RANZCOG module, made up of four units, introduces health professionals to the issue of FGM in Australia, outlines the sexual and reproductive health consequences of FGM and addresses the care and clinical support that women who have experienced FGM may require. Information to support education and advocacy is also provided. An evaluation has found the module to be relevant and applicable to clinical practice. In NSW, this training has been supported by clinical guidelines and a healthcare professional counselling aide.



Angela Dawson with the poster displayed at the international symposium on FGM management and prevention.



The **Colposcopy Online Learning Program (COLP)** is a comprehensive and freely available theoretical online education program for professionals performing colposcopy.

Recently updated to align with the renewed National Cervical Screening Program (NCSP) policy and Guidelines for Management of Screen Detected Abnormalities, Screening in Specific Populations and Investigation of Abnormal Vaginal Bleeding (2016 Guidelines), it offers sequential compliance pathway to track individual progress and certificate of completion.

The revised topics include:

1. The natural history of Human Papilloma Virus (HPV) and its relation to cervical neoplasia
2. The National Cervical Screening Program and risk-based screening
3. Management principle of the patient with an abnormal cervical screening result
4. The fundamental and practice of colposcopy
5. The treatment of pre-invasive disease and its complications

RANZCOG Fellows can claim **5CPD, PAR points** in the self-education component of the Clinical Expertise or Academic Abilities domain for completion of the COLP.

To access the course, please visit [colp.cquip.edu.au](http://colp.cquip.edu.au) or contact [cquip@ranzcof.edu.au](mailto:cquip@ranzcof.edu.au) for further information.

# Just another day in Jahun paradise?



**Dr Jared Watts**  
**MBBS(Hons) FRANZCOG**  
**Kimberley Regional Specialist**  
**Broome, Derby and Kununurra Hospitals**

'Dr Jared, Dr Jared. You are needed in maternity.' For a few seconds, I am confused. Where am I and who is that calling me? I then remember 'Oh, Jahun!' It is the MSF Watchman that has come to my bedroom door and is gently knocking to let me know that I am needed. I go to get out of bed, once again forgetting about the mosquito net, and have to do a dance to unceremoniously untangle myself from it. I quickly put on my scrubs, boots and head out to the gate. I can see the driver and the anaesthetist, who has just arrived from the UK, already in the car, engine running. Oh, it is never a good sign when they call us both, I think.

It has already been a busy day in Jahun Hospital. Located in Jigawa State in northern Nigeria, the Jahun Project is a collaboration between MSF and the Nigerian Ministry of Health. Since 2008, MSF has operated Jahun General Hospital's maternity unit. This includes a vesicovaginal fistula ward for fistulae repairs, a NICU for babies born at the hospital, as well as two theatres, an ICU, and delivery and postnatal wards. Currently, the hospital delivers more than 6000 women a year with a very high acuity, as the majority of women arrive at the hospital extremely late and unwell. Many women still attempt home births with local birth attendants or seek advice and treatment from traditional medicine people, so presenting to the hospital is often the last resort.

Nigeria is ranked as one of the 20 worst places in the world to give birth, with a country-wide maternal mortality rate of 820 per 100,000 people. However, there is a large disparity across the country, with local figures in northern Nigeria demonstrating a staggering stillbirth rate of 15 per cent. The maternal mortality rate is well over 5000 per 100,000 women, which is potentially one of the highest maternal mortality rates in the world. Thankfully, through the collaboration and the work of the MSF outreach midwives and the hospital's growing reputation, this is changing, with more women presenting for antenatal care and earlier in their labour.

With it being malaria season, the hospital has been quite busy and often seems chaotic. Already today I have delivered a vaginal birth of triplets and supervised six vaginal breech deliveries, and we have lost count of the number of twins. At least ten women have presented with symptoms of anaemia from malaria or postpartum haemorrhages (PPH), often with haemoglobins of less than 30. I have performed eight caesareans sections, with two ending in hysterectomies, and repaired three ruptured uteri. Sadly, we have also had a death today: a woman who presented with a PPH and was already in disseminated intravascular coagulation (DIC). The local staff are quite used to expats seeming quite shocked on their first day, and jokily greet new staff with 'Welcome to Jahun Paradise!' I wonder what else Jahun Paradise has in store for us tonight.

On arriving at the hospital, the anaesthetist and I are directed to the pre-delivery ward. As we enter, I am instantly drawn to the readings on a monitor attached to the patient in bed two. She is the only patient not sharing a bed tonight; most other beds have three patients. The blood pressure shows 194/114 and even more concerning is the oxygen saturation of 80 per cent, despite the oxygen concentrator set to max. 'Jijiga?' I ask the midwife sitting at the desk. She nods her head. 'Not again,' I sigh. Jijiga is the local Hausa word meaning 'to shake' and what everyone calls eclampsia. Jahun has an extremely high rate of eclampsia, with often four or more patients presenting with jijiga each day. This mother is aged 21, para 3 and delivered one day ago at home. She now presents after three seizures with likely pulmonary oedema and cardiac failure. Her haemoglobin is 35, a spot test for malaria positive, and she is using every accessory muscle just to keep her saturations at 80 per cent. The staff are trying to help her stay sitting up as this has raised her saturations, but she is quickly tiring. I scan her abdomen to ensure there are no retained products or other confounding problems and, while I do not normally venture out of the pelvis with my ultrasound probe, even with no training I can see the pleural and cardiac effusions and poor contractility of the heart. She is in trouble, big trouble.



The theatre team, made up of a local nurse anaesthetist, two scrub nurses and expat obstetrician.



A rare moment in pre-delivery where beds don't have three patients each.

This follows on from three other cases this week of severe eclampsia that have resulted in maternal deaths. All mothers were aged less than 20. Patients often present in advanced stages of the disease due to having limited transport options, having to wait for their husband to give permission or escort them to hospital, or trying traditional medication first. The other cases had also developed pulmonary oedema and renal failure, which resulted in electrolyte disturbances and then cardiac arrest. All the cases so far had taken traditional medications, which may actually worsen the outcome as these teas and herbs appear toxic on their own. For this mother, under the guidance of the anaesthetist, we started frusemide and an infusion of glyceryl trinitrate and moved her to the ICU. I rang the medical coordinator to keep him abreast. 'I think we may have another maternal death from eclampsia and potentially traditional meds,' I informed him. 'Not again,' he sighed. This was becoming all too common.

I have now been on placement with MSF in Nigeria for a month. Since medical school days, I have always wanted to work for MSF, but the real journey started about two years ago. I was attending the FIGO World Conference in Vancouver and MSF had a booth at the trade show. There, I chatted to an obstetrician who was one of MSF's medical advisors and was very surprised to discover she worked in Sydney with other advisors on women's and child health. She discussed the application process and opportunities to work with MSF.

After completing my RANZCOG Fellowship, I submitted my resume and an essay on my motivation to work for MSF. I was then invited to Sydney for an interview regarding aspects of working for MSF and in humanitarian medicine. Passing the interview, I attended a week-long training course in Sydney, which covered many topics of working for MSF and in developing countries. Finally, I was matched with Jahun, and my employer in Australia was very supportive. I soon found myself back in Sydney for a predeparture briefing and then flew out to Abuja, the capital of Nigeria, full of nerves and excitement.

Back to that night: I missed the ward round the following morning as I was caught up in theatre. The next time I made it to ICU was for the evening ward round. As we changed into our ICU shoes and lab coats, I noticed the patient in bed five was breastfeeding her baby and she looked familiar. The patient had an oxygen mask on with a high respiratory rate, but seemed to be talking in short sentences to her neighbour. Looking more closely, I was surprised to find it was the patient from the night before. She was not only alive, but appeared to be improving rapidly. I think the anaesthetist noticed my surprise and joy, and whispered, 'The jijiga did not win this time.' As I went over to see her, I also recognised the patient she was talking to in the next bed. 'Is she the uterine rupture who presented with a haemoglobin of 21 and DIC?' I asked. 'Yep,' the anaesthetists smirked and teased, 'and she looks better than you, hey?' I had to agree with that, glad too that it was now my night off, and I could rest.

Working for MSF in Jahun has been challenging and difficult, with even a few tears shed, but I can easily say it has been the most satisfying six weeks of my career so far. Yes, you can only do so much, as many of the issues are due to complex social determinants of health, but if you are up for a challenge, want to use your general skills, learn to rely on your examination findings, and see and treat conditions you have only read about, MSF may be the answer. In Australia, you may feel really appreciated when a patient tries to give you a bottle of fine wine or champagne, but wait till a patient tries to give you their food ration for the day as a thank you. It is often all they have, and it means they would go without food. You then realise and appreciate what you and MSF means to these patients. I have also received a lot from working in Nigeria; friendships, skills, knowledge and the satisfaction of knowing I am making a real difference in these people's lives. For many of these patients, it is only MSF and their staff that stands between them and death. We often joke about Jahun Hospital being a paradise, but for the patients it really is their northern Nigerian desert paradise.

Having been home for about a week, the question I am most often asked is 'Will you go back? Will you work for MSF again?' My answer is simple, 'I already have my next placement booked.'

**Médecins Sans Frontières Australia is currently looking for O&Gs to deliver medical assistance to the people who need it most. You must be able to commit to a minimum placement of six weeks and be a resident of Australia or New Zealand. Find out more at [www.msf.org.au/join-our-team/work-overseas](http://www.msf.org.au/join-our-team/work-overseas).**



Surprise twins: a common occurrence in Jahun.



# Catalysts for change



**Dr Pushpa Nusair**  
**President**  
**Pacific Society for Reproductive Health**  
**Associate Professor, Fiji National University**  
**College of Medicine Nursing & Health Sciences**

Over a period of six days during July 2017, the Pacific Society for Reproductive Health (PSRH) held a number of educational training workshops followed by the PSRH 12th biennial conference in Port Vila, Vanuatu. More than 300 health professionals attended the conference. It was a busy, educationally stimulating and thought-provoking time for us as leaders and providers of reproductive health services to women in the Pacific.

The Society has a strong role in advocating for women's health and support for the medical and midwifery workforce who provide the service across the Pacific Island Countries (PICs), and we are proud that this role is being increasingly recognised across the Pacific, Australia, New Zealand and globally. PSRH seeks to provide support for women's health providers, who range from those working in small health posts in a remote island province of Vanuatu or Papua New Guinea, to those working in academic departments responsible for training the next generation of O&Gs for our PICs. Our educational workshops, meetings and events provide an invaluable opportunity to enhance the professional development of our members through educational updates and creates opportunities for networking, collaborating and sharing our experiences, challenges and updates on what is working well, or not so well, in our workplaces.

For those of us in senior roles, this includes looking at the big picture of sexual and reproductive health, from advocacy for measures that will empower women in their health and wellbeing, to being proactive and informed about emerging trends in disease, case management, clinical governance and care for the health and wellbeing of our workforce.

Our membership includes academic and clinical O&Gs, public health specialists, midwives, nurses, reproductive health program analysts and managers, researchers, educators and community health workers. The common denominator for all our members is our work in reproductive sexual health in the Pacific and our commitment to a higher standard of health for women and their families. We hold our biennial conferences in a different PIC every two years and I encourage members of

RANZCOG to come to our meeting, share some Pacific hospitality and learn about the Pacific region we inhabit.

The theme of our conference this year was: 'Reproductive Health and the Sustainable Development Goals – catalysts for accelerating progress'. This theme is in line with the global agenda of the Sustainable Development Goals, a blueprint to improve health and development in the 15-year period, 2016–2030.

The event started from 13–15 July with six technical skills workshops conducted in parallel sessions: Pacific emergency maternal and newborn training, including early essential newborn care; family planning; research and clinical audit; repair of obstetric tears; ultrasound in maternity care; and colposcopy, with the main conference held 15–18 July at the National Convention Centre.

The conference discussed a number of areas, including best practices in maternal and newborn health; health workforce development in obstetrics and gynaecology; midwifery; maternal death surveillance and response; family planning and the unmet needs; prevention of cervical cancer; gender-based violence; adolescent sexual and reproductive health; and leadership in the workplace. In addition to the conference sessions, a side session 'Practice Improvement Marketplace Stalls' was set up that allowed midwives to showcase best practices and innovative methods for improving maternal and newborn health in their own settings.

The biennial general meeting elected members to the PSRH Board. I was honoured to be elected President for the ensuing two-year period. My elected Board members are Dr Kara Okesene-Gafa, Vice President (NZ); Ms Paula Pauwe, Vice President (PNG); Dr Roy Watson, Honorary Treasurer (Australia); Dr Gunzee Gawin, Honorary Secretary (PNG); Ms Kathy Gapirogo, Past President (Solomon Islands) and general members Ms Nancy Pego, (Solomon Islands), Tagiyaco Vakaloloma (Fiji) and Dr Errollyn Tunga (Vanuatu). We also have Dr Alec Ekeroma (Honorary CEO) who manages our secretariat in Auckland.

## Recommendations from the Conference

The PSRH forum brings together senior leaders in obstetrics, gynaecology and midwifery. From the wide experience and expertise at the conference, fine-tuned through a post-conference strategy meeting, the PSRH Board has identified a number of recommendations that form the basis for developing an action plan to guide the work of the Society in the next biennium.

These recommendations are reported in the Executive Summary of the meeting as follows:

### Recommendation 1: Establish a comprehensive cervical cancer prevention and control program

- Cervical cancer is the most common female cancer in the Pacific, contributing to disease burden and causing more than 1500 premature deaths per year in the region. These deaths can be prevented if pre-cancer status is detected



and treated early. Primary and secondary prevention strategies that are effective and practical for PIC settings should be pursued.

- PSRH made strong commitments to develop a Pacific-appropriate guideline on comprehensive cervical cancer prevention to help countries address this problem. PSRH will embark on collaborating with governments and key partners in the region to pursue this agenda.
- A multi-country technical working group on cervical cancer prevention will be coordinated by PSRH to oversee the development of this program and facilitate its progress.

#### **Recommendation 2: Support health workforce development in obstetrics and gynaecology**

- The shortage of health workforce in midwifery and obstetrics is a long-standing problem in the Pacific and affects the quality of service delivery in maternal-newborn care. The issue needs to be positioned high on the agenda of development and in the discussions among governments and development partners.
- PSRH is well-positioned to engage in advocacy dialogue with donors and development partners to leverage resources and sponsorship for strengthening health institutions (midwifery schools, Fiji National University [FNU] and the University of Papua New Guinea [UPNG]) to produce adequate numbers of well-trained obstetricians and gynaecologists for the Pacific region.

#### **Recommendation 3: Strengthen the capacity of midwifery training institutions to produce increased numbers of midwives to meet national targets**

- Shortage of midwives has been a long-standing problem that hinders the provision of essential maternal-newborn care at all levels of the health system. Increasing the numbers of midwives to fill in the large number of vacancies is critical to make progress in quality of care, especially at primary care level.
- The midwifery segment of the PSRH Board will work with governments and development

partners to reassess the situation in the Pacific and develop strategic plans that are practical and affordable in addressing the issues.

#### **Recommendation 4: Increase contraceptive uptake and reduce the unmet need for family planning in the region**

- Family planning is an effective intervention for reducing maternal and newborn deaths and should be strongly promoted to couples and individuals as a key component of the essential maternal health package.
- PSRH will collaborate with countries, donors and development partners on innovative ways to reach more people with effective contraception, with a focus on long-acting methods of contraception, and addressing the unmet needs.

As with any large conference, it takes many partners working together to contribute to the delivery of workshops and the conference itself. PSRH thanks the main sponsors of the conference, the Pacific Community and the United Nations Population Fund for their generous support and contribution that made the conference possible, as well as the Vanuatu government for its hospitality in hosting the conference. We also acknowledge with gratitude the support of the Australian Society for Cytology and Cervical Pathology, FNU, UPNG, World Health Organization, United Nations UNICEF, RANZCOG, Fiji O&G Society, Papua New Guinea Society of O&G, Australian College of Midwives, New Zealand Midwifery Council, Midwifery Societies from Fiji, Solomon Islands and Papua New Guinea, and the assistance from the governments of Australian and New Zealand.

PSRH looks forward to continuing our strong and supportive relationship with RANZCOG and its members and we hope to welcome many of the RANZCOG membership to our next conference.

Members of RANZCOG are welcome to our next conference in PNG in 2019 and can join PSRH via the online application, [psrh.org.nz/apply-online](http://psrh.org.nz/apply-online). Donations to support our work are always welcome at [psrh.org.nz/donation](http://psrh.org.nz/donation).



# RANZCOG Women's Health Foundation

## 2018 scholarships and fellowships

Each year, the Foundation offers several research and travel scholarships for application. The assessment process was once again very competitive this year, with 33 applications being received from Australia and New Zealand. The process for evaluating scholarship applications aims to identify the most promising early-career researchers and the RANZCOG Research Grants Committee, which assesses these applications, was extremely impressed with the high quality of applications received this year.

The RANZCOG Women's Health Foundation is pleased to advise that the following applicants have been offered scholarships and fellowships for research and travel in 2018:

### Research Scholarships

#### Arthur Wilson Memorial Scholarship, 2018–2019

**Recipient:** Dr Natasha Pritchard

**Institution:** University of Melbourne

**Project:** Novel therapeutic agents to treat pre-eclampsia in obese mice models.

Dr Pritchard is a FRANZCOG Trainee at the Mercy Hospital for Women. Dr Pritchard's project will develop an obese mouse model of pre-eclampsia. She will test whether metformin and esomeprazole, two drugs offering potential and safety in pregnancy, can treat pre-eclampsia in this model to determine whether these therapies can improve outcomes for obese women and their offspring.

#### Fotheringham Research Scholarship, 2018–2019

**Recipient:** Dr Maya Reddy

**Institution:** Monash University

**Project:** The cardiovascular toll of pre-eclampsia: determining impacts on the maternal, fetal and placental vasculature.

Dr Reddy is in her fourth year of FRANZCOG training and is an O&G registrar at Monash Health. Her study will predominately be conducted over the course of two years at Monash Health and will explore how the heart and blood vessels change in pregnancies that are complicated by elevated blood pressure. It will then determine whether these changes can be used to predict pregnancy outcomes and long-term heart disease.

#### Norman Beischer Clinical Research Scholarship, 2018–2019

**Recipient:** Dr Amanda Poprzeczny

**Institution:** University of Adelaide

**Project:** Maternal overweight and obesity and gestational diabetes: effect on fetal growth and adiposity.

Dr Poprzeczny is currently enrolled in a PhD at the University of Adelaide, and is a RANZCOG Trainee and senior O&G registrar at Lyell McEwin Hospital. Her project will investigate fetal and newborn growth and fat distribution in women of a normal and elevated BMI, and the additional effects of a diagnosis of gestational diabetes on fetal and newborn growth and fat distribution.

#### RANZCOG NSW Regional Committee Trainee Research Grants, 2018 (Three awarded)

**Recipient:** Dr Amy Goh

**Institution:** Sydney West Advanced Pelvic Surgery Unit

**Project:** The comparison of surgical outcomes using LigaSure and Gyrus PK in total laparoscopic hysterectomy.

Dr Goh is a RANZCOG Trainee in her fourth year of training at Westmead Hospital. Her project aims to compare two types of laparoscopic surgery instruments – the LigaSure system and the Gyrus PK. She will be comparing the outcomes of surgery for women undergoing total laparoscopic hysterectomy with either of these instruments; these outcomes include operating time and blood loss.

**Recipient:** Dr Aiat Shamsa

**Institution:** University of New South Wales

**Project:** Novel biomarkers in women with benign gynaecological conditions and those undergoing IVF.

Dr Shamsa is a RANZCOG Trainee, currently based at the Royal Hospital for Women. Her project aims to investigate the possibility of using a blood test as an indication of women's ovarian reserve – the quantity and quality of her eggs. This blood test will be investigated in women with benign gynaecological conditions such as endometriosis, and women undergoing IVF. Such a new test could potentially help in the diagnosis and management of these women.

**Recipient:** Dr Daniella Susic

**Institution:** St George Hospital, NSW

**Project:** The microbiome in pregnancy and infancy: comprehensive assessment of its composition, and its relationship to health and disease.

Dr Susic is a RANZCOG Trainee and year four Registrar at Wollongong Hospital/Royal Hospital for Women. Over three years, Dr Susic's project will assess the microbiome at stages throughout the critical period of pregnancy and infancy in response to hormonal, metabolic, immune and cardiovascular changes. Samples of the microbiome during pregnancy (faecal, oral and vaginal) and after birth (placental, breastmilk, meconium) will be assessed to determine a link between pregnancy outcome and disease.

### Robert Wrigley Pain Research Scholarship, 2018–2019

**Recipient:** Dr Lauren Kite  
**Institution:** Women's Health and Research Institute of Australia (WHRIA)  
**Project:** Randomised crossover trial assessing the efficacy of adding hyaluronic acid to local anaesthetic in pudendal nerve blocks.

Dr Kite is a FRANZCOG trainee and a Gynaecology Pain Fellow at the Royal Hospital for Women & Women's Health and Research Institute of Australia. Her project aims to improve the treatment and outcomes for patients with chronic perineal pain and assess whether the addition of hyaluronic acid to local anaesthetic for therapeutic pudendal nerve blocks improves pain outcomes and longevity of relief.

### Taylor Hammond Research Scholarship, 2018

**Recipient:** Dr Aaron Budden  
**Institution:** University of New South Wales  
**Project:** Measuring stress in surgeons.

Dr Budden is a RANZCOG Trainee and Fellow in minimally invasive gynaecology surgery at the Royal Hospital for Women in Sydney. He aims to investigate possible markers of acute stress in surgeons undertaking stressful activities. In one phase conducted over 12 months, he will measure markers during simulated exercises and compare when there is a stress-neutral environment with a stressful environment (for example, loud noises or time pressure). In the other phase, conducted over 12 months, he will investigate these markers in surgeons at a live surgery training workshop and compare these to self-reported measures of stress.

### Urogynaecological Society of Australasia (UGSA) Research Scholarship, 2018

**Recipient:** Dr Alex Mowat  
**Institution:** Royal Brisbane and Women's Hospital  
**Project:** Evaluation of Polycaprolactone (PCL) as a tissue engineering scaffold for the surgical treatment of pelvic organ prolapse in the sheep model.

Dr Mowat holds a RANZCOG certificate in urogynaecology and is currently a urogynaecologist at the Royal Brisbane and Women's Hospital in Queensland. Dr Mowat's study will evaluate the efficacy of polycaprolactone as a scaffold for tissue regeneration in hernias of the vagina.

### Travel Scholarships/Fellowships

#### Beresford Buttery Travel Grant, 2018

**Recipient:** Dr Maya Reddy  
**Institution:** St George's University of London

Dr Reddy's grant will allow her to undertake an observership in the Fetal Medicine Unit at St George's Hospital, London, where she hopes to form collaborations with the unit and gain an appreciation for how research is conducted in a different health system.

#### Brown Craig Travel Fellowship, 2018

**Recipient:** Dr Asha-Rhiannon Short  
**Institution:** University College London Hospital/ Great Ormond Street Hospital, London

Dr Short is currently a Paediatric and Adolescent Gynaecology (PAG) Fellow at the Royal Hospital for Women in Randwick. This fellowship will support

Dr Short to visit University College London Hospital and Great Ormond Street Hospital in London with the objectives of understanding and managing Differences of Sexual Differentiation, congenital anomalies of the genital tract, and common benign PAG conditions, gaining exposure to the care and management of adolescents who are transitioning in gender, and observing the running and organisation of a PAG multidisciplinary clinic.

### SCHOLARSHIPS/FELLOWSHIPS CONTINUING IN 2018

The Foundation will also continue to fund the following projects in 2018:

#### Arthur Wilson Memorial Scholarship, 2016–2017 (start date deferred)

**Recipient:** Dr Lufee Wong  
**Institution:** Monash IVF  
**Project:** Reproducibility of three-dimensional ultrasound of the junctional zone in myometrial pathology and their correlation with pregnancy rates.

#### Glyn White Research Fellowship, 2017–2018

**Recipient:** Dr Kirsten Palmer  
**Institution:** Monash University  
**Project:** Targeting placental specific sFLT-1: enhancing the prediction and diagnosis of pre-eclampsia.

#### Norman Beischer Clinical Research Scholarship, 2017–2018

**Recipient:** Dr Monica Zen  
**Institution:** Westmead Hospital  
**Project:** The impacts of kidney disease in pregnancy.

#### Mary Elizabeth Courier Research Scholarship, 2017–2018

**Recipient:** Dr Rachael Rodgers  
**Institution:** University of New South Wales  
**Project:** The administration of anti-Müllerian hormone to protect the ovaries during chemotherapy.

### Support the Foundation

The RANZCOG Women's Health Foundation is very grateful to all those who have so generously supported its philanthropic work in the past year.

Donations to the Foundation, from individuals as well as organisations, enable the College to support not only clinical and scientific research, but also initiatives in global women's health and Aboriginal and Torres Strait Islander Women's Health.

RANZCOG members are able to donate to the Foundation via the payments section of the myRANZCOG Members Portal. To login and donate, please go to [my.ranzcog.edu.au/login](http://my.ranzcog.edu.au/login).

For donation enquiries, please contact Ms Delwyn Lawson, the RANZCOG Women's Health Foundation Coordinator, on [foundation@ranzcog.edu.au](mailto:foundation@ranzcog.edu.au) or +61 3 9412 2993.

### Notice of Deceased Fellows

The College was saddened to learn of the death of the following RANZCOG Fellows:

Dr Ramesh Vasant, Qld, 10 August 2017  
 Prof Alan Hewson, NSW, 19 August 2017