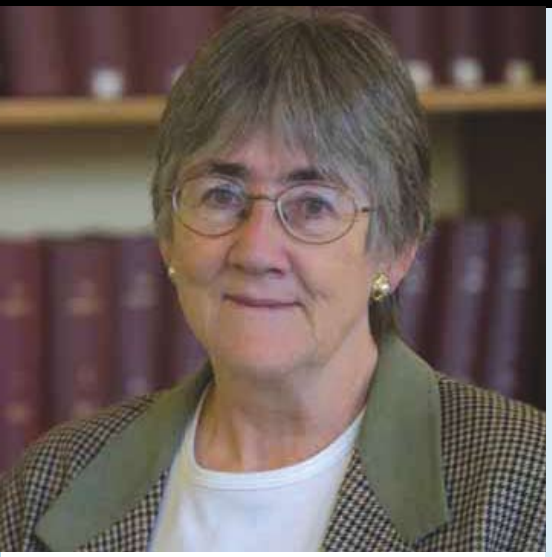
MCHR NEWS

mother & child HEALTH RESEARCH

LA TROBE UNIVERSITY



Thank you Judith

In a few short weeks, our foundation Director, Professor Judith Lumley AM retires. Judith will continue with us in an honorary capacity, but her retirement marks the end of an extraordinary era here at MCHR, the centre Judith established in 1991 with a program grant from the Victorian Health Promotion Foundation.

So, it is timely – but not easy – to pay tribute to Judith. We thank her for the breadth and depth of her many contributions to improving the health and wellbeing of mothers and children. We thank her for her generosity, her wisdom, her humour and her humanity – all shared with us unstintingly. We thank her for her wonderful intellect and for the rigour of her research, and we thank her for the support she has given us all to inspire us to pursue our research with care and with integrity.

Many have wished to pay tribute to Judith on her retirement – colleagues, students, research collaborators, friends. They hail from Melbourne, from around Australia and from overseas. We cannot include everyone's tributes here, but we'd like to share some of them with readers of MCHR News, as a personal way of documenting Judith's many contributions and achievements. All will be included in a book of tributes we are compiling for Judith. If you would like to add a tribute of your own, please email us at mchr@latrobe.edu.au

In appreciation

It is hard to imagine someone like Judith Lumley really retiring. She has contributed so much to maternal and child health, for decades now, and has earned a global reputation for her excellent and enormous body of work. I feel so fortunate to have known her as a valued professional colleague and a special friend, which happily will not change. I wish her lots of long walks in beautiful places in the years to come - she has earned this pleasure.

With great fondness and immense respect.

Leah Albers
Professor of Midwifery,
University of New Mexico USA

I have a large file of correspondence with Judith, going back to 1978. Her handwritten letters to me provide repeated illustrations of the longstanding and exceptional breadth and rigour of her thinking and research. Academia would serve the public more effectively if it had more role models as exemplary as Judith has been to me and others. Thank you, Judith!

Sir Iain Chalmers
Editor, James Lind Library and Former Director, UK Cochrane Centre

Judith has been my inspiration (can I do it as well as Judith can?), my conscience (am I being as rigorous as Judith would be?), my advisor (what did/would Judith say about that?) and my friend. Once you work with Judith, you are a better person.

Jane Halliday
A/Professor,
Murdoch Childrens Research Institute

Judith has done a wonderful job to improve the health of mothers and babies. This has included population based public health collaborative research on care and outcomes, trials of interventions and training of research people. The areas that are particularly impressive are the concentration on the community including people of different origins and recent emphasis on prevention of postnatal maternal depression. I have collaborated with her over a long time and she has helped me set up the Centre for Perinatal Health Research at the University of Sydney by being on the Research Advisory Group.

David Henderson-Smart
Professor and former Director, Centre for Perinatal Health Research
University of Sydney

I met Judith in 1980 when I began working at the Queen Vic Birth Centre. There are only a few people who know of Judith's involvement in establishing the centre, and I feel privileged to be one of them. Through a series of ups and downs, Judith provided the informed and inspired leadership necessary to establish this revolutionary model of maternity care. As a midwife I was grateful that the centre entrusted midwives with the care of low risk pregnant women and Judith was responsible for that. Before evidence-based medicine became a buzz word she taught me that evidence should inform all of our clinical practice. I always knew that I could go to Judith and ask her opinion about clinical matters and she always responded in the most knowledgeable, objective and non-judgemental way. I hold Judith in the highest regard as a person and as a great intellect.

Mary Anne Biro
MCHR

Judith with PSANZ colleagues David Henderson-Smart, Vicki Flenady and Caroline Crowther

Judith Lumley is a hero of public health. Her commitment to rigorous method and her unbending honesty and integrity is famous. However, what I appreciate most is the way she has applied her expertise and energies to really making a difference to people's lives. She has never shied away from the difficult to measure, the complex to analyse and the impossible to control when such challenges arise in the course of making a difference. Not for her the looking for your key under the lamp post 'because that is where our methods work best'.

All this would be enough except that she has shared her skills and her inspiration so generously with so many people. Her leadership in epidemiology and public health has multiplied manifold her own personal contributions. I believe (hope) that I am one who has been marginally more effective in my work because of my contacts with Judith.

David Legge
A/Professor, School of Public Health
La Trobe University

I first met Judith when I was a fifth year medical student doing my rotation through the Monash University Department of Obstetrics and Gynaecology at the "old Queen Vic" in 1975. However, I really came to know Judith well when I started as a PhD student in the same department in 1979. I look back now on all the time that Judith gave me in the early part of my research career and realise that she taught me about critical appraisal and levels of evidence, before these things had such fancy names. We went on to work together in the Perinatal Unit of the then Department of Health and the Centre for the Study of Mothers' and Children's Health. I owe Judith an enormous debt for her generosity, patience and encouragement.

Robin Bell
A/Professor,
Deputy Director, Women's Health Program
Monash University

Judith has always been a source of inspiration, knowledge and wisdom; and always encouraging and interested in new ideas. She is also a stickler for the correct use of language. For example, she gave me this poem midway into my PhD thesis to try and correct one little issue I had with writing. Examples from *The cat sat on the mat*:

Only the cat sat on the mat
The only cat sat on the mat
The cat only sat on the mat
The cat sat only on the mat
The cat sat on only the mat (marked as the correct version in the particular instance in question!)
The cat sat on the only mat
The cat sat on the mat only.

Della Forster
MCHR

My first meeting with Judith in late 1989 changed the course of my research career profoundly. I was an immunologist/biochemist with the vague idea that I would find public health more satisfying; an hour later I was destined to become an epidemiologist and have never looked back. Judith delivered me into a new world where I could bring together scientific rigour, interests in women's health and social justice, and the drive to take on challenging, meaningful projects. Her gentle guidance, patience, intellect, wisdom, friendship and humour continue to influence me on a daily basis.

Alison Venn
A/Professor and Deputy Director
Menzies Research Institute, Tasmania

For 30 years, Judith has been a valued and devoted contributor to the journal *Birth*. Her roles have been many – as author, Editorial Board member, conference presenter, expert reviewer of manuscripts, advisor, critic, supporter, and staunch friend to its two editors, Madeleine Shearer and Diony Young.

Indeed, Judith's input and nurture since 1979 has helped to shape and raise the journal to its current high standard of quality. Her philosophy, broad knowledge, and research in birth physiology, human behaviour, perinatal care, and epidemiology have provided the backbone and direction for *Birth*.

Judith was ahead of her time in assessing the usefulness and future of obstetric technologies. In a 1982 editorial in Birth on "The Irresistible Rise of Electronic Fetal Monitoring," she accurately predicted that

"The 'need' for universal EFM legitimates so many other contentious decisions on the place, style, and management of labor that it will not be discarded in favor of IM (intermittent auscultation) but only displaced when another new, equally unevaluated procedure arrives on the obstetric scene."

Judith, I send my warmest good wishes and my very grateful thanks for your friendship and contributions to *Birth* for most of its life.

Diony Young
Editor, *Birth*, New York, USA

Judith is one of the very best perinatal epidemiologists on the planet. Her work had a huge impact in the United States and Europe, and indeed around the world. I am sure she will continue to make major contributions, and I wish her all the best in her new endeavours.

Pierre Buekens
Professor of Public Health,
Tulane University New Orleans USA

I have been privileged to have Judith as my PhD supervisor and mentor. She has always been able to provide wise advice whenever needed. She has encouraged me and given me the confidence to undertake new projects, such as starting up a new journal and applying for a large project grant as a new investigator.

Lisa Amir
MCHR

Judith's passion for improving the health of women and their infants is legendary and I owe her an enormous amount for sharing that passion with me. It has been an absolute privilege to have her wise counsel and mentorship.

Jane Yelland
Research Fellow
Murdoch Childrens Research Institute

A wonderful lifetime contribution to the health of Australian women and children. Well done Judith. Warmest regards.

Alastair MacLennan
Professor of Obstetrics and Gynaecology,
University of Adelaide

When we first met in 1989, Judith was chairing the Ministerial Review of Birthing Services in Victoria and I had applied for the job of Senior Research Officer. Little did I know that the outcome of that job interview would be 20 years of learning from one of the world's most respected perinatal epidemiologists and public health researchers. There has been much to treasure in those years. Not least has been the simple privilege of knowing Judith as a very special human being.

With a huge and grateful hug

Rhonda Small
MCHR

Early days at MCHR, 1994

To have known and worked with Judith for an extended period of time (in my case 14 years) is a special privilege. So much of what I know about reproductive and perinatal epidemiology comes from Judith - either directly or indirectly. Her focus on the importance of methodological issues in designing and evaluating studies has done, and continues to stand me in good stead. Her quiet caring and compassion are evident in all she does.

Fiona Bruinsma
MCHR

Judith has been such an inspiring leader to researchers in maternity care across the globe. Her leadership of the Centre, of course, but also her short but influential period as Director of the National Perinatal Epidemiology Unit (UK) and her influence through countless committees and editorial boards. It was a real privilege to spend time in the Centre in 2002 and I will always be grateful for Judith's hospitality.

Jo Green
Professor and Deputy Director
Mother and Infant Research Unit
University of York, UK

Judith is the most fabulous role model. Here's why: she demonstrates how to nurture research and researchers. And she does that by stimulating and supporting intellectual and academic collaboration BUT, just as importantly, by sharing food, drink, films, music, literature, walking, talking, singing, laughing and listening. In the words of a Scottish toast: 'Here's tae her, wha's like her? Damn few, an they're aw deid!'

Rona McCandlish
Epidemiologist, National Perinatal Epidemiology Unit Oxford, UK

'Learning to do research' with Judith at MCHR has been an enriching experience for me personally and professionally and I'll never forget the quiet and calming influence that having a cup of tea with Judith at stressful times had in providing clarity and the ability to find ways to move on. She was the perfect choice for a PhD supervisor despite methodological differences and supported me through some very difficult data collection during the Tall Girls Study and my own research.

Jo Rayner
MCHR

Ever since Jeffrey Robinson, excitedly waving a copy of "Having a Baby in Victoria" at me, introduced me to your work I have admired you, firstly from afar, and later as a generous, dedicated and inspiring colleague.
Your quietly extraordinary work makes connections that will continue to engage and inspire generations of researchers to achieve the best for all women and babies.
With deep gratitude and affection

Georgie Stamp
Research Fellow,
Spencer Gulf Rural Health School,
University of South Australia

Judith has provided at the Centre an atmosphere of cooperation and support for each other through our good times and our difficult times. This is a very special attribute not common in workplaces. She provided rigour with research: the question, the design, the analysis and interpretation. Her humility towards others stands out. She always stepped back to let others have a go. And she never put her needs in front of others. Just think how difficult it was to give her a big room or a new computer or printer!

Lyn Watson
MCHR

Before I met Judith in 1974, I had heard about her from Carl Wood. Carl and I were discussing the broad outline of what I planned to research in my PhD, namely women's psychological adaptation to pregnancy and to becoming mothers and the role played by anxiety and childbirth education in this process. Carl said "There's someone you must speak to in the Department (Obstetrics and Gynaecology) about this – her name is Judith Lumley and she has a medical degree but has also completed a PhD on fetal physiology." I remember being a bit miffed about this, thinking what does a fetal physiologist know about psychology.

Of course, when I met Judith I realised how wrong I was because Judith had an encyclopaedic knowledge of many fields and a wonderful sense of intellectual curiosity that went far beyond the borders of her PhD. Subsequently Judith and I shared a room at the old Queen Vic and spent many stimulating hours discussing research methods, (she was instrumental in my conducting a RCT in my PhD), the parlous state of birthing options for Victorian women at that time which resulted in the Queen Vic being one of the few hospitals to develop a Birth Centre, the childhood illnesses and challenging behaviours of our small children and the fabulous contemporary English novels that Judith read at record speed and then kindly passed on to me. I don't think I had any need to buy a novel for several years because Judith had read all the good ones and I was the happy but not sole recipient of her one woman lending library. Judith and I became firm friends and colleagues from that time onwards.

Jill Astbury
Research Professor in Community Psychology, Victoria University

I first met Judith in the late 1980s. I had returned to Australia with a US PhD in Epidemiology, to a public health culture in which there were few non-medical epidemiologists. Judith welcomed me with grace, warmth, enthusiasm, and complete respect. She became a card-carrying member of my support network. Her generosity with time, advice, opinion and mentoring was unstinting. Thank you

Janet Hiller
Professor of Public Health
University of Adelaide

Out of all the good things about Judith I'd just like to mention two. First, in my experience, she has been such a good, warm, supportive colleague who knows how to challenge a person and develop the best in them. Second, she has an amazing ability to focus on what she is doing and not allow herself to be diverted. It was great to work with you when you were at NPEU and in all the years before and since. I hope that retirement will be wonderful for you, Judith.

Jo Garcia
St Stephen's House, Oxford University, UK

I have gotten to know and appreciate Judith over the last dozen years through her participation on the Steering Committee of the Canadian Perinatal Surveillance System (CPSS). Considering the long distances she has had to travel and the many demands on her time, her attendance at the twice-yearly CPSS meetings has been extraordinary. Judith doesn't say much at these meetings, but whenever she raises a question or makes a point, the silence in the room is palpable – it is ALWAYS worth listening to carefully.

My thanks, affection, and best wishes for your retirement, Judith.

Michael Kramer
Professor and Scientific Director
Institute of Human Development, Child and Youth Health
McGill University, Montreal, Canada

Judith has been an inspirational mentor and leader of Mother and Child Health Research. I still remember the first time I spoke with her on the phone in 2002 making a tentative enquiry about becoming a PhD student. I had not expected to speak to "the Judith Lumley", author of Birth Rites, Birth Rights and the former Chair of the Victorian Birthing Services Review. Judith's talents are many but for me the outstanding thing is her capacity to see the big picture and still understand the importance of the particular. Judith has supervised and encouraged many uncertain students. All this laced with humour, humility and the love of writing good English. Thankyou Judith.

Sue Armstrong
MCHR

Thank you Judith for so many extra special things over the last 20 years. Thank you for:

- The enormous contribution you and your team have made to research that improves the health of mothers and children;
- The amazing support and mentorship throughout – always so kindly given – always so very welcome;
- Your never-ending willingness to spend time sharing knowledge as Faculty in the 'too numerous to count' Cochrane/Trials/ Evidence Based Practice Workshops – always positive, always fun; and
- For being the very special person you are.

My special wishes for your retirement days – may they be filled with many beauteous times.

Caroline Crowther
Professor of Obstetrics and Gynaecology
University of Adelaide

Understanding complexity

Karen Willis

My role in COMPASS (our NHMRC Capacity Building Grant) has been to examine the complexity of community-based intervention research, and to explore how qualitative research contributes to knowledge building in this area. Complex interventions aim to address health issues using multi-strategies, the outcome of which is more than simply adding the impact of each individual 'dose or activity'. Because such interventions contain many 'potential' active ingredients[1] that are linked and mutually reinforcing, they pose particular issues for researchers in design, implementation and evaluation. Specified outcome measures may not always reflect the impact and work of the intervention or the complexity of the 'active ingredients'. There may be longer-term, or different, effects to those anticipated.

Using a completed trial as a case study (PRISM[2]), my research focuses on the implementation effects of complex intervention research. While much attention is paid to the beginning and end stages of intervention research (study design and results), with some attention to process evaluation, the effects of implementation are relatively under-explored. So far, my textual analysis of implementation documents has revealed key issues for consideration in broader complex intervention research:

These include:

Theory: Complex intervention guidelines point to the importance of theory, with little discussion about how, and which, theoretical perspectives are integral to research design, implementation and evaluation.

Sustainability: Understanding and defining sustainability requires attention to the 'work' of the intervention, who does this work, how it is legitimated and supported, and community values and expectations about the intervention.

Flexibility: Community-based interventions require flexibility in implementation while retaining minimum (measurable) elements across the trial – capturing flexibility in implementation while, at the same time, gaining transferable knowledge needs further exploration.

A deeper understanding of each of these issues is needed to plan adequately for, and evaluate, the effects of the interventions we wish to trial in community settings.

COMPASS

Building public health capacity for complex questions complex settings complex populations complex interventions

1. Oakley A, Strange V, Bonell C, Allen E, Stephenson J & RIPPLE study team Process evaluation in randomised controlled trials of complex interventions. *BMJ* 2006;332:413-15.
2. For further information on PRISM, see www.latrobe.edu.au/mchr/prism

Karen Willis

Piloting – never a waste of time

Della Forster

Piloting aspects of a planned study can be a valuable step in the research process. Trying out the acceptability of an intervention, testing recruitment or randomisation processes or piloting data collection tools contributes to better studies. Pilot results are also likely to be viewed favourably by funding bodies, especially if they provide evidence of study feasibility and demonstrate willingness of participants to take part. Below are examples of some of our recent pilot studies:

Diabetes & antenatal milk expressing (Dame): a pilot project to inform the development of a randomised trial – MCHR, Mercy Hospital for Women and The Royal Women's Hospital

Infants of women with diabetes are at increased risk of hypoglycaemia. If the infant's blood glucose is low and the mother unable to breastfeed/provide sufficient expressed breast milk, infants are often given formula. Some hospitals encourage women with diabetes to express breast milk before birth; yet there is limited evidence for this practice and triggering premature birth may be a concern. A pilot study with 40 mothers and infants was undertaken to establish the feasibility of conducting an adequately powered randomised trial; obtain baseline figures from which we could calculate the trial sample size; explore whether women would participate; and look for any evidence of adverse outcomes.

An alternative approach to postnatal care: a pilot study - MCHR and RWH

Exploring the feasibility of conducting a trial of a new approach to early postnatal care, women were offered early discharge in conjunction with extra domiciliary visits at times which they could nominate to suit their individual needs, and for which they could prepare during the pregnancy. We investigated the ability of the hospital to adapt staff and resources; the views and experiences of women and clinicians; and the cost of this alternative approach to postnatal care for providers and families. We also piloted and refined the data collection tools, recruitment processes and the intervention to be tested.

Breastfeeding interventions (in planning)

Increasing the duration of breastfeeding in settings with relatively high breastfeeding initiation is difficult. The proportion of infants breastfed to at least six months in Australia has been static for 15 years (~ 46% receiving any breast milk), with a decreasing proportion of infants from low socioeconomic circumstances breastfed.[1] We have been piloting ideas for interventions with women who have lower breastfeeding rates, including: (1) focus groups with women on relatively low incomes, and with Vietnamese women, exploring the idea of peer support for breastfeeding – whether women would be happy to accept or offer peer support; and (2) focus groups and interviews with women larger than their ideal weight finding out from them what might facilitate breastfeeding, to inform our ideas about possible interventions.

In our experience, piloting has always enhanced the final study – it's never been a waste of time, or of resources.

1. Amir LH, Donath SM. Socioeconomic status and rates of breastfeeding in Australia: evidence from three recent national health surveys. *Med J Aust* 2008;189:254-6.

Support for Vietnamese families experiencing partner violence

Angela Taft

MOSAIC (Mothers Advocates in the Community) – an NHMRC and Victorian government funded study at MCHR – has been evaluating the support of mentor mothers for pregnant and recent mothers abused by their intimate partners. The study aims to reduce mothers' levels of depression, abuse and strengthen women's general health and relationships with their children and will be completed early in 2009. MOSAIC is located in the western and northern Melbourne suburbs where many young Vietnamese families live. Women born in Vietnam are also the largest group of immigrant mothers giving birth in Victoria. MOSAIC has had a commitment to being culturally inclusive, so the project has had a special focus with the Vietnamese community.

As part of this commitment, Kim Hoang, Rhonda Small and I conducted a comprehensive review of the prevalence, attitudes to help-seeking and intervention for partner violence in Vietnam and its diaspora communities. We also examined the role played by immigration, acculturation and gender roles in help-seeking by women and in health care and community responses. The review was recently published in a special issue on Family Violence in the Journal of Family Studies, launched on 29 October by the Deputy Vice-Chancellor (Academic) of La Trobe University, Professor Belinda Probert.[1]

Our review found that while much progress had been made in Vietnam in recognising the damaging effects of partner violence and while there has been government commitment to its reduction, including legislation, many women are unaware of the changes. Intimate partner violence in Vietnam shares a similar profile of risk factors and adverse health outcomes as

Kim Hoang and Phung Nguyen outside Tu Du Hospital in Ho Chi Minh City (Saigon)

is found globally. We describe the major cultural and social barriers to women seeking and receiving help and how this is often exacerbated in diaspora communities by isolation and communication difficulties. We conclude that for intervention to be most effective in these communities, the beneficial role of bicultural and bilingual advocacy should be recognised and supported.

1. Taft A, Small R, Hoang K. Intimate partner violence in Vietnam and among Vietnamese diaspora communities in western societies: a comprehensive review. *J Fam Studies* 2008;14):167-82.

Giving birth post-migration: outcomes for Somali women

Rhonda Small

In the international context there are many challenges for investigating pregnancy outcomes in women giving birth post-migration. The international perinatal research collaboration ROAM (Reproductive Outcomes And Migration), has been exploring what migration-relevant data are collected routinely at the time of birth in Western receiving countries, and discovered that whilst maternal country of birth is frequently collected, even these data are not available in all countries. Other relevant migration variables such as length of residence in the country of settlement, language(s) spoken or reason for migration (eg whether migration was forced or voluntary) are seldom available.

In the absence of such data at the individual level, ROAM recently completed a project examining pregnancy outcomes among Somali women giving birth post-migration.[1] Almost all Somali-born women giving birth in Western countries have been forced to flee the internal strife troubling their homeland for many years, some arriving in receiving countries after years in refugee camps.

Data on the confinements and births of 10,431 Somali-born women were compared in a series of meta analyses with those of 2,168,891 receiving country-born women in six countries – Australia, Canada, Belgium, Finland, Norway and Sweden, in the period 1999-2004. Although limited by the availability of common data items across countries, the main outcomes examined were: events of labour (induction, epidural use, proportion of women using no analgesia), mode of birth (spontaneous vaginal birth, operative vaginal birth, caesarean section) and infant outcomes (preterm birth, birthweight, Apgar at five minutes, stillbirths and neonatal deaths).

The first thing we noted in the findings was the huge amount of variation revealed in clinical practice between countries. For example, induction varied in receiving country-born women across countries from as low as 10.9% in Sweden to a high of 31.5% here in Victoria; and caesarean section varied from 14.3% in Norway to 22.4%, again in Victoria.

Compared with receiving country-born women, Somali-born women were less likely to give birth preterm (pooled OR 0.72, 95% CI 0.64-0.81) or to have infants of low birthweight (pooled OR 0.89, 95% CI 0.82-0.98), but they experienced an excess of caesarean sections, particularly in first births (pooled OR 1.41, 95% CI 1.25-1.59) and an excess of stillbirths (pooled OR 1.86, 95% CI 1.38-2.51).

These disparities in outcomes support the previous findings of a small number of single country studies and do not appear to be readily explained by maternal factors or risk differences alone.[2-4] Problems of miscommunication, fear of caesarean section by women leading to a reluctance to seek care early in labour, and caregivers resorting at times to caesarean section due to inexperience with traditional genital cutting and defibulation have all been suggested as complicating factors. All require further investigation if care and outcomes for Somali women are to improve.

1. Small R, Gagnon A, Gissler M, Zeitlin J, Bennis M, Glazier RH, Haelterman E, Martens G, McDermott S, Urquia M, Vangen S. Somali women and their pregnancy outcomes post-migration: data from six receiving countries. *BJOG* 2008;115:1630-1740.
2. Johnson EB, Reed SD, Hitti J, Batra M. Increased risk of adverse pregnancy outcome among Somali immigrants in Washington state. *Am J Obstet Gynecol* 2005;193:475-482.
3. Vangen S, Stoltenberg C, Johansen R, Sundby J, Stray-Pedersen B. Perinatal complications among ethnic Somalis. *Acta Obstet Gynecol Scand* 2002;81:317-322.
4. Yoong W, Kolhe S, Karoshi M, Ullah M, Nauta M. The obstetric performance of United Kingdom asylum seekers from Somalia: a case control study and literature review. *Int J Fertil* 2005;50:175-179.

Awards

Congratulations to two MCHR staff were awarded their doctoral degrees in 2008. In May, **Michelle Kealy** graduated with a Doctor of Philosophy. Her thesis is titled 'Caesarean section – a response to risk and fear: an Australian study of women's experiences'. Then in October, **Mary-Ann Davey** graduated with a Doctor of Public Health. Her thesis is titled: 'Birth outcomes and maternal and perinatal morbidity associated with induction and augmentation of labour in uncomplicated first births'. Michelle and Mary-Ann are pictured here at their graduations, with supervisors and colleagues.

Michelle Kealy (R) with Rhonda Small, Helen McLachlan and Pranee Liamputtong

Mary-Ann Davey (R) with Judith Lumley and James King

Following submission of her PhD thesis in September, **Lyn Watson** has recently been given a La Trobe University Institute of Advanced Studies Writing-Up Award (October to December 2008). Well done Lyn!

Recent publications

In addition to articles mentioned elsewhere in this issue, staff have published the following papers since July 2008:

Amir LH, Donath SM. Socioeconomic status and rates of breastfeeding in Australia: evidence from the 1995, 2001 and 2004/5 National Health Surveys. *Med J Aust* 2008; 189:254-56.

Amir LH, The Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #4: Mastitis. Revision, May 2008. *Breastfeed Med* 2008; 3:177-80.

Cooklin AR, Donath SM, Amir LH. Maternal employment and breastfeeding: results from the Longitudinal Study of Australian Children. *Acta Paediatr* 2008;97:620-23.

Chin LY, Amir LH. Survey of patient satisfaction with the Breastfeeding Education and Support Services of The Royal Women's Hospital, Melbourne. *BMC Health Serv Res* 2008;8:83.

Donath SM, Amir LH. The effect of gestation on initiation and duration of breastfeeding. *Arch Dis Child* 2008;93:F448-50.

Donath SM, Amir LH. Maternal obesity and initiation and duration of breastfeeding: data from the longitudinal study of Australian children. *Matern Child Nutr* 2008;4:163-70.

Forster D, McLachlan H, Rayner J, Yelland J, Gold L, Rayner S. The early postnatal period: exploring women's views, expectations and experiences of care using focus groups in Victoria, Australia. *BMC Pregnancy Childbirth* 2008;8:27.

Hegarty K, Taft A, Feder G. Violence between intimate partners: working with the whole family. *BMJ* 2008;337:a839.

Jakobsson M, Bruinsma F. Adverse pregnancy outcomes after treatment vvfor cervical intraepithelial neoplasia. [Editorial] *BMJ* 2008;337:a1350.

Linford W, Forster D. Exploring women's reactions to a diagnosis of endometrial carcinoma: a pilot study of Australian women. *Aust J Adv Nurs* 2008; 26:34-41.

McLachlan H, Forster D, Davey MA, Lumley J, Farrell T, Oats J, Gold L, Waldenström U, Albers L, Biro M . COSMOS: COmparing Standard Maternity care with One-to-one midwifery Support: a randomised controlled trial. *BMC Pregnancy Childbirth* 2008;8:35.

McLachlan HL, Forster DA, Yelland J, Rayner J, Lumley J. Is the organisation and structure of hospital postnatal care a barrier to quality care? Findings from a state-wide review in Victoria, Australia. *Midwifery* 2008;24:358-70.

McNair R, Taft A, Hegarty K. Using reflexivity to enhance in-depth interviewing skills for the clinician researcher. *BMC Med Res Methodol* 2008, 8:73.

Natalier KA, Willis KF. Taking responsibility or averting risk? A socio-cultural approach to risk and trust in private health insurance decisions. *Health Risk Soc* 2008;10:399-411.

Rayner J, Forster D, McLachlan H, Yelland J, Davey M-A. What are the views and experiences of midwives working in hospital based postnatal care? Findings from a state-wide review of hospital postnatal care in Victoria, Australia. *Midwifery* 2008;24:310-20.

Watson LF, Lumley J, Rayner J-A, Potter A. Recruitment to research studies in maternity hospitals: An example from the Early Births Study. *Midwifery* 2008;24:509-20.

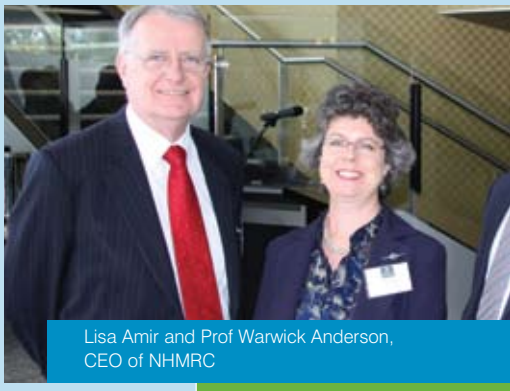
Willis KF. 'I come because I am called': Recruitment and participation in mammography screening in Uppsala, Sweden. *Health Care Women Int* 2008;29:135-50.

Wills G, Forster D. Nausea and vomiting in pregnancy: what advice do midwives give? *Midwifery* 2008;24:390–98.

Grants

Congratulations to **Lisa Amir** who has been awarded an NHMRC project grant of $751,600 for "A longitudinal study to determine aetiology of the condition known as "breast thrush" in lactating women" (also known as the CASTLE Study). Co-investigators are Judith Lumley, MCHR, Susan Donath, Murdoch Children's Research Institute, Suzanne Garland and Sepehr Tabrizi, Royal Women's Hospital and Catherine Bennett, The University of Melbourne.

This project looks at two common breast problems in breastfeeding women: "breast thrush" and mastitis (bacterial infection). Some health professionals believe "breast thrush" is caused by *Candida albicans* (thrush) while others believe it is caused by the bacteria *Staphylococcus aureus* ("golden staph"). This study will follow 400 women, from late pregnancy until two months after birth, to determine if *S. aureus* or *C. albicans* is the cause of "breast thrush" and to describe the transmission of these organisms between mother and baby.



Lisa Amir and Prof Warwick Anderson, CEO of NHMRC

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