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HEALTHMATTERS

A PUBLICATION OF THE VANCOUVER WOMEN'S HEALTH COLLECTIVE

Summer 1987

Vol. 3 No. 2

APPREHENSION OF FETUS —— Is This The Future?

A frightening precedent has been set, a precedent that reminds us of the painful, degrading and sexist scenarios described for us by Margaret Atwood in her novel The Handmaid's Tale. For the first time in B.C. the Ministry of Social Services and Housing has apprehended an unborn child - legally known as a fetus.

The case involves a woman who arrived at Grace hospital, a Vancouver maternity hospital, Wednesday May 20th to give birth. Details about the woman or about the circumstances of the case have not been made public, but by all accounts there was a difference of opinion over how the woman should birth. As we understand it, she refused to have a caesarean section and on the basis of her non-co-operation the Ministry moved to apprehend the unborn child.

While the legal status of this apprehension has not yet been defined, many community, women's, health, human rights and legal advocates are outraged that the Ministry would move into an area over which it has absolutely no jurisdiction.

This is not the first case in Canada where a fetus has been apprehended. Earlier this year the Children's Aid Society of Belleville, Ontario, apprehended the unborn child of a woman who was eight months pregnant. In his ruling Judge Kirkland made an order that the woman could be forced to have a medical examination to see if the fetus was healthy. He also cited in his judgement a statement from "a local psychiatrist (who) was quoted recently as saying, `Every child should have certain basic rights such as: the right to be wanted, the right to be born healthy, the right to live in a healthy environment, the right to such needs as food, housing and education, and the right to continuous care.'" This is the only case considered where the fetus is given status as a person.

Canadian law, unlike American law, does not distinguish between a 6 week old fetus and a thirty eight week old fetus. Given this, the apprehension of any fetus puts women on the slippery slope of having their rights become secondary to the rights of the fetus.

Already a so-called medical ethicist, Eike Kluge, of the University of Victoria, has confirmed many of the fears women have about this precedent. In a radio interview Kluge said in reference to a seven month old fetus "it doesn't matter where you live, whether you live in an incubator or in a womb, the ministry should have the authority to treat you equally". Mr Kluge initially said that the ministry should have the authority to apprehend in cases where the fetus is at least 26 weeks old. Later he said fetuses from 20 weeks to 26 weeks should be considered appropriate for apprehension!!

Outraged by the inhumane treatment of this woman and by the implications of the precedent-setting apprehension, the Women's Health Collective speedily called a press conference, taking the opportunity to bring to light some of the issues this case touches upon. Participants at the conference included representatives from the Vancouver Status of Women, the National Association of Women in the Law, the B.C. Human Rights Coalition, and the B.C. Coalition for Abortion Clinics.

Our statement read:
First, we are deeply concerned about the woman whose life has been disrupted by these events. We want to ensure that her interests are protected and represented in the way she decides is best. We do not pretend to, and we can never speak for her.

Whatever the precise circumstances of this case, we know that if the Ministry of Social Services and Housing's apprehension order is upheld, this decision will have severe implications on the rights of women to make individual, autonomous choices about our reproductive health. We also know that if upheld, this decision will make such questionable apprehensions, which occur all too often in this

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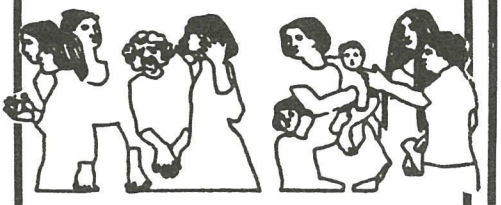

INSIDE HEALTHMATTERS

HEALTH CARE IN LATIN AMERICA — Where There Is No Doctor

The Oxfam Global Health Project has been holding a series of workshops on health care in developing countries. One session reviewed the work in Latin America of David Werner (author of Where There is No Doctor). The following is a summary of this workshop.

Throughout Latin America, the use of health auxiliaries has, in recent years, become an important part of the new international push of "community oriented" health care. Village health workers in Latin America are far from new. Various religious groups and non-governmental agencies have been training *promotores de salud* or health promotors for decades. And to a large but diminishing extent, villagers still rely, as they always have, on their local *curanderos*, herb doctors, bone setters, traditional midwives and spiritual healers. More recently, the *medico practicante* or empirical doctor has assumed in the villages the same role of self-made practitioner and prescriber of drugs that the neighbourhood pharmacist has assumed in larger towns and cities.

Until recently, the respective Health Departments have either ignored or tried to stamp out this work force of non-professional healers, yet the Health Departments have had trouble coming up with viable alternatives. Their Western-style, city bred and city trained M.D.'s not only proved uneconomical in terms of cost effectiveness; they flatly refused to serve in the rural areas.
The first official attempt at a solution was, of course, to produce more doctors. In Mexico the National University began to recruit 5000 new medical students per year without the resources to adequately train them (and still does). The result was a surplus of poorly trained doctors who stayed in the cities.

The next attempt was through compulsory social service. Graduating medical students were required (unless they bought their way off) to spend a year in a rural health center before receiving their licenses. The young doctors were unprepared either by training or disposition to cope with the health needs in the rural area. With discouraging frequency they became resentful, irresponsible or blatantly corrupt.

Next came the era of the mobile clinics. They too failed miserably. They created dependency and expectations without providing continuity of service. The net result was to undermine the people's capacity for self care.

-Matrix

It was becoming increasingly clear that the provision of health care in the rural areas could never be accomplished by professionals alone. But the medical establishment was - and still is - reluctant to crack its legal monopoly.

At long last, and with considerable financial cajoling from foreign and international health and development agencies, the various health departments have begun to train and utilize auxiliaries. Today, in countries where they have been given half a chance, auxiliaries play an important role in the health care of rural and peri-urban communities. Given a whole chance, their impact could be far greater. But, to a large extent, politics of the medical establishment stand in the way.

David Werner found that the skills demonstrated by village health workers varied enormously from program to program. In some, local health workers with minimal formal education were able to perform with remarkable competence in a wide variety of areas embracing both curative and preventive medicine, as well as in agriculture, village co-operatives and other aspects of community education.

In other programs - often those sponsored by Health Departments - village workers were permitted to do very little. In addition, many Latin American countries have programs to provide minimal training for and supervision of traditional midwives. Unfortunately, Health Departments tend to refer to these programs as "*Control de Parteras Empiricas*" - Control of Empirical Midwives - a terminology which too often reflects the attitude of governing health departments. Thus, to Mosquito Control and Leprosy Control has been added Midwife Control. Small wonder so many midwives are reticent to participate! David found the most promising work with village midwives took place in small non-governmental programs. In one such program the midwives had formed their own club and organized trips to hospital maternity wards to increase their knowledge.

David also found, with certain exceptions, that the most successful programs which were community supportive, were small non-governmental efforts usually operating on shoe-string budgets. As for the larger regional or national programs - with all their international funding, top ranking foreign consultants and glossy bilingual brochures portraying community participation - when it came down to the nitty-gritty of what was going on in the field, there was usually a minimum of effective community involvement and a maximum of dependency creating handouts, paternalism and superimposed, initiative destroying norms.

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Northern Woman Journal

HEALTH cont. from page 2

Many people still tend to think of the primary health worker as a temporary second best substitute for the doctor; that if it were financially feasible the peasants would be better off with more doctors and fewer primary health workers. The day must come when we look at the primary health worker as the key member of the health team, and at the doctor as the auxiliary. The doctor, as a specialist in advanced curative technology, would be on call as needed by the primary health worker for referrals and advice. S/he would attend those 2-3% of illnesses which lie beyond the capacity of an informed people and their health worker, and s/he might even, under supportive supervision, help out in the training of the primary health worker in that narrow area of health care called Medicine.

Pat Foote-Jones

ADVERSE cont. from page 6

drug regulations and testing are much stricter.

Although this book addresses this complex issue well, identical examples are often repeated in separate chapters, and some chapters finish with less informative, emotional arguments against drug companies.

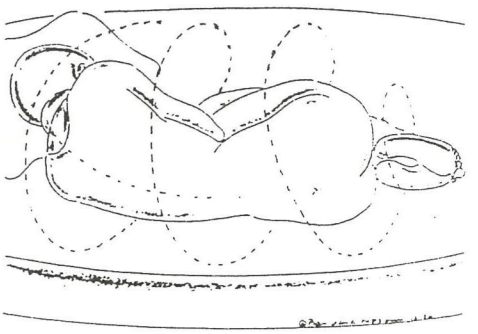
The anthology closes with a picture of how people are challenging the power of the drug industry. An exploration of primary health care in the Philippines illustrates how local women in a community can be trained to offer health care and can incorporate their own traditional medicine to give treatment to local communities. This process helps to balance the top-heavy specialized health care facilities available to a minority by using resources existent in rural communities.

The strength of networking among women is applauded, as women share and exchange information and personal experiences. Specific organizations such as DES Action International serve to inform and warn women worldwide of the effects of DES use.

Alternative health care services offer more time with the patient, giving health information, counselling, or fostering a self-help approach.

Not only does this book identify specific areas where women are abused by the drug industry, it also extends this experience to the Third World, and illustrates how we can take health care back into our own hands. Those interested in the politics of the drug industry and how it affects women will find this an informative and readable book.

CHERYL ARRATOON



APPREHENSION cont. from page 1

province, much easier in the future, thereby depriving women of the right to parent their children. We firmly believe that this precedent has the potential of adversely affecting women who choose to have children as well as women who choose to have an abortion. We are not about to sit back and watch the courts further limit the control we have over our bodies.

We call on Claude Richmond, Minister of Social Services withdraw this apprehension order

Regulations outlined in the Protection of Children Act, which gives the superintendent of Child and Family Services the authority to apprehend children, require the ministry to bring each apprehension case to court for a 'Presentation Hearing', within seven days of the apprehension. The presentation hearing examines the circumstances surrounding the apprehension and determines whether it was legal or not. At the first presentation hearing on May 26, the court adjourned the case to June 9th because the woman involved was still recovering from surgery and did not have legal counsel.

On June 9th, a new player became involved in the case. Nancy Morrison, a former Provincial Court Judge, acting on behalf of the Legal Education Action Fund (LEAF) moved a motion that LEAF be granted permission to intervene in the case as a friend of the court. Before addressing her request, Family Court Judge Davis inquired whether Ms. Morrison was a Miss or a Mrs.!! He then went on to say "Frankly Miss Morrison, you have a long way to go to convince me that you have a right to intervene in this case". Ms Morrison aptly said that she was prepared to give her arguments at the appropriate time and place.

If justice is ever served by the court system, it is served painfully and slowly. To the surprise of no-one, the hearing was again adjourned. Davis granted the ministry authority to remain guardian of the baby boy and suggested that the Ministry's lawyer, Mr.Gove notify the mother of the new court dates.

The court will hear LEAF's reasons for intervening at the Family Law Courts in New Westminster on June 29th at 9:30am. The case itself will be heard beginning the week of July 13th, again at the New Westminster Family Court House.

We encourage those of you who share our outrage over this case to write to:

Claude Richmond
Minister of Social Services and Housing
Legislative Buildings
Victoria, B.C

and to your MLA, expressing your views. Those of you who want to become involved in the Ad Hoc Committee for Maternal Autonomy can contact the Health Collective to find out how.

AIDS — A Woman's Concern

When a woman learns that she has been exposed to the AIDS virus, possibly by donating blood and having it refused, she is faced with ambiguity. Because there is no way of knowing whether she will develop AIDS, she may feel as if she is in limbo between life and death. She does not know whether she will continue to be healthy, or have to adjust to a progressive, incurable, fatal disease.

She will probably want to obtain as much information as possible. This might be difficult. Gay men have been dealing with the threat of AIDS for several years, and have developed resources of information and support within their community. A woman looking for assistance might not realise that these resources are available. AIDS-related services specifically for women have been very limited. Visibility and outreach efforts have been minimal. A heterosexual woman who has the disease but lacks the support of the gay community could be extremely isolated.

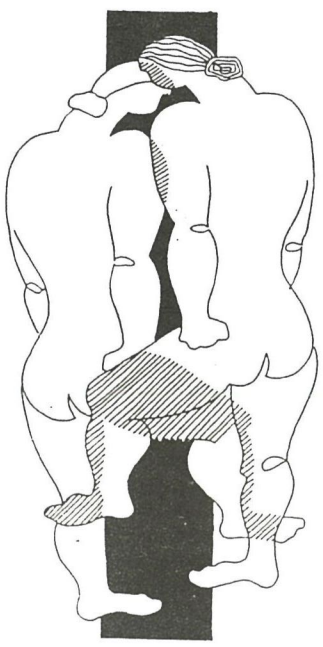
In spite of the somewhat confusing facts and figures presented in the daily press, the message is clear: most of us are at risk from AIDS. We can no longer think in terms of risk groups, but of risk behavior. Anyone who has sexual contact with a person whose background she doesn't know, is putting herself in danger.

Because in North America AIDS hit gay men first, most heterosexuals still think of it as a "gay disease", something they don't have to worry about. As a result of their lack of concern, thousands of heterosexual people are carrying the virus and passing it on to others. According to Dr. Theresa Crenshaw, a U.S. expert, the number of AIDS cases among heterosexuals is ten times what it was among gay men five years ago. A frightening statistic quoted from another source is that an American woman having a casual sexual encounter has one chance in ten of being exposed to AIDS.

Because the test presently available detects not the virus itself but the antibodies that the person's immune system has developed to fight it (HIV antibody), a positive test does not mean that the person has AIDS, or even that s/he will develop AIDS. Some people have lived for several years with a positive test result and remained healthy. Others have become sick and died within months of contacting the virus.

How easily the virus infects is uncertain. Some women have hundreds of sexual contacts with infected persons before testing positive themselves, while for others, one contact is enough to give them AIDS. Apart from using drugs herself and sharing needles, having sexual contact with an infected intravenous drug user seems to be the most certain way for a woman to get AIDS. In a study done in the U.S., 42% of women who had any amount of contact with IV drug users became infected.

The growing attention paid to the heterosexual transmission of AIDS has meant that a lot of women are now looking back at their sexual partners over the last 10 years, wondering if one of them might have been an AIDS carrier. Women who use intravenous drugs, or have used them in the past, and have ever shared needles, will be concerned that they might have been infected.



Frownie Makara Magazine

Because AIDS is viewed as a sexually transmitted disease (STD), mainstream society places a stigma on people who have it, and on people who, by testing HIV positive, are seen to have come into contact with it. The sexual double standard in our society that says sex is to be spontaneous, while condemning those who contract a STD, will cause the victim of such a disease to be blamed for her own infection. Someone who has contracted the AIDS virus through a blood transfusion rather than through sexual contact may feel the need to explain how s/he got it, and might find people more sympathetic once they are aware of her situation.

Many people still do not understand the methods by which AIDS is transmitted, and are fearful of being infected by contact with an AIDS sufferer. Because it is such an emotional subject, people often react irrationally when confronted with an AIDS victim. Therefore, a woman who discloses her positive antibody status cannot predict the degree of acceptance or rejection she will experience from the people she tells.

Of the women diagnosed with AIDS in the United States, the vast majority (73%) are women of colour. These are the women who receive the fewest social services, and are the most likely to suffer from poor nutrition and little or no health care. In New York City, more women aged 25-29 die from AIDS than from any other single cause. Because they do not have information in a form they can relate to, they continue to put themselves at risk. Women who test HIV positive are advised to avoid getting pregnant until more is known about the transmission of the virus to the fetus. However, cutbacks in family planning funds mean that contraceptives and information are not available to those women who need them. Abortion also is inaccessible to most poor women in the U.S. because Medicaid funding for abortions is not permitted in most states.

Here in British Columbia there have not yet been many women

continued on p.5

AIDS continued from p.4

diagnosed with AIDS, although the number testing positive for the HIV antibody has more than doubled in the last six months. AIDS Vancouver has, for the past four years, provided practical and emotional support to people directly affected by the virus, as well as information to the general public. This spring the B.C. government refused to continue funding the organisation, even though they say education on AIDS is a priority. The government takes a moralistic attitude, using the threat of AIDS to try to frighten people into monogamy or chastity rather than accepting the range of human sexuality and giving people the information they need to protect themselves.

The people most at risk from AIDS have been those not in the mainstream of society. Some consider these people expendable. Because of this, the money necessary to do research and education has been slow in coming from governments on all levels. Although they say that AIDS is a priority, they have not backed their words with the money to do the job. It is only now that it has become obvious that anyone can get AIDS, including white, heterosexual men, that attention is being paid.

Isis

There have been some cases of the AIDS virus being transmitted from a woman to a man, but the other way seems to be more common, probably because semen has a higher concentration of white blood cells, which are the ones that contain the HIV. Prostitutes are often blamed for spreading AIDS, even though it is more likely they who are at risk of infection from their male clients or from IV drug use. Most prostitutes will insist the man wear a condom, but some men refuse, and look for a woman who, because she is using drugs doesn't care, or because she is desperate for money, is not going to insist.

Jo Beclelheimer

Safer Sex for Women

THIS IS AN ADAPTATION OF THE SAFER SEX GUIDELINES FOR WOMEN CREATED BY THE GAY MEN'S HEALTH CRISIS IN NEW YORK

Safer sex can be fun, exciting, and completely satisfying. Safer sex is a personal choice. These guidelines reflect the most current information on AIDS and should be seen as an overview of safe sex practices.

Who is at risk of AIDS?
Any woman who is sexually active is at risk of exposure to the AIDS virus. The women at highest risk are:
- Women who use IV drugs and share paraphernalia;
- Women with sexual partners who have used IV drugs;
- Women with bi-sexual male partners;
- Women who have received contaminated blood transfusions or products;

How is AIDS transmitted to women?
- The AIDS virus is transmitted by infected blood, semen, and possibly vaginal fluid. It is not transmitted by saliva, sweat, or tears.
- It is not necessary to have repeated encounters with an infected person to acquire the virus; one unsafe sexual encounter can do it.

What is safer sex?
- Massage, hugging, kissing and masturbation do not spread the disease. (Small amounts of the virus have been detected in saliva, so exchanging saliva, as in `french kissing', is not necessarily safe.)
- When having sex with a male partner, always use a latex condom with a water-based lubricant; this is necessary even if you use another form of contraception.
- A condom should be used for anal intercourse as well as oral sex; women should use a latex barrier when engaging in oral vaginal sex.
- Use a condom or other latex barrier if putting a finger in the rectum or vagina.
- Don't use a douche unless prescribed by a doctor because a douche can force an infection deeper into your body and destroy the body's natural immune protection.

FOR MORE INFORMATION CALL
AIDS VANCOUVER AT 687-2437

For women, heterosexual intercourse has never been risk-free. To protect ourselves from unwanted pregnancy, we have had to either give up sexual spontaneity or risk our health. Many men view having to wear a condom as a curtailment, but now it's a matter of life and death to them, as it is to us, that they abandon their privilege of spontaneous sex and assume personal responsibility for their actions.

WORKERS FOR THIS ISSUE

Cheryl Arratoon, Barbara Bell, Daphne Hnatiuk, Colleen Penrowley, Lee Saxell, Joy Thompson, Maggie Thompson

Vol. 3 No. 2 July, 1987
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ADVERSE EFFECTS —— Women and the Pharmaceutical Industry

ADVERSE EFFECTS
Women in the Pharmaceutical Industry

Ed. Kathleen McDonnell
Women's Educational Press, 1986

ADVERSE EFFECTS addresses the detrimental impact that the pharmaceutical industry and its products can have on women's lives. This book presents a rounded perspective using an anthology to present the views of health activists from North America, Europe and Third World countries.

Women are the primary care givers in the family and usually pay more visits to the doctor, especially if children are involved. We are usually encouraged to use medication to treat health problems in our families. We are also encouraged to see natural changes in our reproductive system as medical problems. At any time during a woman's reproductive life, from the onset of menstruation, through her fertile years, pregnancy and menopause, she can be treated with hormones as if her reproductive system was a pathological condition. Our frequent contact with the medical profession makes the question of safety and the right to make an informed decision about whether to use medication at all an important issue.

The first part of this book describes some drugs used particularly by women and how they have been repeatedly advocated for use on women, often with disastrous results.

For example, in the 1950's high dosage estrogen-progestogen combination drugs (EP drugs) were widely used as a pregnancy test - if the drug did not induce menstruation pregnancy was assumed. Later studies showed not only the ineffectiveness of EP drugs but that fetal abnormalities occurred if the drugs were taken during pregnancy. In 1975-80, EP drugs were removed from the U.S. and many European markets, but similar action was not taken in developing countries. In the 1970's, in India, EP drug use increased, as did the rate of birth abnormalities. Recent attempts by the Volunteer

Health Association of India to ban EP drugs have been promptly repressed by the powerful drug companies, and widespread use continues.

In a similar situation, Diethystilbestrol (DES) was given to pregnant women from 1941-1971 to prevent miscarriage. It was later found to cause a rare type of cancer in some daughters of these women. Genital abnormalities may also occur in both sons and daughters. Although these effects of DES are well known, it is still marketed worldwide for many indications and is still being used to prevent miscarriage in Third World countries.

The present controversy surrounding estrogen replacement therapy (ERT) illustrates yet another hormonal intervention, this time at menopause. Although the safety of this treatment is not fully known it is strongly advocated to minimize this natural change. ERT is advocated for osteoporosis which is advertised as a horrible, debilitating disease. This strong promotion by drug companies reaches doctors and their patients without information on alternative, safer treatments. This use of hormonal intervention ignores the potential health risks of tampering with the natural, complex hormone system. These examples also illustrate the irresponsible use of drugs in Third World countries.

Another target of the drug industry has been women's emotional well-being. Health professionals have been encouraged to develop a practice of treating emotional problems with suppressants to produce a pacified, compliant patient, without probing more deeply to remedy the causes. Older women, especially, are victims of this over-prescription. This is made clear by an analysis of the Saskatchewan Drug Plan (1978). In all age groups examined, except 0 - 9 years, women received the largest number of prescriptions for mood-modifying drugs, compared to men of the same age. At age 20-29, eight times as many women as men received anti-depressants, and four times as many women received tranquillizers or sedatives and hypnotics. Nearly one in three women, and one in five men, above the age of 60, received tranquillizers and sedative-hypnotics; the elderly women received more prescriptions per person than did the men. Although this high use is attributed to medical reasons of old age, when tranquillizers and sedative-hypnotics were compared to analgesics (pain killers), no sex difference was found. The sex discrepancy clearly involves treatment for psychological conditions.

The drug industry makes a lot of money by pushing drugs on women. The result is often to diminish the degree of control an individual woman has over her health. This is readily apparent in the difficult problem of birth control versus population control, as discussed in the second part of the book. Ideally, birth control programs provide a woman with complete information of risks and benefits so that she can make an informed personal choice. However, the ready compliance of misinformed or uneducated women in developing countries and the lack of back-up medical care leaves them vulnerable to the abuse of birth control, used to enforce population control programs. These programs are used to reduce population growth rates and often use widespread, long-term methods that take away reproductive control and decision making from the individual. Two chapters describe the use of the injectable synthetic progestogens, Depo-Provera and Neo-Den, by family planning programs in India and Southeast Asia. These two examples illustrate well the abuse of women in developing countries by the unethical use of drugs banned in Western countries. where the

cont. on page 3

HEALTH SHORTS

Reproductive Health Project

The Women's Reproductive Health Project is heading into it's 5th month. The 4 topics we are covering are Infertility, Fertility Awareness and Control, Menstrual Problems and Miscarraige. The Health Promotion Directorate of Health and Welfare Canada has funded us to research, write and design workshops and to train facilitators. We will present these workshops in six communities in western Canada, and the facilitation training will enable the participants to continue giving workshops on their own, or to establish support groups.

This project is exciting in a number of ways. We are reaching women we have not adequately reached before: native women, low income women and rural women. Women from the communities we are visiting are involved in all aspects of the development of the materials, the workshops, and the design of the training sessions.

We have already visited 5 of the 6 regions to meet with organizations and individuals. We have established a co-sponsorship with a number of organizations who represent the women we want to meet and work with. The experience and committment of our co-sponsors has enabled us to reach the communities we had hoped to involve. We are working with a number of band offices and Indian Area Councils and have met and talked with a great number of Community Health Representatives who often provide essential community health services to women living on reservations in B.C., Alberta, and the Yukon. Women's Centres, such as the Victoria Faulkner Women's Centre in the Yukon and Campbell River Women's Centre on Vancouver Island have been extremley supportive. Anti poverty groups have also been involved in these initial consultation visits.

We have begun to build a picture of the needs of the women we are working with. In public meetings they have told us of their minimal access to support, information, and sometimes essential health care. They have pointed out the need to expand our focus, to include information on patient rights: access to medical records, the right to a second and third opinion, and the usefulness of having an advocate when visiting a doctor. It has become clear that the facilitation training we provide must include not only health information on the relevant topics, but also the tools to empower women to work together effectively within their communities.

We will be holding the workshops and facilitation training in the Lower Mainland in February. In March and April we will return to the six communities and hold a series of workshops and the training for women who want to facilitate workshops and start self-help or support groups. If you are interested in becoming involved in any aspect of this project we would be very happy to work with you.
Call us at the Vancouver Women's Health Collective.

The Poison Fluoride

Some of us deliberately add it to our diets, or go to the dentist for special treatments: we may even give it to our children. It is used to kill rats, and leads to bone degeneration and genetic damage. Flouride: The Aging Factor, by American biochemist John Yiamouyiannis examines the adverse effects of a chemical that is routinely added to water systems in North America.

The Vancouver School Board in conjunction with the Vancouver Health Department actively promotes the use of Flouride by implementing rinse programs in schools. source: Option

AZT Available

People with Aids have been assured by eight of the ten provinces that supplies of the drug Retrovir, (AZT) will be available by the end of the year. Spokesman for the drug's manufacturer, Burroughs Wellcome Inc., said the company has spent $3.4 million supplying it to two clinical trials in Canada. The apparent success of AZT in prolonging patients' lives prompted AIDS advocacy groups to demand it be available to all AIDS affected people who want it. Prince Edward Island and the North West Territories, with no reported cases of AIDS, and Newfoundland, with one reported case have so far not agreed to buy the drug under their medical insurance programs. Other provinces have agreed to begin buying the drug at a cost of $1,000 per patient per month. The drug will be administered under what has become known as compassionate trials, thereby complying with Health and Welfare's Health Protection branch regulations for new drugs.

source: Globe and Mail June 4, 1987

B.C. Coalition for Abortion Clinics

On January 25, 1987, the B.C. Coalition for Abortion Clinics was established. There are several working committees in need of your active support:

FUNDRAISING
EDUCATION/OUTREACH
MEDIA
CLINIC

Be an active member for a woman's right to choose!

For further information, write:
P.O. Box #66171 Station F
Vancouver, B.C. V5N 5L4
or call: 873-5455

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