Victorian Medical Women's Society
Newsletter
Founded 1896
Celebrating our history, advancing our future
Volume 6, Issue 2 April 2008

President's report: Dr Jan Coles

I sit writing this report on International Women's Day. In Victoria it is the centenary year of women's suffrage, with white Victorian women being granted the vote in 1908.[1] Women have forged ahead, achieving excellence across diverse fields of endeavour, many of those who made a difference have been members of VMWS and their stories, and those of other medical women who have made a difference are shared with you in the Marvellous Medical women section of this newsletter.

As I reflect on International Women's day, two of my professional mentors come to mind, both are women. These women inspired me to think outside the square, to challenge and think differently, to be prepared to advocate for patients. Both of them opened doors for me, not to a bigger and better job, but doors to new ways of thinking and seeing the world. Both were exceptional teachers, who taught by expanding my mind's horizons rather than by making me feel small. What an extra ordinary gift they both gave to me. I was thrilled to see one of these women, Professor Jill Astbury honoured for her work on gender based violence at the weekend.

Many of my colleagues have similar stories, different women who have inspired them for different reasons, but crucial in their development as medical women.

In 2007, ten of the founders of the Queen Victoria Hospital were honoured, Dr Constance Stone was honoured in 2001. Many of these women were foundation members of VMWS, they were remarkable and visionary women who established a hospital when women doctors were "unemployable" and offered better health services to the women of Victoria.

The Victorian Women's Honour Roll 2008 celebrates thirty women who dared to make a difference; empowering, supporting and inspiring others, their stories can be viewed at www.women.vic.gov.au or as a multimedia presentation from www.theage.com.au.

I wonder what the future holds for our current members, who will inspire and who will make a difference?

2008 VMWS Committee

Jan Coles	President, AFMW representative	**Natalie Marijanovic**	AMA Representative
Marilyn Jones	Vice President	**Raie Goodwach**	General Committee
Jill Tomlinson	Treasurer, Web	**Kathleen Hayes**	General Committee
Mariolyn Raj	Secretary	**Ivy Tan**	Med Student Rep (Monash)
Desiree Yap	Immediate Past President, AFMW representative	**Linny Kimly Phuong**	Med Student Rep (Melb)
Deb Colville	AFMW national co-ordinator	**Jenny Huang**	Med Student Rep (Melb)
Julie Teague	Social Secretary	**Shueh Hwuei Lim**	Med Student Rep (Melb)
Laura Edwards	Social Secretary	**Carnjini Thambaiya**	Med Student Rep (Melb)
Kate Duncan	Western Pacific Congress Convener	**Javeriah Siddiqui**	Med Student Rep (Melb)
		Bronwyn Scarr	Med Student Rep (Melb)

[1] Aboriginal Australians were given the option to vote in federal elections in 1962, but state voting rights were varied.

VMWS Medical Adventures Night

Join us for inspiring tales of international medical adventures.

Speakers include: Dr Barbara Martin and Dr Annette Holian.

Date: Tuesday 27th May
Time: 7pm – 10pm

Venue: St Vincent's Hospital Melbourne, 11th Floor conference room, Victoria Parade, Fitzroy.

Cost: - Attendance free for VMWS members, Non-members $15. Food and drinks provided.

RSVP (essential): by Tuesday 20th May. Email vic@afmw.org.au or SMS your details to 0416 456 316

Sexual Abuse in Religious Contexts: An Interdisciplinary Conference

University of NSW, Sydney
June 20-21, 2008
A 2 day workshop with experts in psychiatry, psychology, philosophy, ethics, law, theology, indigenous studies, religious studies and social sciences, examining the issue of sexual abuse and exploitation in religious contexts.
For more information visit:
http://www.ranzcp.org

WONCA Asia Pacific Regional Conference

Melbourne, October 2-5
With the RACGP 51st Annual Scientific Convention and hosted by the Royal Australian College of General Practitioners
Conference theme 'A celebration of diversity'.
For more information visit:
http://www.wonca2008.com

2008 VMWS Event Calendar

Fight Like A Girl Self Defence for Medical Women Seminar - Sunday April 6th
Join us at the FLAG training centre in Brunswick where Adori Bubble will instruct us on the techniques of Tactical Krav Maga. Contact VMWS now to register!

Adventure Medicine Meeting – Tuesday May 27th
Join us for dinner and inspiring tales of international medical adventures – details above.

Financial information evening - June
An informative evening presented by Caroline Poon and Jo Dawson on behalf of Medical and Dental Accounting. Come along to find out more about the importance of Asset Protection, Family Trusts, Managing your Mortgage and the basics of Personal Insurance.

Lyceum Luncheon - Wednesday July 16th
Held in the grand Lyceum Club, this annual event allows a break from the winter hustle and bustle. A chance to catch up with old friends and meet some new ones too!

Women Doctors, Lawyers and Barristers evening - September
Revived in 2006, this long standing annual event is an opportunity to share stories with our professional colleagues.

MWIA Western Pacific Congress - October 17-19th
Join with medical women from around the Western Pacific to be inspired, amazed and invigorated by this exciting Regional Congress. This event will include the VMWS Annual General Meeting.

How We Do What We Do – March 4

Security tips, packing lists and the importance of mums were just some of the messages that came across in the recent VMWS event "How we do what we do".

A/P Robyn Langham

Associate Professor Robyn Langham, Director of Nephrology at St Vincents Health started her speech saying "I'm not really sure why you asked me of all people to speak tonight" before giving a humorous and personal viewpoint of how she manages to juggle children, a demanding job, innumerable committee positions and still have time to catch up with old friends.

Dr Chris Drummond, Specialist in Public Health and Infectious Diseases with a Masters in Applied Epidemiology spoke second of her career dedicated to International medicine. She has worked extensively overseas in countries as varied as Cambodia, Sudan and the Maldives for a variety of organisations including the Red Cross and the World Health Organisation.

Dr. Chris Drummond

She encouraged all to pursue the career that they are most passionate about and if intending to work overseas gain as much relevant experience as possible before leaving. She finished with the quote: "*Do what you think you were put on this Earth to do".*

This evening is always open to the interpretation of the speakers and we give thanks to both Chris and Robyn who inspired us with their confidence and dedication to their chosen careers.

Laura Edwards – Social Secretary, VMWS

Borrowing to invest through your superannuation fund

In our last newsletter we featured an article regarding borrowing to invest through your superannuation fund. There has been lots of press in relation to this in recent times and we thought it opportune to discuss this in more detail now.

Up until now there have been very few opportunities for funds to borrow directly (although they have been able to borrow indirectly via geared investment funds and listed and unlisted trusts and companies).

A superannuation fund can now borrow through a structure known as an 'instalment warrant'. This is simply a way in which to gear/borrow on a limited recourse basis property or shares. A non recourse basis means that in the event of the superannuation fund defaulting on repayment of the loan, the lender only has the right to recover an amount up to the value of the investment that is subject to the loan. Instalment warrants are not a new invention and have been around with the large institutional banks for many years.

The borrowings can be made by a bank, related party or someone else. The legislation provides the investment is held on trust for the superannuation fund so the superannuation fund has a beneficial entitlement to the investment. It has the right to acquire the ownership of the investment or its replacement.

The trust can be a bare trust or a unit trust and we like the idea of a bare trust. This means that the trustee simply holds the investment and transfers it to the beneficiary (the self managed superannuation fund) at the appropriate time. This is the most cost effective vehicle as the asset is simply shown in the balance sheet of the superannuation fund e.g. "Instalment Warrant (on property)" It should be noted that the trustee/s of the bare trust cannot be the same as the trustees of the superannuation fund. We recommend that if mum and dad are the trustees of the superannuation fund then just mum (or dad) can be the trustee of the bare trust.

Repayments are required to be made by the superannuation fund on an arms length and commercial basis (we would recommend monthly). When the last payment is made the investment is transferred to the superannuation fund.

If the superannuation fund defaults on the loan, the lender's right to recoup the amount outstanding is limited to the value of the property i.e. there is no access to other assets owned by the superannuation fund. For example a property is bought for $500,000 and the superannuation fund has borrowed $400,000 to purchase this. It is then sold for $350,000. The lender can only get $350,000 back and the loss of $50,000 will be borne by the lender.

The instalment warrant can invest in any asset that is allowable under SIS legislation e.g. commercial or industrial property, residential property and listed and unlisted shares.

Only one asset can be held in each trust for the superannuation fund. To this end we really only recommend property be held this way. If you have a large parcel of only one blue chip share, this is not spreading the risk or diversifying your investments!

What happens if the superannuation fund is unable to pay or does not continue to pay the loan? The lender may force the sale of the asset to recoup the value up to the amount of the outstanding loan. The legislation is yet to address refinancing.

Which clients can benefit from this type of investment?

1. Clients who are sole traders so cannot borrow to fund superannuation contributions and claim an interest deduction on the borrowings.

2. Clients who are employed who can't get extra money into super by way of spouse employer contributions who wish to use gearing in superannuation but can't contribute. Clients around 40 or younger who wish to bring forward the

purchase of property via superannuation earlier. By getting into the property market earlier, you accumulate unrealized capital gains and then sell the property at 60 tax free once you are in allocated pension mode. Those that have reached the concessional ($100,000 for 50 and over or $50,000 for under 50's) or non concessional ($150,000 undeducted per annum or $450,000 undeducted prior to 65) caps. If you or a related party make a loan to your superannuation fund, your fund will not get caught up in penalties that apply if you have the potential to breach these caps.

Personally I still prefer the more direct ways of investment to more or less achieve the same effect.

1. Borrow to fund employer contributions to superannuation and get a tax deduction and buy the property outright in the superannuation fund
2. Buy a property as tenants in common between the individual and the superannuation with the security for the individual's borrowings on a property other than the one that will be part owned by the superannuation fund.

However these arrangements are not available to part of our client base e.g. employees, self employed (if borrowings are required to get contributions into super), etc. Financial modeling is a must to prove that this type of investment adds value to your overall wealth strategies. Product providers are starting to emerge and it will be interesting to see interest rates on these loans, lending to valuation ratios (predicted to be between 40 to 70%). We would envisage that personal guarantees will be required also.

We will be organizing some informal seminars in relation to this particular topic using working scenarios based on actual client circumstances (with the identity of the client/s disguised of course). Further information will be advised once we know what the banks/financial institutions are offering regarding lending on instalment warrants.

The contents of this newsletter are general in nature and are not advice that applies to any particular client situation. Whilst every care has been taken in preparing the newsletter, specific advice should be obtained before proceeding with any suggestion or recommendation made in this newsletter.

By Caroline Poon, Director, Medical and Dental Accounting Pty Ltd.

Marvellous Medical Women Project

Members of the Victorian Medical Women's Society who graduated from medical school between 1930-1970 will be asked to participate in this project. The aim is to explore and record the experiences of women doctors for future generations of medical women.

Medical students will contact members on the VMWS mailing list by telephone or by mail over the next twelve months to explain the project, send out a detailed description of the project and to arrange an interview time. The interview is expected to last 1-1 ½ hours and asks you basic biographical details, medical training and career details, reflections on your career in medicine and the role of VMWS.

If you **do not wish to be contacted** please fax this form back to 95334214, telephone Dr Jan Coles on 8575 2226, or email jan.coles@med.monash.edu.au within two weeks.

Name: ……

☐ I **do not wish** to participate in this project.

With our thanks
Dr Jan Coles and Dr Jillian Tomlinson

Dr Mamta Gautam, MD, FRACP(C)

Dr. Mamta Gautam is an internationally known expert and speaker on physician health who treats exclusively physicians in her clinical practice. Dr Gautam is also the current President of the Ottawa branch of the Federation of Medical Women of Canada. Her excellent website http://drgautam.com contains many resources for medical professionals. Dr Gautam has given VMWS permission to include excerpts from her work in our newsletter; we share these with thanks and gratitude.

5 Early Warning Signs of Serious Stress

Increased physical problems and illnesses:
Under stress, your immune system is not able to function at its optimal level. You are more susceptible to illnesses, such as viral infections, and these occur more frequently and seem to last longer. Preexisting physical problems will be exacerbated, and become more difficult to control using your current regimen.

Increased problems with relationships:
As you become more frustrated and irritable, your usual patience is tested. You are not as easy to get along with. You seem to overreact to situations, and become easily angered. This occurs both at home and at work. You have increased negative thoughts and feelings, about things and people that you previously enjoyed. It becomes difficult to remember what you saw in them to begin with - you become more critical, and less content.

Increased unhealthy behaviors:
We all have some "bad habits," some things that we know we should not do, but do anyway, rarely. When stressed, these behaviors increase in frequency. Sometimes, it is what we do that is unhealthy-overeating, spending too much, smoking, drinking, gambling. Other times, it is what we stop doing that was good for us-exercising regularly, eating health, talking with friends, laughing.
Inability to continue to push ourselves:
We have learned to give up our own needs, and continue to do the right thing. Most physicians function under an amazing amount of stress, and are likely at the threshold into exhaustion, and cannot keep going as before.

The Three Stages of Burnout

1. Emotional Exhaustion
In this initial stage, people are still able to continue at work, but feel emotionally drained. They go through the paces, and appear to be functioning as normal, but have little or no reserve. The inter personal interaction is the hardest. For physicians at this stage, we see increasing impatience, frustration and irritability; both at work with patients, staff and colleagues, and at home with partners, children and friends.

2. Depersonalization
At the end of the workday, we have nothing left to give. Since interacting with others is so draining, and we feel exhausted, we start to avoid others, and depersonalize when we are among other people. It seems easier to pull away, than to stay and deal with them.

3. Decreased Sense of Personal Accomplishment
At this advanced stage, physicians no longer enjoy work, find little of the usual satisfaction in dealing with patients and practicing medicine. It becomes hard to remember what it was about medicine we liked. Physicians at this stage often think about leaving medicine entirely. Actually, we should reassess and reconsider what we are doing at work about every seven years, and make minor adjustment; such as the number of patients we see, the hours that we work, location of the practice, or the focus of our practice. However, this is a healthy, positive, proactive process, unlike the last stage of burnout, which is purely reactive.

Twenty Training Tips To Deal Better With Stress

1. Take care of yourself first.
2. Get your own family doctor.
3. Learn about time management.
4. Set priorities.
5. Anticipate and prepare for situations.
6. Consider and use options.
7. Learn to say NO.
8. Add fun to work.
9. Plan for transition times.
10. Don't take you work home.
11. Take regular time off.
12. Use support systems.
13. Share your stories.
14. Remember the 90: 10 rule-only 90% of your reaction is from the past; only 10% is due to the situation you are currently dealing with.
15. Set realistic expectations.
16. Learn a relaxation technique.
17. Laugh more often.
18. Take solo time.
19. Plan your finances.
20. Let go of the guilt.

Two Lessons

By: Victoria Sasongko, Med III, Uni of Melb

During the summer holiday last year, I went back to Indonesia for three months. I got a chance to sit in my father's practice and fill in as a clinical assistant. I learned a lot clinically, seeing him doing Ultrasound, Pap smear, and doing routine check on pregnant women. However, I feel that I learnt more important lessons only by sitting and observing what was happening.

My dad's practice was a small private O&G clinic in the middle of Tangerang, the city half-an-hour drive away from the capital city, Jakarta. Being near to the central of the development, we are fortunate enough to experience the advancement the capital city is having, including in health care system. There is one big public hospital in the middle of the city and some other fast-growing private hospitals, ranging from lower-middle-to higher class hospitals. There are also smaller clinics, both public and private. However, despite the development in health care facilities, many people still cannot afford sufficient level of health care. The modern private hospitals are often too expensive to access while the public services are frequently inadequate. What makes it harder is that our country does not really have 'Medicare'. What come close to that are some cards in which people, who by fulfilling certain criteria, are defined as less fortunate financially, can obtain and use in certain public hospitals.

Having less exposure to that situation, however, I was less aware of the significance of inadequate public hospital and the high cost of private medical care until I was struck by one patient. She was a middle-age lady coming with her husband, modestly dressed in traditional sarong, flip-flops, and shirt. It was quite apparent that she did not come from a well-off family. When my father asked what brought her today to the practice, she voluntarily mentioned her painful breast. My father was a little bit surprised as it was not really his area, but not wanting to send her away more confused than she already seemed, he decided to have a look at her breast to see if he can help a bit.

When she exposed her breast, it was obvious that it was something rather serious. She had a big lesion of her breast with a little bit of bleeding, covered by tissue paper to stop it from bleeding more. My father mentioned to me later on of the possibility of something on the line of carcinoma. After doing a bit of observation, Dad decided to refer her to another doctor to gain more understanding about the condition. Nevertheless, it was obvious that if she decided to get a proper treatment for her condition, she would then undergo a lengthy and costly diagnostic and treatment procedures, something that she might not easily afford.

Two lessons were taught to me at that moment. First, health care is still something luxurious for many people. Even in a quite developed area like ours, in which there are so many health care facilities available, one lady could experience a difficulty to get appropriate treatment for such a serious condition. Say she would qualify for 'the Card'; she would have to face a lengthy political process. If she can successfully obtain that, she would still need to fight her way in a public health system which can be quite daunting and sometimes unsatisfying. This might be the reason why she came to an O&G clinic, desperately hoping that she might get a better chance though having to sacrifice more financially.

Secondly, education is something that is still desperately lacking however important it may be. The fact that the lady came after we can actually see the advanced physical manifestation of the possible breast carcinoma might show her unknowingness about what might be happening. Compared to in Australia, for example, breast cancer seems to be something that has been brought to public awareness quite a while ago. Back in Indonesia, many people are still oblivious about it.

There are surely many other lessons to be learnt. In the end, though, two of the lessons I learnt make me realize, there are a lot to be done to fill in the holes in public health care in many regions of the World, especially in the sector of women's health. Improvement of health care system by suitable targeting of health care subsidy and raising public awareness of important women medical condition, such as cervical cancer and breast cancer, might be two things that can be brought into attention. It is a long way to go to achieve those, but it is definitely not something impossible to fight for.

Say No to Violence Against Women

UNIFEM has launched an internet campaign asking people all over the world to raise their voices and add their names to an ever-growing movement of people saying NO to violence against women. Click www.saynotoviolence.org to say NO to violence against women.

Violence against Women – Facts and Figures from UNIFEM

Violence against women and girls is a problem of pandemic proportions. At least one out of every three women around the world has been beaten, coerced into sex, or otherwise abused in her lifetime — with the abuser usually someone known to her. Perhaps the most pervasive human rights violation that we know today, it devastates lives, fractures communities, and stalls development.

Statistics paint a horrifying picture of the social and health consequences of violence against women. For women aged 15 to 44 years, violence is a major cause of death and disability. In a 1994 study based on World Bank data about ten selected risk factors facing women in this age group, rape and domestic violence rated higher than cancer, motor vehicle accidents, war and malaria. Moreover, several studies have revealed increasing links between violence against women and HIV/AIDS. Women who have experienced violence are at a higher risk of HIV infection: a survey among 1,366 South African women showed that women who were beaten by their partners were 48% more likely to be infected with HIV than those who were not.

The economic cost of violence against women is considerable — a 2003 report by the US Centers for Disease Control and Prevention (CDC) estimates that the costs of intimate partner violence in the United States alone exceed US$5.8 billion per year: US$4.1 billion are for direct medical and health care services, while productivity losses account for nearly US$1.8 billion. Violence against women impoverishes individuals, families and communities, reducing the economic development of each nation.

In 1996, the United Nations General Assembly established the UN Trust Fund to Eliminate Violence against Women. The Trust Fund is managed by UNIFEM and is the only multilateral grant-making mechanism that supports local, national and regional efforts to combat violence. Since it began operations in 1997, the Trust Fund has awarded more than US$19 million to 263 initiatives to address violence against women in 115 countries. Raising awareness of women's human rights, these UNIFEM-supported efforts have linked activists and advocates from all parts of the world; shown how small, innovative projects impact laws, policies and attitudes; and has begun to break the wall of silence by moving the issue onto public agendas everywhere.

Early Marriage

The practice of early marriage is prevalent throughout the world, especially in Africa and South Asia. This is a form of sexual violence, since young girls are often forced into the marriage and into sexual relations, which jeopardizes their health, raises their risk of exposure to HIV/AIDS and limits their chance of attending school.

Parents and families often justify child marriages by claiming it ensures a better future for their daughters. Parents and families marry off their younger daughters as a means of gaining economic security and status for themselves as well as for their daughters. Insecurity, conflict and societal crises also support early marriage. In many African countries experiencing conflict, where there is a high possibility of young girls being kidnapped, marrying them off at an early age is viewed as a way to secure their protection.

According to a 2006 report by the UN Special Rapporteur on Violence against Women on her mission to Afghanistan, an estimated 57 percent of girls in Afghanistan are married before the age of 16. Economic reasons are said to play a significant role in such marriages. Due to the common practice of "bride money," the girl child becomes an asset exchangeable for money or goods. Families see committing a young daughter (or sister) to a family that is able to pay a high price for the bride as a viable solution to

their poverty and indebtedness. The custom of bride money may motivate families that face indebtedness and economic crisis to "cash in" the "asset" as young as 6 or 7, with the understanding that the actual marriage is delayed until the child reaches puberty. However, reports indicate that this is rarely observed, and that young girls may be sexually violated not only by the groom, but also by older men in the family, particularly if the groom is a child too.

HIV/AIDS AND VIOLENCE

Women's inability to negotiate safe sex and refuse unwanted sex is closely linked to the high prevalence of HIV/AIDS. Unwanted sex — from being unable to say "no!" to a partner and be heard, to sexual assault such as rape — results in a higher risk of abrasion and bleeding, providing a ready avenue for transmission of the virus. A study conducted in Tanzania in 2001 found that HIV-positive women were over 2.5 times more likely to have experienced violence at the hands of their current partner than other women. Young women generally know significantly less about HIV/AIDS than their male counterparts. Just 1 in 5 married women in Bangladesh had heard of AIDS; in Sudan only 5 percent of women knew condom use could prevent HIV infection. Both realities — lack of knowledge and lack of power — obliterate women's ability to protect themselves from infection.

Violence is also a consequence of HIV/AIDS: for many women, the fear of violence prevents them from declaring their HIV-positive status and seeking help and treatment. A clinic in Zambia reported that 60% of eligible women opt out of treatment due to fears of violence and abandonment resulting from disclosing their HIV-positive status. Such women have been driven from their homes, left destitute, ostracized by their families and community, and subjected to extreme physical and emotional abuse. In 1998 Gugu Dhlamini was stoned to death by men in her community in South Africa after she declared her HIV-positive status on radio and television on World AIDS Day.

A 2002 UNIFEM-sponsored report on the impact of armed conflict on women underscores how the chaotic and brutal circumstances of armed conflict aggravate all the factors that fuel the AIDS crisis. Tragically and most cruelly, in many conflicts, the planned and purposeful infection of women with HIV has been a tool of war, often pitting one ethnic group against another, as occurred during the genocide in Rwanda in 1994.

Source:http://www.unifem.org/attachments/gender_issues/violence_against_women/facts_figures_violence_against_women_2007.pdf

Being HIV Positive

By: Krithika Murali, Med V, Uni of Melb

"Who is there in this world that doesn't have a disease? Don't they have diabetes? Aren't there people with 'BP' [hypertension]? There are even people who die from low 'BP'. How many people died in the tsunami? How much more comfortable than them are we. This disease isn't a big problem. Women need courage."
- 36 years old, Illiterate, Widow, HIV positive

I spent a year in India recently on a pilgrimage of sorts. Most of our family still remains there rooted to a village in the very southern tip of India unmoved by the wider Indian Diaspora. I understand them little and the bewildering country they reside in even less. It was to be a year of searching for an elusive answer and eventually an ambiguous acceptance of many paradoxes.

I worked on a research project for eleven months in Vellore. It is located in the south Indian state of Tamil Nadu which has the highest HIV prevalence in the country. It is a small town of just over a 100,000 (very small by Indian standards) with a large floating population of visitors and patients to the local Christian Medical College Hospital where I was based. I had been interested in working with HIV positive Indian women for some time - feeling they carried the double discrimination of both their gender and stigmatised health status - but also because it would allow discussion of taboo topics in a country renowned for its conservatism. In the end I did just that under the auspices of a 'qualitative study' that would allow me to roam freely through the town and their lives. Many see HIV in Indian women as a dichotomous virus affecting the prostitute and the chaste housewife - both victims of poverty and cultural subjugation. No one had really spoken to me of individual stories.

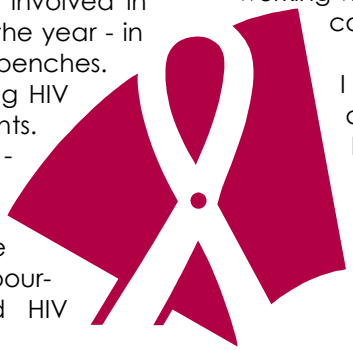
I would speak to the thirty women involved in my project many times throughout the year - in hospitals, in their homes, on park benches. Countless others I would meet during HIV Network Meetings or similar events. Many stories were grim indeed - married young, trafficked into red light districts, husbands dead from AIDS, abandoned. Many were illiterate and worked in low paid labour-intensive jobs. Some even had HIV positive children to care for. If the women weren't poor to begin with they were most certainly rendered poorer after contracting HIV. This I had expected. What I had not expected was being left at the end of it all with a strange sense of hope, remembering only their insurmountable optimism and courage - to provide for their children, to live independently and positively with HIV.

Some of my fondest memories of India were of these women. A lady in her colourful one-room home in the old red light district - bequeathed to her by her husband's mistress who had died of AIDS and now peered out of a large photo on the wall wreathed in blinking fairy lights. 'Kennedy' her fluffy white dog wagging its tail to a booming Bollywood love song as she spoke to me about forgiveness. Another loved to laugh at her tears and would request 'a kilo of silver and gold please' when the local greengrocers asked her what she wanted. Another found true love after HIV.

But then a few days later someone would ring because they had no money for the interest or because they had given sex for money and now needed an abortion. Some became sicker; some became widows at twenty one.

Nonetheless, they defiantly persevered.

It is clear that some of the changes needed to improve their lives are the dismantling of deep-rooted structural forces. In the eyes of many they are victims, but my time with them has opened me to see their resilience and resourcefulness in spite of difficult social circumstances. I then began to see that throughout my travels in India - in the knotted muscles of the female construction workers, in the starched khaki trousers and shirts of groups of female police officers gripping long rifles, in a fifty year old communist and mother of two who smoked like a chimney and the sorority-spirit of working women in the "Ladies Only" carriages of countless suburban trains.



I finished my project with more questions than answers - many yet to be resolved. My head remains filled with their stories, their misfortunes and their laughter. I used to see life in black and white - I now no longer do that.

Why join the VMWS?

There are many personal and professional benefits of belonging to a vibrant, active network of medical women!

- Regular networking and mentoring opportunities at meetings, clinical and medico-social guest speaker events and panel discussions.
- Receive a bimonthly newsletter advertising events, scholarships and prizes, and updates on gendered socio-political issues.
- Receive the VMWS e-Updates, e-Newsletters, e-Event Notifications and e-Special Communications via email.
- Be part of the Medical Women's International Association and have your say in the United Nations and other global forums.
- Receive assistance with applications to training programs and advice on career development.

Treasurer's Announcement

Receipts for the 2007-08 membership subscriptions were sent to all members in March via mail or email. If you believe that you have paid but have not received a receipt please contact the VMWS Treasurer via email at vic@afmw.org.au or mail at PO Box 202, East Melbourne 8002. Membership renewal forms for the upcoming membership year (July 1, 2008 to June 30, 2009) will be sent out with the June 2008 newsletter.

– Dr Jill Tomlinson

"Hope is the thing with feathers
That perches in the soul
And sings the tunes without the words
And never stops at all"

- Emily Dickinson

Membership Application Form

Full Membership $140
Student Members $35
Retired or Rural Members (>100km from GPO) $100
Gift membership $100

Send with a cheque or money order to:

VMWS Secretariat
PO Box 202
East Melbourne VIC 8002
E-mail: **vic@afmw.org.au**

Or direct transfer to VMWS:
BSB: 033 089
Account Number: 297664

Please include your initials and surname in the transfer information, and enter the date of transfer here: _____

Name: _____
Email: _____
Address: _____
_____
_____
Phone: _____
Fax: _____
Practice Address: _____
_____
_____
Specialty:_____ ____
Students: Year of graduation:_____

☐ *Please save trees – send my VMWS correspondence via email, not mail**

☐ I do not want other VMWS members to have access to my e-mail address.

☐ I do not want to receive electronic AFMW correspondence.

☐ I do not wish other AFMW members to have access to my e-mail address.

*** Student members will receive only electronic correspondence**

Car-pooling: Potential driver: ☐
Potential passenger: ☐

Contact the VMWS **Mail**: The Secretariat, PO Box 202, East Melbourne 8002; **Email**: vic@afmw.org.au; **Website**: vmws.wordpress.com