President's Message

New Year ... New Plans!

I hope that the past six months have treated you all kindly. Here in the United Kingdom we are currently experiencing a mild but very wet winter. Many parts of the country have been affected by flooding with no signs of it abating. Summer seems a long way away in the northern hemisphere!

Since I last wrote, the executive committee has continued to communicate via email and Skype, and we are moving forward steadily with the action plan which resulted from our general business and committee meetings in Singapore. I am sincerely grateful to all of my fellow officers for their contributions.

In addition I have participated in a call of WCPT subgroup presidents and chairmen, and contributed to two surveys on behalf of the Organization.

In my last report, I mentioned this November’s WCPT European Region Congress in Liverpool, United Kingdom from 11th-12th November 2016, where Kari

Gill Brook
IOPTWH President

Continued…
President’s Message (Continued)

Bø will present a keynote speech. I am delighted to report that IOPTWH, along with our UK member group Pelvic, Obstetric & Gynaecological Physiotherapy (POGP) will host a networking session during the meeting, following the acceptance of our submission. Details will follow later this year. This promises to be a great congress, and I would encourage as many of you as possible to attend.

Plans are also underway for our involvement in next year’s WCPT Congress in Cape Town, South Africa from 2nd – 4th July 2017. Although the meeting seems a long way off, we anticipate a call for pre-and post-Congress course proposals within the next few months. The IOPTWH executive committee has already discussed this, and are also consulting our South African member group on the matter.

In case you missed the announcement late last year, the 2019 WCPT Congress will be held in Geneva, Switzerland though no further details are available to date.

Delegates and Friends of IOPTWH should by now be aware that we launched our new website www.iopth.wcpt.org on the 1st of January 2016. Following our long collaboration with CaduceusWebs, we took the decision to move to WCPT for various reasons. It will confirm our association with the Confederation and should increase traffic to our site as visitors to the WCPT website may well access our pages. In addition the change offers improved value for money to IOPTWH.

Finally, a message to our chief delegates and delegates. Thank you for your continued commitment to IOPTWH. We executive officers really appreciate your timely response to any emails that we send out, be that a request for your annual dues or information about your national group. Most recently you should have received an email concerning our consultation on the Organization’s name. We hope that you will consult your committees and membership about this, and complete our online survey. This is the way to ensure that any decision agreed by our executive committee is only taken after considering your views.

My very best wishes to you all.

Gill Brook

Pictures featuring IOPTWH executive meeting with member organizations in Singapore 2015.
**Treasurer’s Message**

Dear Members

I am writing to you as the new Treasurer for IOPTWH. Luckily Ros Thomas has graciously been assisting the seemingly difficult transition of bank paperwork and bill payments from 2015 WCPT congress, so that I can start fresh with this year’s dues and bill payments.

Our current funds total **£2258.20 GBP**. We expect our website costs to be dramatically reduced as of this year with our recent move to a new website platform off the WCPT site.

My first task will be collection of 2016 dues. I respectfully ask that all Member countries please pay their dues on time so as to allow us to pay 2016 expenses in a timely fashion. With the plans for WCPT 2017 in Capetown beginning, we will need funds to sustain projects and programming for this meeting.

Please look out for a message regarding dues payment in February from Ros and myself, and then follow-ups after that as needed.

I look forward to acting as your Treasurer and to continued communication with you.

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**Secretary’s Message**

Kia ora from New Zealand where we are in the grips of an El Nino weather pattern and having very hot and sunny weather.

I’m still in the learning stages of the role of secretary, having taken over from Gill in May 2015 at the wonderful WCPT Congress in Singapore. She has been a great help with handing over the tasks and has been very patient with all the requests for information from myself.

Over the last six months my focus has been on setting up systems to enable electronic saving and sharing of documents related to the committee work, reviewing strategic plans and the governance manual. This background work will ensure smooth processes over the next few years and when handover is needed it should be simple. I’ve also been updating delegates and friends lists so if you haven’t been getting group emails from me please let me know to ensure I have you on the list.

After the Congress it was clear that a number of member countries were going through changes regarding their group name (New Zealand being one of these). Good debates were had by different members during break out social times over the length of the congress itself, and it was also discussed at the Organization’s general business meeting. In response to this, the committee is now seeking input from all members regarding potential name changes – this is being done through survey links sent out to all delegates in early January. Please respond by June to ensure you can contribute the thoughts from your country.

I look forward to your emails over the next few years, if you have any questions please get in touch.

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**Social media**

Within the July edition of the IOPTWH Newsletter, president Gill Brook reported that the IOPTWH executive committee would be considering the potential use of social media e.g. Facebook, Twitter following a discussion on the subject at our General Business Meeting in May. Since then, our officers have discussed the pros and cons of such a development, and monitored activity on both national and international forums.

During our most recent executive committee conference call we reached the decision that we shall not develop an IOPTWH presence on either Twitter or Facebook at present. There are various reasons for this, including the ongoing volume of work such a venture would involve. However, the decision was also based on our belief that the national and international Facebook groups that we monitored work very well to meet the needs of physiotherapists with an interest in our specialty. We do not think that a specific IOPTWH presence on social media will add any value.

We shall, of course, remain open to new ideas and potential developments and welcome your comments.

Kind regards
Melissa Davidson
IOPTWH Secretary

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Contributions to the newsletter are welcome, please contact the editor:

Hana Al-Sobayel
Saudi Physical Therapy Association
h.alsobayel@gmail.com
Women’s Health Physiotherapy Facebook Group: Using Social Media to Promote International Collaboration and Discussion.

By Gerard Greene, MSc Manip Physio, MMACP, MCSP, PG Cert H Ed*

Women’s Health Physiotherapy Facebook Group

The Women’s Health Physiotherapy Facebook group was set up in December 2013 by Gerard Greene and Michelle Lyons. It has grown to become a leading International women’s health Facebook group with approximately 4000 members from all the WCPT regions. The members comprise women’s health PT clinicians, tutors, researchers, academics, post graduate and undergraduate students. It has also reached out to midwifery, oncology, urogynaecological, obstetric and pregnancy related exercise professionals. An abstract on the group was presented as a poster presentation at WCPT 2015 in Singapore.

Evolvement of Social Media in Women’s Health Physiotherapy

The group is now well established with members from the CSP, ISCP, APTA, APA, CPA, NZPA and other WCPT member organisations. There are daily postings of discussions relating to clinical practice, research and education. It facilitates sharing of resources such as clinical guidelines, patient resources, podcasts, blogs, research papers and webinars.

The Facebook group supported the first International women’s health Tweet chat with the UK based Physio Talk group www.physiotalk.co.uk This was led by Irish women’s health PT Teresa Costello. The #globalpt hashtag was launched at WCPT 2015 and the first tweetchat was organised by the APA and Joanne Millios (@Prostatejojo) and focused on Men’s Health Physiotherapy. This ran for 24 hours involving physios from all the WCPT regions and helped to raise the profile of Men’s Health Physiotherapy.

A Blog relating to the group was also established in June 2015 and been accessed from PTs in over 75 countries. It has also featured guest blogs from some of the World’s leading WH PTs and has become a key source of high quality free accessible CPD. https://womenshealthphysio.wordpress.com

The world of pelvic Physiotherapy has also embraced the use of podcasts as a medium to disseminate information. The leading Pelvic Physiotherapy Podcasting site is http://physiodetective.com by Australian PTs Antony Lo and Lori Former. The APA released the 1st podcast focusing on Men’s Health Physiotherapy in November 2015. A Men’s Health Podcast was also launched by the UK based MACP in
December 2015 with Dr Ruth Jones and Mr Bill Taylor from the UK. www.macpweb.org

The women’s health group has also forged international links with other leading Facebook groups such as Australian Physiotherapy Continence and Women’s Health Group, Men’s Health Physiotherapy group and the Oncology in Physiotherapy Group.

The group recently established a Twitter feed @womenshealthfb which has approximately 1400 followers. The twitter feed has allowed further engagement with the wider international physio community and other health professionals such as midwives, continence advisors, medics and pregnancy related exercise professionals. The twitter feed also encourages engagement with women’s health related conferences through the promotion of the conference #. The feed also allows engagement with the wider public and health community to promote the role of women’s health physiotherapy.

Who to follow on Twitter. Here are some examples but who you follow will depend on your areas of interest:

Dr Emma Stokes @ekstokes
WCPT @WCPT1951
POGP (UK Special interest group) @ThePOGP
APTA Women’s Health Assoc @womens_PT
Jo Millios @Prostatejojo
Stephanie Predergast @PelvicHealth
Elaine Miller @GussieGrips
Marianne Ryan @MarianneRyanPT
Sandy Hilton @SandyHiltonPT

* Physiotherapy lecturer in Coventry University, UK & Women’s Health Tutor
Email: gerard@greenephysio.co.uk
@gerardgreenephy | @womenshealthfb
The following two articles that appear in the newsletter have been submitted by Australia and New Zealand. To help share the task of producing the newsletter the committee will ask a different region every six months to assist in providing articles for inclusion.

This means that each region will be approached every three and a half years. Hopefully this will spread the load and also provide a richness in diversity.

The WCPT Regions (and IOPTWH group members) are:

- **Asia Western Pacific** - Australia, Hong Kong, Kuwait, New Zealand, Saudi Arabia
- **Africa** - Nigeria, South Africa
- **Europe (1*)** - Croatia, Denmark, Finland, Germany, Ireland
- **Europe (2*)** - Israel, Netherlands, Norway, Portugal
- **Europe (3*)** - Slovenia, Sweden, Turkey, United Kingdom
- **North America/ Caribbean** - Bermuda, Canada, United States of America
- **South America** - Brazil, Chile

*As there are so many IOPTWH members within the European region we have subdivided them into 3 groups

If we move in a clockwise direction we look to Africa for a couple of articles for the next newsletter due out at the end of July. Please remember that the article does not have to be original as it is not appearing in a peer reviewed journal. The Australian article was reprinted from their local E News. The committee do not want this to be an onerous task and will happily provide support to all member regions.
PATIENT BROCHURES & RESOURCES

Information sharing
At the IOPTWH General Business Meeting (GBM) earlier this year, Doreen M-Clurg, United Kingdom chief delegate, asked about the possibility of sharing patient information literature in different languages. There was agreement that this would be a good idea as many of us see patients who have migrated from other parts of the world, and are not fluent in the native tongue of their new country of residence. The executive committee discussed the matter further at a conference call in late 2015. To facilitate the sharing of brochures and resources designed for patients and the general public, we agreed on the following action.

If your national group (or other groups within your country) have any such information leaflets or brochures, or other resources that you/they are happy to share, please contact IOPTWH secretary Melissa Davidson (melissa@remarkablephysios.com). She will create a link via the IOPTWH website to any suitable information that she receives.

Also, take time to look at www.continence.org.au. This site offers some wonderful resources for pre and post pregnancy, and the treatment of bladder and bowel dysfunction. The resources are available in 28 LANGUAGES including Mandarin, Serbian and Persian to name just a few. The fact sheets cover BLADDER AND BOWEL function, dysfunction and treatment. There are also some fact sheets more specifically for the treatment of WOMEN, MEN and CHILDREN.

Translation services
In addition to the matter of information sharing amongst IOPTWH member countries, there was discussion at the GBM about help with the translation of resources into different languages. Hana Al Sobayel (chief delegate for Saudi Arabia) said that she had experience of this and it was agreed that the executive committee should put out a call to the membership to see if anyone else has been similarly involved, or knows of others who offer such a service. The executive committee can then consider this further. Please contact Melissa Davidson if you have information.

IOPTWH – Consultation with Membership on the Name of the Organization

In early December 2015 we sent all delegates of IOPTWH an email about our plan to consult member organisations regarding a name change for IOPTWH. This was in response to comments from members that the name International Organization of Physical Therapists in Women’s Health does not reflect changes to clinical practice that have occurred over the last decade in many countries.

To facilitate the consultation process, we are gathering information using a simple online survey to answer 5 questions:

1. Do you think that IOPTWH should consider a name change?
2. What is the reasoning behind your answer to Q1?
3. If there is agreement that a name change is indicated, does your group have any suggestions on what that name might be (please give details)?
4. What is the current name of your national IOPTWH member group?
5. If your group previously had a different name or names, please list them.

Please discuss the matter within your country’s executive committee/board/group over the next few months and consult with your membership. Once you have completed your consultation, please have an appropriate person complete ONE response to the online survey for your organisation using the survey link. Please complete your response before 30th June 2016

If you have any questions, please contact us.

Kind regards

Gill Brook – IOPTWH President & Melissa Davidson - IOPTWH Secretary
We would like to encourage more international physiotherapists who are conducting original work to consider submitting for publication. We are interested in receiving all styles of high quality research from well written and interesting case studies to audits, reviews and RCTs. We can also publish posters with abstracts. All submissions are taken through the peer review process and feedback given as the high standard for publication must be met. Guidelines for writing are available online http://pogp.csp.org.uk/documents/acpwh-journal-writing-guidelines

We look forward to publishing more original research from around the world.

**POGP membership and journal subscription**

Paper copies of the journal are delivered to all members and affiliates as part of the membership package. See http://pogp.csp.org.uk/pogp-membership for a full list of benefits.

There are two categories of membership available to international physiotherapists plus it is now possible to purchase journal subscription without membership for both individuals and libraries. We hope you enjoy reading the journal.

**Membership £67.60**

Membership is available to annually subscribing members of the CSP and to international physiotherapists who do not reside or work in the U.K. The international physiotherapists must be members of their country’s physiotherapy governing body. The physiotherapist must also have successfully completed a post-registration Course in Women’s Health or Continence. Please see http://pogp.csp.org.uk/pogp-membership for details of acceptable courses and portfolio route for membership.

**Affiliate membership £67.60**

Affiliate membership is available to annually subscribing members of the CSP who are not full members and to International physiotherapists who do not reside or work in the UK, provided that the physiotherapists are members of their country’s physiotherapy governing body.

**NEW- Journal Subscription** is available without membership (no access to member’s area of website or EOC)

- Individuals £67.60
- Libraries and other institutions £75
- Postage charges for all categories above
  - EU postage £6.50
  - International postage £10.50

Please contact me for further information or to submit your work. I look forward to hearing from you.

Contact info@fitwise.co.uk to order journal subscription and membership
Background
Despite growing awareness of the dangers to health and the infringement of human rights, the practice of female genital mutilation (FGM) persists, in declining numbers, but with some changing trends. The two most disturbing are a lowering of the average age at which girls are subjected to the practice and the medicalization of the procedure. Younger girls are less likely to resist and by having a healthcare professional perform the cutting, some parents believe that the procedure is safer, thus mitigating the risk of adverse health effects. In the same report The World Health Organization (WHO) reports that 18% of all women who have undergone FGM have done so at the hands of healthcare providers, with this trend increasing in all practicing countries. Dr Marleen Temmerman, Director of the WHO Department of Reproductive Health and Research, suggests that education about the health risks of FGM has resulted in many families choosing a clinical environment rather than the traditional context. She also warns of the danger of practicing milder cuts in the knowledge that the majority of health risks come from type III FGM (infibulation). Dr Temmerman states that it is imperative the practice in all its forms is abandoned.

Tradition is often quoted as the reason for the persistence of FGM, just as slavery, foot binding and other inhumane practices were once defended. The convention model is credited with ending the practice of foot binding in China in the early 1900s. And it is this model, using collective change and public declarations, reported by non-government organizations such as Tostan to have had the most success in the abandonment of the practice in parts of Africa.

FGM is defined as procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. A classification of FGM was first drawn up by the WHO in 1995 and then modified in 2007 noting that there is inevitably simplification because of the difficulties in reflecting vast variations in the practice from traditional cutters in villages with young girls held down by female relatives as part of a traditional ceremony, to the sterile conditions of an operating theatre by a health professional.

International survey of physiotherapists
Since many of the long-term effects of FGM are within the scope of practice of Women’s Health Physiotherapists the IOPTWH conducted a survey of its member countries in 2010 to determine if women who have undergone FGM are receiving physiotherapy and to identify any current research or the level of interest in such research. Survey Monkey was the tool used. This survey showed that approximately 13% of 423 respondents had treated women with FGM mostly in small numbers of up to 4 per year with some treating 20 or more. Urinary incontinence, perineal trauma/tears in childbirth, dyspareunia, post-partum urinary problems and chronic pain were the conditions for which treatment was most often sought. A synopsis of this survey has been communicated to the WHO.

Because the worldwide survey showed that the United Kingdom (UK) was the country in which the most women were treated by physiotherapists, a further survey was conducted in this country during March/April 2015 and the results are reported below.
2015 UK Survey

Overall numbers
This survey, with a total of 109 respondents, showed that 21% had treated women or girls for the effects of FGM, concurring with the percentage result in the first survey.

Numbers treated in practice
Of those respondents treating women or girls with FGM, 73% treated numbers ranging 1-4, 11% treated 5-9, 4% treated 10-14 and 11% treated 20 or more. Unfortunately this question did not specify the time frame; the first survey had asked approximately how many women were treated per year.

Reasons/symptoms treated (see chart 1)
Urinary dysfunction and postnatal perineal trauma were the reasons for most referrals, followed by dyspareunia, chronic pain and postnatal urinary dysfunction. These results are almost identical to the worldwide membership survey; the only difference being that in the United Kingdom chronic pain was treated with a higher frequency than postnatal urinary dysfunction. Other reasons included functional bowel disorder, faecal incontinence and pelvic organ prolapse.

Referrals
64% of referrals were from specialist obstetricians & gynaecologists followed by family doctors (28%) then midwives (24%). One comment mentioned a new service for specialist midwives enabling them to refer women and girls directly to physiotherapists for symptoms relating to the practice of FGM.

Treatments (see chart 2)
Pelvic floor muscle exercises were included in 96% of treatments, followed by biofeedback (32%), myofascial release and trigger-point pressures (28% each), facilitation techniques (24%) and muscle energy techniques (16%). Additional treatments in the comments box included anal biofeedback, perineal massage, scar management, bladder training and electrical stimulation.

Classification of FGM
The 2007 WHO classification of FGM, documents 4 types:
Type I: (clitoridectomy) partial or total removal of the clitoris and/or the prepuce.
Type II: (excision) partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III: (infibulation) narrowing of the vaginal orifice with the creation of a covering seal by cutting and apposition of the labia minora and/or the labia majora, with or without excision of the clitoris leaving a pencil sized common orifice for menstruation and urination. This may lead to slow and painful menstruation or bladder emptying drop by drop. Another consequence of infibulation is the difficulty of initiating sexual intercourse by penetration or which may only be possible surgically by defibulation.
Type IV: unclassified
All other harmful procedures to the female genitalia for non-medical purposes: e.g. pricking, piercing, incising, scraping and cauterization.
**Episodes of care**
This question related to the different reasons for treatment of the same women (e.g. urinary incontinence and postnatal perineal trauma) and 55% of those treating women with FGM responded that 3 or more episodes of care were required.

**Education of therapists**
45% of the UK respondents had attended lectures on the subject, but not specifically on physical therapy and FGM. Such sessions were reported as having the effect of increasing knowledge and awareness as well as understanding of legislation against the practice of FGM in the United Kingdom. This included raising awareness of the responsibility of reporting any knowledge of the practice being carried out in the UK to appropriate authorities.

**Perceived barriers to treatment (see chart 3)**
Many barriers to treatment were identified. One comment suggested a reluctance to acknowledge and refer to physiotherapy by other health professionals.

**Awareness of migrant populations**
47% of respondents were aware of migrant populations residing in their area of practice.

**Survey summary**
There is a paucity of research concerning the effectiveness of physiotherapy for women with symptoms relating to FGM. Currently best practice is extrapolated from evidence-based research data for the efficacy of pelvic floor muscle training and other modalities for urinary dysfunction not related to FGM. In the first survey of the IOPTWH worldwide membership in 2008, only one person reported being actively involved in research. However, a large number of therapists did express an interest in such research.

There are now case reports documenting the use of biofeedback and pelvic floor exercises. Abdulcadir et al. writing in the British Medical Journal in 2013 have reported the use of biofeedback re-educative therapy in a case report of ‘Overactive bladder after female genital mutilation/cutting (FGM/C) type III’. Dr Abdulcadir states, in correspondence, that in her hospital in Geneva midwives trained by physiotherapists carry out the therapy. The same author, in her paper on ‘Research gaps in the care of
women with female genital mutilation,\textsuperscript{10} stated that ‘further studies could evaluate long-term postpartum complications such as the prevalence of incontinence postpartum or the effectiveness of treatments (e.g. biofeedback or Kegel exercises)’. She suggests that perineal re-education could improve not only the lower urinary tract symptoms and dyspareunia, but also a woman’s self-knowledge. Research in evidence-based physiotherapy care for women and girls with FGM and validated outcome measures are needed.

\textbf{References:}


2. Ibid


5. Ibid

6. \url{http://www.tostan.org/female-genital-cutting}


8. Ibid


Pregnancy-related pelvic girdle pain (PPGP) affects around 20 per cent of women at some point during pregnancy (Vleeming et al 2008, Wu et al 2004). It is theorised to result from increased burden on the lumbar spine, stretching and weakening of the abdominal and pelvic floor muscles (PFM), hormonal effects on the pelvic ligaments, and altered motor control around the lumbopelvic region (Lee et al 2008 & Vleeming et al 2008).

Pelvic floor dysfunction (PFD), including stress urinary incontinence (SUI), occurs in about 30 per cent of all primiparous pregnant women (Hansen et al 2012). This is postulated, not unlike PPGP, to be due to stretching and weakening of fascia, ligaments and muscles that support and control the bladder neck and urethra (Liang et al 2012).

It has been suggested that there may be a connection between these two common conditions. The focus of this literature review is to evaluate evidence to support or refute this hypothesis by Fitzgerald et al 2012 in their paper, ‘The association between pelvic girdle pain and pelvic floor muscle function in pregnancy’. The main reason this paper was chosen was due to its participants being pregnant; most other studies that look at PPGP and PFD are performed on the postnatal population and even then the evidence is sparse at best.

Fitzgerald and Mallinson (2012) is a cross-sectional study, which is preferable when looking at normal population groups as these studies can collect and then analyse a number of outcomes at once. Currently there is little literature relating to the effect of PFD on PGP in pregnancy. Most of the available literature analyses postnatal subjects and uses these results to hypothesise what occurs in the pregnant population.

For the purpose of evaluating the quality of this paper, a checklist developed by Hicks entitled ‘Research Methods for Clinical Therapists’ (2009) was used.

Overall, we found the quality of the study to be high. The selection of a cross-sectional study design is clear and appropriate for the objectives of the study. Most participants were highly educated and Caucasian, which was a potential source of bias but also aligns closely with a particular section of the Australian population that we may treat. Numbers in the PPGP and the group without PPGP were evenly matched for age, level of education, parity and past medical history, meaning that this potential bias probably would not affect the results of the study. The study was explained clearly, making it easily reproducible, with all questionnaires standardised and easily accessible via the references supplied.

Fitzgerald and Mallinson’s personal health information questionnaire (2012) was not referenced but was supplied in table form. This could potentially hinder exact reproduction of the questionnaire in future studies. Another issue that would restrict replication of this study was that the directions given to the participants prior to assessing their pelvic floors were not standardised or recorded. The clinician performing the physical examination was also not blinded to the participant’s pain status. However, this was acknowledged in the discussion section of the paper.

One of the major issues with this paper was that the statistics package used to formulate the results was not mentioned, therefore making the statistics impossible to analyse objectively.

However, the results and conclusions are clearly stated—there is an association between PPGP and deep but not superficial PFM tenderness in pregnancy (Fitzgerald, & Mallinson, 2012). They found no significant difference in PFM function between PPGP patients and patients without PPGP. However, these results were not deciphered completely as five of the questionnaires that were filled in were not reported upon.

The main limitations in this study are noted in the discussion including a small homogenous sample group, single examiner not blinded to pain.
status and use of subjective clinical physical examination. Recommendations are put forward for future research to include blinding of the examiners, objective measures of PFM strength and testing in more functional positions when PPGP is triggered (using vaginal EMG whilst performing active straight leg raise).

Results have been interpreted with these limitations in mind. Practically, it can be assumed from this study that there may be a relationship between PFD and PGP in pregnancy and it is something for physiotherapists to consider when treating patients who present with these conditions. However, more studies, with larger cohorts, are needed to definitively accept this association.

References


IOPTWH EXECUTIVES

President
Gill Brook, UK
president@ioptwh.wcpt.org

Vice President
Darija Šćepanović MSc PT, Slovenia
vp@ioptwh.wcpt.org

Secretary
Melissa Davidson, New Zealand
secretary@ioptwh.wcpt.org

Treasurer
Meena Sran, Canada
treasurer@ioptwh.wcpt.org

Member-At-Large
Robyn Willcock, Australia
member@ioptwh.wcpt.org

Newsletter Editor
Hana Alsobayel, Saudi Arabia

http://www.wcpt.org/ioptwh

IOPTWH Office:

IOPTWH
Gill Brook
Burras Lynd
Burras Lane
Otley, West Yorkshire
LS21 3ET
England
UK