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The Influence of the Agreement between the Calgary Regional Health Authority and the Salvation Army on Women's Participation in Health Policy.

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SCIENCE

DEPARTMENT OF COMMUNITY HEALTH SCIENCES

CALGARY, ALBERTA

APRIL, 2001

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ABSTRACT

The purpose of this case study was to explore the influence of the agreement between the Calgary Regional Health Authority and the Salvation Army on women's participation in health policy and planning. Data were collected from key informant interviews, document review and newspaper archives and analyzed using the constant comparative method of qualitative analysis. The eight key informant interviews provided valuable insight with respect to public participation and the relationship between the CRHA and Salvation Army. The internal document review provided important information with respect to the legal agreement between the CRHA and the Salvation Army and the newspaper archives provided an understanding of the context within which the agreement was negotiated and implemented. This study provides a description of several public participation strategies including a partnership between a regional health authority and a faith community.

ACKNOWLEDGEMENTS

This thesis would not have been possible without the help and support of many people. Thank you to my family, especially Mom and Dad for all your love and encouragement throughout the entire process. Your support has meant the world to me. Thank you to Paul for all your love and support, from both near and far.

Thank you to the participants who took the time to meet with me and share your expertise and experiences and your passion for women's health. Without you, this thesis would not have been possible. Thank you to Donna Kynaston in the CRHA Archives, without whom, I would still be wandering, searching for documents.

Thanks to my fellow students in the Department of Community Health Sciences for setting such high standards of achievement and accomplishment. Thanks especially to Laurie, Jeanne, Mona and Danielle who provided so much laughter and support. Thanks to the entire QUIG group, who provided invaluable feedback, advice and mental health breaks during the process of completing this thesis.

I would like to especially thank my supervisory committee, Dr. Arlene Vollman and Dr. Lynn Meadows for their gracious help and suggestions throughout the process. Your willingness to take the time to guide students through the exciting process of research is really appreciated. And finally I'd like to thank my supervisor, Dr. Billie Thurston for the example that she sets for all her students. The energy and passion that you bring to your work is such an inspiration and I hope that I can live up to the standards that you have set by example.

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CHAPTER 1: BACKGROUND

I. INTRODUCTION

In 1998, the Calgary Regional Health Authority (CRHA) initiated a process to develop and implement a regional Public Participation Framework (PPF). The goal of this framework was to describe the key areas in which the public could influence CRHA decisions (Maloff, Bilan & Thurston, 2000). A rationale for regionalizing health services is the belief that the resultant system will be more responsive to the particular health needs of the communities that they serve (Sullivan & Scattolon, 1995). A second widely held belief is that increased consumer participation will provide the information needed to make systems more responsive (Bowie, Richardson & Sykes, 1995). At the same time, increased attention to strategies for individual responsibility and self-care, combined with increasing access to health information through a variety of media, have accelerated the public's desire to take a role in the planning and provision of health care (Milewa, Valentine & Calnan, 1998).

As researchers interested in women's health, we were aware that after the regionalization of the Alberta health care system, the CRHA signed an agreement with the Salvation Army to provide women's health services through the Salvation Army Grace Women's Health Centre. This Centre and the services provided would comprise a major part of the CRHA women's health program. We wondered how this agreement between the CRHA and a faith community would impact women's participation in policy development.

A case study was designed to look at the agreement reached by the CRHA and the Salvation Army and its impact on public participation in planning and policy for women's health. The agreement appeared to meet the criteria of a partnership (Arnstein, 1969, Scott & Thurston, 1997).

II. REVIEW OF THE LITERATURE

Given the nature of the case, we decided to review what the published literature identified as key issues in the participation of faith communities in health at individual and group levels as well as women's participation in health policy. Although there is considerable written about women's health and policy, there were few articles about women's participation in health policy. For this reason, we expanded our review to include women's participation in policy in other areas in order to increase our understanding of issues surrounding women's participation. A search of MEDLINE, PSYCHinfo, ERIC, Healthstar, Sociological Abstracts, GEOBase, International Political Science Abstracts, ProQuest Direct, Women's Resources International, ATLA Religion Database, Pubmed and the Cochrane Reviews was carried out with specific keywords including: public; community; consumer; stakeholder; participation; involvement; consultation; gender; women; organizational models; partnership; planning; policy; religion; faith; church; temple; mosque and women's health. The large number of keywords searched was due in part to the different terms used in different disciplines as well as varying definitions used. In addition, a manual search was undertaken to search recent, uncatalogued issues of appropriate journals.

The following sections will provide an overview of the CRHA Public Participation Framework (PPF) and a summary of the findings of the above search.

A. The Calgary Regional Health Authority

In Canada, nine of the ten provinces have established some type of regionalization of their medical systems (Lewis, Kouri, Estabrooks, Dickinson, Dutchak, Williams, Mustard & Hurley, 2001). In Alberta, the official process of regionalization began in 1994 although the background stretched back to the late 1980s. *The Rainbow Report: Our Vision for Health* (1989) included a number of recommendations for the future of health care in Alberta. The Rainbow Report suggested that the province be divided into nine regions, accountable through Health Authorities. This was one of many recommendations contained in the report and was not supported by the government of the day. Although the government declined to adopt the recommendation to form Health Authorities, its response to the Rainbow Report included the government's endorsement of coordination and cooperation on a regional basis.

The move to regionalization in Alberta resurfaced when Premier Ralph Klein was elected in 1993. The plan to establish regional health boards was included as part of the first business plan of the new government (*A Better Way*, 1994). Following brief consultation as to the numbers and boundaries of regions, the Regional Health Authority Act was passed in June of 1994. Under the Act, the province of Alberta was divided into 17 geographic regions. The regions replaced over 200 separate boards of various hospitals, health units and health service institutions (Casebeer, 1996). The regional

health authorities were given the responsibilities (Regional Health Authorities Act, 1994) of :

- Promoting and protecting the health of the population in the health region and work to wards the prevention of disease and injury;
- Assessing on an ongoing basis the health needs of the health region;
- Determining the priorities in the provision of health services in the health region and allocating health resources accordingly;
- Ensuring that reasonable access to quality health services is provided in and through the health region and ;
- Promoting the provision of health services in a manner that is responsive to individuals and communities and supports the integration of services and facilities in the health region.

In Calgary, regionalization brought with it hospital closure and job losses. It was argued that the previous management system had been confusing and led to competition among institutions. The CRHA, established in June 1994, was designed to replace the five boards governing eight hospitals.

The board of the CRHA was made up of fifteen members, appointed by the province, after an open application process. Many of the members had been on the boards of the hospitals and continued their involvement in the healthcare system. For example, the Chair of the Foothills Hospital board went on to become Chair of the Board of the CRHA, while the Chair of the Grace Board of Trustees went on to become Vice-Chair of the CRHA. The CEO of Foothills hospital became CEO of the CRHA. This

continuity may have helped the agreement between the Grace and Foothills remain a high priority within the new Health Authority.

The first task of the CRHA board was to cut $157 million in hospital spending by 1997. The new authority acted on reports from Price Waterhouse which suggested that Calgary needed fewer beds for maximum efficiency, and the Hyndman report, which recommended a wholesale shuffling, including the integration of the Children's Hospital into the Foothills Hospital and the closure of the Grace.

B. CRHA Public Participation Framework

The need for public participation in health decisions and policy has been acknowledged for nearly half a century (Havighurst, 1986; Preston, 1982). The Ottawa Charter lists strengthening community action as one of five action strategies (World Health Organization, 1986) to improve the health of populations. Policy makers have increasingly paid attention to strategies for the involvement of communities in decisions that impact their health and well being (Bogue, Antia, Harmata & Hall, 1997; Bowie, Richardson & Sykes, 1995). The public has a strong desire to shape the future of the health care system (Sullivan & Scattolon, 1995), but organized, systematic, public participation in the health field is still relatively new (Carpenter, 1999).

In 1998, the CRHA began a process to develop and implement a Public Participation Framework in the region. The CRHA established an Advisory Committee made up of representatives from the CRHA, the University of Calgary, Alberta Community Development and the Calgary Chamber of Commerce. The committee members used a process of discussion and compromise (personal communication, 2000)

to clarify and define the values and assumptions which would underpin the framework. They then developed the specification and parameters of the framework, which included this definition:

> ***Public participation**: the process by which public concerns, needs and values are incorporated into governmental decision-making. Public participation is a two-way communication with the overall goal of better decisions, supported by the public. Participation processes may be a single event or they may be embedded in long-term system activities or partnership processes. Adequate public information is always a central element in any public participation program. (CRHA, 1999 p. 6)*

The purpose of the framework is: "to outline the context and opportunities for public participation within the Calgary region; enhance CRHA decision-making; and promote a working relationship between the CRHA and its diverse publics" (CRHA, 1999 p. 2).

The CRHA has differentiated public participation from crisis intervention and regular public relations activities. The framework is an attempt to make public participation part of normal business practice. The framework is designed to supplement and enhance the CRHA's current public participation procedures, taking into account the regulatory requirements and legislation that govern the CRHA. Public participation should be planned and budgeted for as part of normal business practice. Although the CRHA has made public participation a priority, they have noted that public participation activities require dedicated resources (CRHA, 1999).

The framework includes an acknowledgement that the skills and knowledge required to effectively develop public participation initiatives are not widely held within most organizations, including the CRHA (CRHA, 1999). The framework also contains a

reminder that the development of appropriate supports for both the publics and CRHA staff will be necessary in order to develop public participation within the organization.

The framework is organized around four components: the organizational units and responsibilities; the areas for participation; who should participate; and the level of participation. The *organizational units and responsibilities* refers to the groups in the region which are responsible for specific functions, including setting direction, establishing priorities and allocating resources, monitoring performance and establishing clinical practices (CRHA, 1999). The *areas for participation* are eight existing and future opportunities for public participation within the four organizational units. The areas are: significant issues affecting health services; values; health policies; health goals; allocating resources; what services are delivered; planning and evaluation of services; and development of clinical pathways. Under each of the eight areas for participation, the CRHA has laid out *who should be participating* and at *what level* (CRHA, 1999).

1. Definition of Public

The CRHA has differentiated the public by virtue of the degree of involvement in the issues to be discussed. For the purposes of its framework, the CRHA has described *citizens* as '*those who have no direct, immediate involvement in the program or issue*', while *stakeholders* are '*those who have a personal stake in the issue at hand*' (CRHA, 1999). By this definition, *stakeholders* can be employed in the health sector. Within the published literature, the term *public* has been used in conjunction with *community*, *citizen*, *consumer* and *stakeholder*. Different systems have used different terms at different points in time (Hughes & Larson, 1991). The literature from the United States

has regularly used the term *consumer* which is consistent with concepts of choice and the health care system as a marketplace.

2. Arnstein's Ladder of Citizen Participation

The CRHA Public Participation Framework (1999) and Wiebe, MacKean & Thurston (1998) note that public participation is a broad concept, often structured around Arnstein's (1969) ladder of citizen participation. This ladder has eight rungs, where each rung corresponds with an increasing degree of public power in the decision-making context.

On the lowest rungs of the ladder, Arnstein placed *therapy* and *manipulation.* These two levels of participation are characterized by token citizen involvement (Arnstein, 1969) and no power to affect change.

Further up the ladder of participation is the process of *informing.* Having access to information is a prerequisite for meaningful participation in a democratic process. One of the limitations of this method is that the flow of information is one-sided, with little opportunity for feedback. While information is a prerequisite for effective participation in the decision-making process in this model, it does not confer any decision-making power. Usually people are being informed of decision-makers' opinions and/or choices.

Consultation is the next rung on the ladder and is an important aspect of informed participation. The shortcoming of consultation is that it does not make explicit the ways in which the public input will be used. In practice, Arnstein (1969) argues that consultation is often little more than a public relations exercise.

Advising is associated with increasing power in the decision-making process. Some of the limitations at this level surround the composition of advisory boards, which often include minimal public representation. It is important to take into account who holds the balance of power on the advisory board as public participation can be easily controlled by powerful opposition.

The top three rungs of the ladder are *partnership*, *delegated power* and *citizen control* which are associated with decision-making by the participants. Within partnerships, decision-making power is negotiated between groups (e.g., there has been a decision to share planning and decision-making responsibilities).

Delegated power and *citizen control* are characterized by the public's control of substantive aspects of the program or policy. *Citizen control* is further characterized by the control of the funds; that is, members of the public make decisions regarding funding allocation and policy.

3. Partnership Framework

Scott & Thurston (1997) have developed a framework for evaluating community partnerships which provided a useful point of reference for examining the agreement between the CRHA and the Salvation Army. The categories in this model are: external factors; domain; partnership characteristics; partner characteristics; communication; and operations (Scott & Thurston, 1997).

External factors are those factors that influence the partnership. This includes the social, political and economic context within which the partnership functions. The impact of external factors can vary, but they must always be considered. The context of

the partnership may impact the other factors that determine the effectiveness of the partnership.

Domain is the area of interest of the partnership. The partners may have differing interests but the success of the partnership is facilitated if the partners are able to identify the shared focus of the partnership.

Partnership characteristics are the factors which distinguish the partnership. These may include the organizational structure of the partnership; the resources available; and the reputation of the partnership.

Partner characteristics are the factors that distinguish the partners. Each organization entering into a partnership will bring its own culture; history; and resources; which will influence the resulting partnership. *Communication* impacts all of the aforementioned categories. Formal and informal strategies of communication must be recognized. Communication will directly or indirectly affect the partnership. Communication will have a critical impact on the partnership and should be continuously monitored and evaluated to determine the appropriateness of the strategies at a given point in time.

Operations are the activities carried out by the partnership. The operations impact the success of the partnership. The structure and the context of the partnership will impact the operations. The success of the activities will be impacted by the available resources (including time) and the knowledge of similar programs.

C. Women and Public Participation

Although the literature on women's participation in health planning and policy is sparse, other disciplines include public participation in their methods and have included some gender analysis. Little (1994), in speaking of the analysis of the urban planning literature on gender and public participation, stated the goal as "...to identify the extent to which planning, almost by default, can act against women's interests and in doing so help maintain the unequal distribution between women and men" (p.8). The literature focuses on two issues: the recognition (or lack of it) of women's needs in planning policies: and women's relationship with the decision-making process in fields other than health. The following sections examine the field of urban planning as an example of how women's needs have come to be recognized in the planning process and the issues with respect to women, power and decision-making, including examples of women's organizing in Canada.

1. Women's Needs as a Focus of Planning

One field in which women's needs have received notable attention is urban planning (Little, 1994; Garber & Turner, 1995). Since the 1980s, there has been extensive analysis of women's needs in the built environment. The evolution of the contemporary city is linked to the organization and operation of gender and power relationships. There exists a two-way relationship between gender and land use planning. The way that cities are designed is a response to gender relationships and the organization of women's lives, but women's lives are also responses to the city as it has been planned (Little, 1994)

The early industrial city was designed to reflect changes to work and home. Prior to industrialization, the home was the primary site for most economic production. The industrial revolution led to the separation of work and home (Little, 1994). With the move to work in factories, the differentiation and reinforcement of women's social position was solidified. Women's place was in the home and the home was no longer the site of important economic activities, thus women were not seen as important contributors to economic life.

Over time, urban development focused on public and private spheres. The public sphere was the site of employment, economic and political activities, while the private sphere was the site of home and domestic activities (Little, 1994). The gendered use of space examines the use and purpose of the private and public spheres.

The move to suburbanization and the further separation of home and work in the twentieth-century has had a huge impact on women. Despite the positive health effects of moving residential areas away from the pollution and noise of factories within the city, it has served to separate women from employment opportunities. It increased their need for transportation and mobility, as shops and services were also removed from residential areas. This has continued to be a factor, as women's entrance to the public sector is often hindered by lack of transportation and child care, without which they are isolated in their suburban homes (Little, 1994; Watson, 1999).

The shifting boundary between public and private spheres is a hallmark of a more gender sensitive planning of land use. One example where this has happened is the revitalization of inner city neighbourhoods (Little, 1994). The inner city has many of the

qualities that meet the needs of women. Access to transportation and proximity to employment opportunities are some of the benefits of mixed use land zoning. On the other hand, busy roads, pollution and safety concerns for women and their children have been some of the hallmarks of the inner city. These health and safety topics for women and their families have been the focus of much of women's organizing around land use planning (Little, 1994).

This review of urban planning shows that women's needs must be incorporated into the larger planning framework and not be left to appear as a benevolent afterthought. Women's participation in planning and policy cannot be divorced from their wider access to power. The lack of involvement in the past and the low priority given to gender issues in planning is symptomatic of women's lack of power in the decision making process, discussed in the next section.

2. Women, Power and Decision Making

Women's access to political power and channels of decision-making impacts the role of women in policy and planning (Lovenduski & Hills, 1981). For women, their ability to participate in politics is often reflective of their ability to participate within other areas of the society. Traditionally, women's involvement in the parliamentary system has surrounded the issues of suffrage, contraception, child care, children's health, and abortion (Little, 1994). Women's organizing has tended to be at the grassroots level and is often the work of community action groups. This action is often at the local level and is frequently nonpartisan (Brodie, 1995; Vickers & Brodie, 1981). The areas where women have affected decisions tend to be within the private sphere.

In Canada, women obtained the right to vote federally in 1919. Several factors impacted the movement for the vote in Canada. Canada's system of governance is a decentralized federal system with a complex separation of powers between the provinces and the federal government. This complex division of power makes it necessary for any group wishing broad societal reform to develop organizations that are able to lobby the provincial and federal governments simultaneously (Vickers & Brodie, 1981; Briskin, 1999). In addition to the barriers posed by the complex structural organization, Canada is also home to several regional divides as well as a linguistic divide. Since there was not a cohesive, nationwide movement for suffrage, there were no lasting allegiances or alliances formed. The barriers faced by women's suffrage remain for any group wanting to develop a cohesive movement for social change (Bergqvist & Findlay, 1999). Nevertheless, strong regional women's movements have combined to form an active national movement.

In Canada, the Royal Commission on the Status of Women (RCSW) was established in 1967. The Commission came about due to the work of a grouping of more than thirty women's groups, under the auspices of the Committee on Equality and the Federation des Femmes du Quebec. These groups lobbied the federal government to establish a royal commission to investigate the status of women in Canada and to recommend policy responses (Brodie, 1995; Bergqvist & Findlay, 1999).

Launched by the Pearson government in 1967, the Commission was directed to " recommend what steps might be taken by the Federal government to ensure for women equal opportunities with men in all aspects of Canadian society" (Canada, 1970, as cited

in Bergqvist & Findlay, 1999). In 1970, the Commission completed its report, which included 167 recommendations.

The Commission and its report had a major effect on the political agenda for the women's movement during the 1970s (Brodie, 1995). Most important was the changed relationship of women's organizing with the government. One of the ongoing struggles within the women's movement is the debate over whether it is possible to work with the government to effect change or whether it is necessary to struggle outside the mainstream in order to avoid co-option (Brodie, 1995; Bergqvist & Findlay, 1999).

Following the Royal Commission, many women felt that the government would respond to their concerns (Brodie, 1995). As a result, during the 1970s the women's movement started to look much like any other lobby group. Feminists began to develop expertise in a variety of areas, including social policy, as well as developing formal lobbying skills. Many government departments charged with "women's issues" were developed at both the federal and provincial levels (Brodie, 1995).

During this time, many women's groups organized under the umbrella of the National Action Committee on the Status of Women (NAC). The target of most NAC lobbying was the federal government. The women's movement was increasingly viewed as a legitimate political lobby and was treated accordingly with access to higher levels of political bureaucracy, and program funding for women's programs.

The political impact of NAC and women's organizing in Canada was highlighted during the constitutional reforms in 1981 (Kome, 1983). The federal government appeared to support constitutional guarantees for sexual equality. It soon became

evident, however, that the federal government was trying to build public support for its planned unilateral constitutional changes to which the provinces objected. The women's movement discovered that the government was prepared to allow the provincial governments to override the equality guarantees included in the Canadian Charter of Rights and Freedoms by using the notwithstanding clause. A massive lobbying effort was organized across the country and the sexual equality clause was included in the Charter and protected from the use of the notwithstanding clause (Brodie, 1995). This mobilization had significant implications for women's participation in policy because it not only empowered established women's organizations but also energized women who had never previously been involved in women's organizing.

3. Women's Health Movement

Health issues were among the first to spark large scale organizing by women. One of the hallmarks of feminist women's organizing has been the effort to bring what was hidden by the private sphere into the public sphere of responsibility. Subjects that were previously considered as belonging to the private, reproductive world of the home, such as child care, access to safe contraception, abortion and violence against women have become part of the public sphere through the organizing of women. Instead of being private, personal issues, these subjects are now being recognized as important determinants of the health of women (Doyal, 1995). The women's health movement is therefore at the intersection of the private and the public spheres.

The women's health movement has been closely associated with the idea of public lay participation in healthcare (Levin, 1995) with an emphasis on making

women's voices heard within the health system (Cohen, 1994). The women's health movement began in the late 1960s and early 1970s in North America and focused on a growing discontent with the practice of medicine and the power imbalances intrinsic to the biomedical model (Doyal, 1995). Women have traditionally been involved in the healthcare system, as patients, workers and caregivers, but have had very little power over the content and practice of medicine as it related to them (Pan American Health Organization, 1993).

One of the initial goals of the women's health movement was the demystification of women's bodies (Doyal, 1995). Towards this end, the Boston Women's Book Collective produced the seminal book Our Bodies, Our Selves (1970). This best selling book encouraged women to become experts on their own bodies and to believe that their concerns were valid. The increase in women's knowledge and confidence led to the questioning of medical professionals' monopoly on health care information (Rogow, 1994). The subsequent demand for knowledge took the women's health movement to the level of information on Arnstein's ladder of participation.

Historically, the women's health movement has protested against the medicalization of women's health, particularly women's reproductive health and mental health (Auerbach & Figert, 1995). Within these contexts, medicalization was seen as a tool to reinforce societal inequities facing women (Doyal, 1995). The movement to reclaim women's knowledge about their bodies also led to the development of women-centered health centres which focused on the context of women's lived experiences (Wuest, 1993).

Globally, the women's health movement has many shared characteristics. Women's health has focused on the social justice and human rights implications of women's health (Gray, 1998; Pedalini, Dallari & Barber-Madden, 1993). Women around the world have been strong advocates of access to health care, advocating women-centered care, protesting the medicalization of women's health and fighting violence against women (Griffin, 1994; Pan American Health Organization, 1993).

The women's health movement has historically been linked with the fight for human rights. Through this work, the women's health movement has developed links with other social justice organizations, including faith communities. The relationships among faith communities and the women's health movement are complex but have played important roles in the delivery of women's health care.

D. Faith Communities

When examining the literature surrounding religion and health, we were struck by the complexities surrounding the choice of appropriate terms. We have used the term *faith community* to refer to a religious group in the broadest sense. We have used the term *church* to refer to the physical site or location of the faith communities operations. This was a deliberate choice of phrase because, although multiple search terms were used, the published literature only referred to Christian churches in their discussion of health and site. By no means does this negate the impact that other types of faith communities have on the health of their communities but simply reflects the current, published literature in English. In addition, we have used the term *religion* when describing parts of the practice of a particular faith community, such as prayer or the

general beliefs of a faith community. It is also important to note that although there is considerable research on faith communities and health, none of the published literature referred to the Salvation Army.

1. The Salvation Army

The Salvation Army is a faith community with a history of involvement in social justice and health care issues. The Salvation Army developed from the missionary work of William Booth in England in 1865 (Moyles, 1977). It was his combination of "Soup and Salvation" that provided the key to the success of his Army. The soup became a metaphor which included hostels, women's shelters, emigration department, and help for the unemployed. The salvation was based on Methodist teachings, and was preached by an Army of dedicated officers and soldiers complete with flags, uniforms, bands and war songs (Moyles, 1977). By the end of the nineteenth century the Salvation Army had become one of the leading social reform agencies in the England.

Although the Salvation Army's first mission was salvation, they established themselves early as an agent for social reform. One of its first social changes was lobbying in Britain to change the age of consent in an attempt to minimize the numbers of girls being sold into prostitution (Moyles, 1977). Following a campaign led by the Salvation Army, the age of consent was changed from thirteen to sixteen in 1885. After this early experience, the Salvation Army dedicated much energy to services for women, including shelters, homes for unwed mothers and programs for prostitutes. One focus of the Salvation Army's social services for women, worldwide, has been the provision of services for unwed mothers, and adolescent women.

In addition to providing services to women in need, the Salvation Army has a history of including women within the religion. Founder William Booth's wife Katherine was a powerful figure in the church and the status of women within the church has remained high, including opportunities for leadership in all levels of the organization (Moyles, 1977).

In Canada, the Salvation Army has been active since 1882 (Moyles, 1977). The Salvation Army was introduced to Canada by the arrival of hundreds of immigrants who had been introduced to the Salvation Army in England. In Calgary, the Salvation Army opened a small home for unmarried mothers in 1910 (Hardwick, Jameson & Tregillus, 1975). Over the years, the demand for this service grew and the Salvation Army moved to bigger quarters. Soon the demand for maternity services led them to open their doors to private patients in addition to charity cases. In 1926, it became known as the Grace Maternity Hospital and Girl's Home (Hardwick, Jameson & Tregillus, 1975; Rothwell, 1976).

Grace Hospitals were opened in several locations across Canada. Owned and operated by the Salvation Army, they were originally designed to meet the health needs of those who could not pay for care. The Salvation Army has historically provided service to all those in need, rather than only those of their denomination. Over time, the Grace Hospitals have expanded their mandates, and are now public hospitals financed by the public health system but operated in accordance with Salvation Army principles (Moyles, 1977).

In Calgary, the Salvation Army Grace Women's Hospital provided a range of women's health services including surgical services, low-risk maternity and obstetrics. In 1986, the Grace Women's Health Resources Centre was opened and began providing health information and education to women in the Calgary region.

The Governing Council of the Salvation Army in Canada established a board of trustees to govern the Grace Women's Hospital and the Agape Hospice. After the CRHA was established, the board of trustees of the Salvation Army Grace Women's Hospital was terminated in March 1995. In its place, the Salvation Army established the Salvation Army Health Council to look after the interests of the Salvation Army within the Calgary Regional Health Authority. The Health Council is responsible for ensuring that the mission, vision and values of the Salvation Army are maintained. The mission, vision and values of the Salvation Army are not represented in a single document but rather are a reflection of the tenets, publications and the mission of the Salvation Army, put in practice through the processes of the Health Council. The Health Council includes community members as well as representatives of the Salvation Army.

2. Religion as a Determinant of Individual Health

A growing body of evidence has examined the connection between religion and health. In the mid-1980s, a series of review articles examined the evidence concerning the effects of religion on an individual's health status (Ellison & Levin, 1998). The reviews drew on hundreds of studies containing at least one religious indicator and one or more physical health indicators. As a body of literature, these studies indicate that rates of morbidity and mortality vary across religions and religious denominations (Jarvis &

Northcott, 1987), and that, on average, high levels of religious involvement are moderately associated with better health status (Ellison & Levin, 1998). The positive effects have been shown in men and women of all ages, in samples drawn from a wide-range of religious groups, and from diverse social class backgrounds (Ellison & Levin, 1998).

Religious involvement, broadly defined, has generally desirable effects on a wide range of 1) health outcomes, including: heart disease, hypertension and other circulatory ailments, stroke, mental health (Mirola, 1999), cancer (Troyer, 1988) and gastrointestinal disease 2) cancer screening (Fox, Pitkin, Paul, Carson & Duan, 1998), as well as 3) perceived overall self-rated health status. Despite variations in the particular health outcomes and the religious measures used, most of the review articles tend to show significant, positive effects of religious involvement on health (Ellison & Levin, 1998).

Some of the proposed mechanisms for the protective actions of religious involvement include: the regulation of individual lifestyles and health behaviours; the provision of social resources through social ties; and both formal and informal support (Ellison & Levin, 1998; Davis, Bustamante, Brown, Wolde-Tsadik, Savage, Cheng. & Howland, 1994).

The social support and control of the religious community may provide an environment that discourages certain behaviours that increase the risk of health problems and encourages positive, low-stress lifestyle choices (Ellison & Levin, 1998). The most obvious example of this is certain sects and denominations (particularly Mormons and Adventists) which discourage tobacco, alcohol and substance use and abuse. These

groups have significantly lower rates of many chronic diseases such as cancer (Troyer, 1988). In addition, religious factors may impact risky sexual behaviours, through constraints on pre-marital and extra-marital sex (Ellison & Levin, 1998). The studies discussed above, however, did not examine or speculate about whether religious involvement made one more health conscious or more likely to participate in community affairs.

3. Religious Organizations as a Site for Health Promotion

Churches provide an established physical location within the community, including a set of social and physical support systems, factors that make the church an important site for health promotion activities. Churches provide an established power structure – the clergy and laity, as well as established social programs and a volunteer base (Thomas, Quinn, Billingsley & Caldwell, 1994). In addition, churches have a built-in system to provide social support and normative behaviour that may reinforce behaviour change.

Churches have been used as sites mainly for education- and prevention-based health promotion programs. This type of health promotion program most widely described in published literature is the use of churches in African-American communities as sites for programs addressing cardiac risk factors (Thomas, Quinn, Billingsley & Caldwell,1994). Church-based programs have included: smoking cessation programs; exercise programs; cholesterol and blood-pressure monitoring; and dietary change (Thomas, Quinn, Billingsley & Caldwell, 1994). Programs to encourage cervical cancer

screening (Davis, et al., 1994) and mammography have successfully operated out of churches, as well as programs for asthma and mental health.

There are several factors that impact the involvement of churches in health programs. Programs based out of or partnering with faith communities have high rates of adherence (Prohaska, Peters & Warren, 2000) and high rates of completion (Strogatz, James, Elliott, Ramsey, Cutchin & Ibrahim, 1985). In addition, programs originally established for research trials often continue to be delivered within the church after the trial ends (Prohaska, Peters & Warren, 2000). Churches are also a source for participants for health programs. Individual churches tend to be quite homogenous, so a program developed for a specific church may be effective because the church congregation will tend to have similar demographic characteristics. The church also provides a source of volunteers and lay health educators who have connections to the community and may be seen as influential peers (Davis et al., 1994).

Programs offered by churches are often closely matched to the issues which the neighbourhood ranks as important (Thomas et al., 1994). The church is often a responsive institution to the needs of a community which means that there is a potential for churches to impact public participation. There is little published on this aspect of church work within the traditional academic literature. The Salvation Army is known world-wide as a social service agency, but its role as a faith community is less well-known.

Faith communities may provide access to under-served populations who may not access medical services in traditional ways. Programs often build on the relationships

built by the church in order to improve service provision (Levin, 1984). The church has been shown to be particularly effective in reaching minority communities (Davis et al., 1994) and older women (Ransdell, 1995).

Many health initiatives situated within a faith community have been successful, but it is important to examine what programs are most often offered through churches. Churches are most likely to participate in programs that do not require liberalization of church doctrine; programs that address cardiac risk factors are easy for the church to support, as they espouse the virtues of "clean living" (Thomas et al.,1994); programs that encourage cancer screening, such as cervical screening or mammography are also popular.

More problematic are programs that address sexual health or drug and addiction issues (Coyne-Beasley & Schoenbach, 2000). Although faith communities can be important sites for health promotion, some barriers have become apparent. Some churches are hesitant to develop new programs, citing a shortage of dedicated volunteers and resources (Thomas et al., 1994). Like most institutions, churches are faced with limited resources and developing a new program requires finding funds from another area or church program. Churches have a history of providing a site for health programs but the possibility exists for faith communities to play a larger role in the health of their communities.

4. Religious Organizations as Community Organizers

The important role that churches and faith communities play in the realm of health is not surprising. There has been a growing acknowledgement of the broad

determinants of health and the role that faith communities may play in supporting healthy behaviours and health programs in the communities (Abuelouf, 1999; Connelly, 1999).

Community empowerment toward health-related goals requires both organizational and individual empowerment. All organizations can contribute to social capital and the building of community capacity. Faith communities have long been seen as strong community organizers, often organizing for social justice and grassroots advocacy (Cochran, 1999).

Well-connected communities tend to be well-organized internally, and capable of collective action. The three dimensions of connectedness include a sense of identification with the community, interaction within the community and linkages outside the community. Faith communities meet all the dimensions of connectedness, making faith communities powerful organizations and a source of social capital (Greeley, 1997). Like all social institutions, churches and faith communities are organized in ways that impact who participates and who does not. These structures have historically excluded some. While the traditionally marginalized such as immigrants and the economically disadvantaged have found a place within faith communities, the role of women continues to be contested, as do the rights of homosexuals.

Faith communities are made up of individuals with shared ties and concerns, as well as ties to other organizations outside the community. Faith communities provide formal and informal ways for residents to interact. Churches are social institutions that have a position of power in the lives of their congregations (Greeley, 1997).

One of the ways that faith communities interact with the broader community is through social service activities, including the provision of healthcare. One example is the advent of parish nursing programs, where a particular church partners with a nurse to provide care to their parishioners in the community (Weis, Matheus & Schank, 1997). Within the Canadian system, hospitals affiliated with religious groups have not served as an alternative stream of health care, but rather have been integrated within the larger health system (Ellison & Levin, 1998). Denominational hospitals are open to all those in need of care, but operate within the principles of the particular faith community, often in conjunction with a local health authority.

Often faith communities and the health care system have very different world-views which can contribute to mistrust and a lack of understanding (Gallagher, 1997). Some of the areas where religious communities have ethical opinions are reproductive technology, contraception, abortion, and end of life decisions (Place, 1999). Many of these areas fall within the mandate of women's health (Gallagher, 1997; Weisman, 1999). This has made it especially problematic for faith communities to remain involved in women's health programs while balancing their convictions and the rights of patients to complete information and medical care (Weisman, 1999).

E. Summary

The CRHA's desire to develop and implement a Public Participation Framework is consistent with an increasing emphasis on the use of public participation within the health system. The legal agreement between the CRHA and the Salvation Army offered an opportunity to examine women's participation in health policy. The Salvation Army

is a faith community with a history of involvement in women's health, as well as social services. Faith communities play a role in the health of communities as well as providing a venue for public participation. Women's participation in policy is linked to the inclusion of women's needs in the planning and policy process, as well as women's access to power and decision-making.

III. Research Goal and Objectives

A. Research Goal

The goal of this case study was to explore the influence of the agreement between the Salvation Army and the CRHA on women's participation in health policy and planning.

B. Research Objectives

1) Characterize the relationship between the Calgary Regional Health Authority and the Salvation Army;
2) Describe the implementation of the agreement between the Calgary Regional Health Authority and the Salvation Army;
3) Identify and assess strategies for public participation used and proposed by the Grace Women's Health Centre; and
4) Identify women's health issues affected by this agreement and the current status of those issues within the policy development process.

CHAPTER 2: METHODS

I. INTRODUCTION

This project was well suited to a case study, since the research is exploratory, the relationships among variables are uncertain, and the context is important to understanding (Yin, 1993). A case study offers an opportunity to provide rich, thick description which can enhance the relevance of the findings to other settings (Yin, 1993). The case study method is ideally suited to an investigation that must include both a particular phenomenon and the context within which the phenomenon is occurring. The context was hypothesized to contain important explanatory variables about the phenomenon. The CRHA Public Participation Framework (1999) and Arnstein's (1969) ladder of participation both identified the context as an important variable. The phenomenon for this case study was the agreement between the Salvation Army and the CRHA. The case study method allowed for the use of multiple strategies for data collection (Marshall & Rossman, 1995) including: interviews with key informants; document review; and newspaper article review. This case study was a time-limited investigation but included key informants who had historical knowledge of the case.

II. SAMPLING STRATEGY

Marshall and Rossman (1995) assert that because of the positions that they hold within the organization, key informants can provide valuable information about the policies of a particular organization as well as the past history and future plans. A list of people believed to be key informants was developed by the research team and included stakeholders from the following groups: Salvation Army Health Council; CRHA Board;

CRHA manager – Administration Leader Women's Health; Grace Foundation; Maternal-Child Health Group; staff of the Grace Women's Health Centre; and community-based women's health groups. These groups were involved with the planning and delivery of women's health in the Calgary region for the past five years.

The sampling strategy began with the founding head of the Salvation Army Grace Women's Health Centre. Due to the historical context of the agreement, she was asked to identify people who would be rich informants. The next interview was the current head of the Grace Women's Health Centre, who was also asked to nominate key informants. The generated lists were compared and decisions were made in a purposive way, with all decisions accounted for and included in the data analysis. Potential informants were contacted by either telephone or e-mail to establish their willingness to participate in the study. Upon their approval, information forms were e-mailed or faxed to them. If the informant was interested, a date was established to commence the data collection process.

Prior to the commencement of interviews, informants were asked to identify and provide documents that would address the research questions, (e.g., meeting minutes and project proposals).

III. DATA COLLECTION

One of the data sources examined was the archive of a local newspaper. These documents gave an idea of the issues that were being discussed in the local media. The public receives much of its information from the media and by examining the news coverage of a particular event it is possible to see how that coverage may impact the

public's perception of that event. "Media discourse is part of the process by which individuals construct meaning..." (Scheufle 1999 p105).

Another data source was the key informant interviews. The purpose of each interview was to get the informant's perspectives on the agreement and on public participation in women's health policy. Through probes and questions, the interviewer encouraged the respondents to provide descriptive data to enhance the understanding of the topic. Although an interview guide (Appendix A) identified the areas of interest to the research, the order of the interview topics and the phrasing of the questions and probes remained flexible. The guide was used in its original format throughout the interviews.

Data collection from the interviews included the audio-recording of interviews, the subsequent preparation of a verbatim transcript, and field notes. Field notes included descriptions and reflections detailing the day to day activities, methodological notes and decision-making procedures, personal notes about motivation and experiences with informants.

Several steps were taken to ensure thorough and complete data collection. The interviewer spot checked the tape-recorder and ensured the quality of taping. During two interviews, portions of the tape were inaudible, once due to background noise, the other it was unclear why. In these cases, the tape was immediately transcribed by the interviewer to ensure that the general tone of the interview was preserved. The transcripts were then returned to the interview subjects for their confirmation before beginning analysis. Both transcripts were accepted by the interviewees as accurate representations of the

interviews. The interviewer recorded descriptive and reflective information during the data collection and analysis sections. A commitment to well-labeled materials and well-organized notes helped to deal with the copious amounts of data collected during the study.

IV. DATA ANALYSIS

The data analysis process was not entirely separate from the data collection process. The analysis process was an iterative one, with the researcher moving among data sources as questions emerged, in order to build a clear picture of the case. Both the student and research supervisor were involved in the decisions with respect to data collection and analysis which allowed for further discussion of decisions.

The verbatim transcripts produced from interviews, document summaries and field notes were imported into the QSR NUD*IST 4 (Qualitative Solutions & Research, 1999) software program for qualitative analysis. NUD*IST allowed for each subject's data to be kept as a separate file in the case. Each interview was first considered as a single unit and analyzed separately before being compared to other interviews. Interviews were then compared to each other, public documents were compared to each other and internal documents were considered in another file. The legal agreement remained in a file by itself. The decision not to merge the files came about as a result of discussion of the student and supervisor. This separation of documents by source was maintained throughout analysis since although similar themes emerged from all the documents, the separation allowed the researchers to track changes in tone, differences in

information availability between the public and private discourse and differences in focus.

The basic data analysis procedure was broken into two parts: a) data reduction, the write-up of field notes and transcription; b) data reconstruction, development of categories, connections to existing literature and integration of concepts (Marshall & Rossman, 1995).

An analysis method called the constant comparative method was used (Glaser & Strauss, 1967). Open coding refers to the part of analysis that dealt with the labelling of phenomena as indicated by the data (Strauss & Corbin, 1990). Data were initially broken down by asking simple questions such as what, where, how, when and how much and given a code. This process involved noting similarities among the data. Subsequently, data codes were compared and grouped under a conceptual label. The process of grouping concepts at a higher, more abstract, level is termed categorizing. As categories emerge, the researcher searched for those that had internal convergence and external divergence (Lincoln & Guba, 1985). The categories should be internally consistent but distinct from one another. Whereas open coding fractures the data into concepts, axial coding puts those data back together in new ways by making connections among a category and its sub-categories, and across categories (Strauss & Corbin, 1990). Thus, axial coding refers to the process of developing main categories and their sub-categories.

V. ESTABLISHING TRUSTWORTHINESS, CREDIBILITY AND TRANSFERABILITY

Lincoln and Guba (1985) have proposed several constructs that may stand as criteria for determining the soundness of a qualitative research project.

Trustworthiness speaks to the concept of confirmability (Lincoln & Guba, 1985). That is, could another researcher have confirmed the findings of the study? In order to ensure trustworthiness, the interpretations of the researcher were compared to those of the thesis supervisor. This allowed for the assessment of similarities, differences and documentation of the decision process. Strategies for ensuring trustworthiness are designed to balance the possibility of bias in interpretation or by making it explicit..

One of the techniques used to demonstrate the validity of the data collection and analysis process is *bracketing* (Ahern, 1999). Bracketing is described as the means by which the researchers attempt to ensure that their assumptions do not shape the data collection process (Ahern, 1999). To this end, the researchers considered each interview separately, and later considered the interviews in relationship to each other. The goal of this process is to allow the data, rather than the biases of the researcher, to shape the analysis.

Credibility is the demonstration that the project was conducted in a manner that ensures that the subject was accurately identified and described (Marshall and Rossman, 1995). An in-depth description clearly demonstrating the complexities of the variables and the interactions with the setting will aid in determining the credibility of the study. In order to enhance credibility, a modified audit was performed. A member of the

supervisory committee randomly selected a transcript and the corresponding audio-tape and ensured that the interview had been accurately transcribed. In order to enhance analytic credibility, the thesis supervisor coded several sections of data and those coding decisions were then compared to the coding decisions of the student researcher.

Each participant was asked if she/he would like to review a preliminary report of the analyzed data. The preliminary report was provided to those persons who were interested; they were asked to consider the preliminary report and asked if it made sense to them. Participants were given ten days to return comments to the researchers; these comments were considered new data and were included in the analysis and discussion.

Transferability describes the burden of demonstrating that the findings from one case are applicable to another context (Lincoln & Guba, 1985). The burden of transferability lies with the audience who would transfer the information rather than with the initial investigator. The responsibilities of the investigator are to ensure that a complete, rich description of the context and findings are provided to allow readers to evaluate the applicability of the results to different settings and situations. The transferability of a study can be enhanced through the use of triangulation of multiple sources of data (Lincoln & Guba, 1985). Triangulation is the process of bringing multiple sources of data to bear on a single point. Within this study, the use of multiple key informants, and the use of interview data, document review, field notes and media analysis were used to corroborate, elaborate or illuminate the topic in question (Marshall & Rossman, 1995)

VI. ETHICAL CONSIDERATIONS

The Salvation Army Spiritual Values Committee, thesis supervisory committee, and the Conjoint Medical Research Ethics Board reviewed and approved the protocol.

A. Confidentiality and Anonymity

Each informant was asked to sign a letter of informed consent (Appendix B) and was given a copy to retain in his/her records. There was little or no physical or emotional risk to the participants in this study. There may have been a perceived social risk when expressing unpopular opinions in an often highly political arena; this risk was minimized by assurances that all interviews will be private and quotations, opinions and conclusions will not be attributed without permission. Identity of participants and non-participants were kept confidential. Since there are few individuals in leadership positions, the researchers did not attribute findings to positions or levels of the organizations without permission from those people. Thus, some findings were presented as "from the CRHA (or Salvation Army) perspective" without saying where in the organization the data were collected. Very few quotations from the key informant interviews are included in the Results chapter. The small numbers of participants who had access to specific knowledge and the close ties among many of the participants made it impossible to present this data without inadvertently identifying the key informants.

Protection of the anonymity of the participants includes the way in which interview material was handled. All transcripts and audiocassettes were labelled only by subject number and were kept in a locked file cabinet. No one other than the researcher and the research supervisor had access to the materials linked to the subject name. The transcriptionist and committee members had access to copies without personal identifiers.

Upon completion of the study, the research supervisor will keep the list of subject names and numbers for a period of seven years, in accordance with the University of Calgary policy.

Individual interviews were chosen to ensure that confidentiality was protected. Interviews were held at the location of a participant's choice and included offices and homes. The transcriptionists signed pledges of confidentiality (Appendix C).

B. Obtaining Consent

Participants received written assurance of their rights to not answer particular questions and to terminate the interview at any time without penalty. These rights were described orally and they were asked to read and sign a paper that described these rights fully before proceeding with the interview. The participants were also asked to consent to the audio-taping of the interview at this time. Due to their employment positions, it was assumed that subjects understood both oral and written explanations.

C. Confirmation

Those participants who had indicated an interest received a copy of an interim report. This was done to assess how well impressions and conclusions accurately reflected the views of the key informants. Key informants were asked to return comments to the student researcher. One set of comments was returned. The student researcher and thesis supervisor discussed the comments and reached consensus as to whether or not the conclusions would be amended.

CHAPTER 3: RESULTS I

I. INTRODUCTION

This chapter includes a full description of our current case including a description of our sample and the resulting legal agreement. The case study was designed to explore the impact of the agreement between the Salvation Army and the CRHA on women's participation in health policy and planning. This description will allow others to understand the context of the current case, which is situated in place and time.

II. THE SAMPLE

Four sources of data were analysed to develop the understanding of the case. Data from key informants was provided during eight individual interviews which took place between January 2000 and December 2000. The key informants included staff of the Grace, current and past Grace management, members of community women's groups involved with a public participation project, a past CRHA board member, and a member of the Salvation Army Health Council. Sampling continued until saturation was reached, that is until no new, relevant information was gleaned from additional interviews or documents (Marshall & Rossman, 1995). This occurred after the review of documents and the eighth interview.

The second data source was the internal documents of the CRHA and the Salvation Army. The researcher attempted to access documents that discussed or mentioned the Grace or the agreement from both the CRHA and the Salvation Army. Although many informants suggested documents, they were either unable or unwilling to provide them, so the documents were accessed by requests to the Salvation Army

Territorial Headquarters and the CRHA board office and archives. The CRHA archives were able to provide access to minutes of the Board of Trustees of the Salvation Army Grace Women's Health Centre from 1993 until the termination of the board in 1995. These documents included minutes from regular board meetings, special board meetings, and joint board meetings with the Board of the Foothills Hospital. In addition, the Salvation Army Health Council provided a copy of the legal agreement, excerpts from the Health Council by-laws and a summary of issues arising during Health Council Meetings from 1995 – 2000. The Salvation Army Grace Women's Health Centre staff also supplied the terms of reference for the Women's Health Express advisory committee.

The minutes of the public portions of the CRHA board meetings from 1994 until December 2000 were requested. The initial request was made to the CRHA archives which in turn referred the researchers to the CRHA board office. The researcher contacted the CRHA Board office and requested the documents. Following over 40 phone calls and two months of waiting, the researcher was informed that the documents could not be released because they might contain sensitive contract information. In December 2000, a formal request to access the CRHA Board minutes was made under the Freedom of Information and Protection of Privacy (FOIPP) Act. Although the researcher was requesting access to the minutes of the public portion of the meeting only, the CRHA stores all the meeting minutes together, so that considerable fees would apply in order to prepare the documents for disclosure. At this time, the research team decided not to further pursue these documents.

The third source of data was the archives of the Calgary Herald. The electronic archives of the Calgary Herald were searched for articles referring to the Grace, Women's Health, the CRHA and the Salvation Army. Nearly 200 articles were reviewed and the 25 articles which touched on the subjects of interest were chosen for analysis.

The final data source was the field notes of the researcher. These field notes were descriptive and reflective notes detailing the day to day activities, methodological notes and decision-making procedures, personal notes about motivation and experiences with informants.

The decision to limit the documents from the Calgary Herald and the Salvation Army Board to those since late 1993 was due to the fact that both the CRHA archive and the electronic archives from the Calgary Herald were not available for dates prior to 1993, making further document retrieval difficult and inefficient.

For this particular case, the historical context was important to our understanding of the agreement as it exists now. The events taking place in the Alberta health system at the time helped to shape the agreement. For the purposes of this case study, we have considered the agreement between the Salvation Army and the CRHA from the fall of 1993 to the end of December 2000. By taking a historical perspective, we were able to examine the development of the agreement within a context of change in the health system as well as the implementation of the agreement within the restructured health system and the continued implementation of the agreement over time.

Although many different terms were used when searching the literature and data sources for this project, we have chosen to use the term *public participation* to refer to

the involvement of either citizens or stakeholders in the policy and planning process. For the purposes of this thesis, stakeholders employed in the health sector will be referred to as *health professionals*.

III. DESCRIPTION OF THE CASE

The phenomenon of interest is the legal agreement between the CRHA and the Salvation Army. The legal agreement has defined the relationship between the two organizations and has allowed the relationship to survive during a period characterized by change in the health care system in Calgary. The following section will describe the events leading up to and the context and implementation of the agreement.

A. Sequence of Key Events

Several major events were highlighted in the documents and interviews. These major events were principally about the physical site of the Grace but also served to illustrate the magnitude of the changes that occurred leading up to the legal agreement. Figure 1 (p.42) illustrates some of the key events in the history of the Grace.

Figure 1. Timeline of key events in the history of the Grace

1904	Grace begins as home for unwed mothers – 211 11th Ave
1926	Moves into 14th street location – Salvation Army Grace Maternity Hospital and Girls Home
1954	2 story west-wing added to existing hospital
1958	Third story added to west wing – approved as Women's General Hospital
1959	Department of surgery opened
1965	Girls Home relocated to Cameron Avenue
1967	South Wing opened
1986	Women's Health Resource Centre started
February 1994	Talks begin with Foothills and Grace – possible site partnership
April 1994	Hyndman Report suggests Grace services move to Bow Valley site
June 1, 1994	CRHA Board members announced
June 1994	Regional Health Authorities Act passed
July 14 1994	Grace move to Foothills site announced by Minister of Health
November 1994	Finalizing agreement to move to Foothills site
January 31 1995	Maternity ward closed
March 31 1995	▪ Termination of Grace Hospital Board of Trustees ▪ Signing of interim agreement between the Salvation Army and the CRHA – covering the interim governance of the Grace and the agreement to move to the Foothills site
August 1995	First legal agreement signed
November 15 1995	In-patient surgery, surgical wards closed at Grace site
February 14 1996	Announcement of Nova's $2 million dollar donation for Grace Women's Health Resources
February 29, 1996	Closure of Grace Hospital site
March 11, 1996	Move to Foothills site completed and programs begin
May 5 1998	Current Legal Agreement is signed

B. The Agreement

1. Leading Up to the Agreement

By the fall of 1993, it had become apparent that changes were going to take place within the healthcare system and institutions were lobbying to consolidate their public and political support. Following the Hyndman Report, it was suggested that the Grace programs should be moved to another site as part of a Community Health Centre. The programs would not be part of a holistic women's health program but rather simply outpatient programs within a bigger centre. This recommendation did not allow for the continued involvement of the Salvation Army.

Faced with hospital closures, the Chair of the Salvation Army Grace Hospital Board of Trustees met with the Chair of the Board of Foothills Hospital, discussing the possibility of a partnership between the Grace and Foothills Hospitals. Discussions were based on a site partnership, an arrangement similar to the agreement between the Tom Baker Cancer Centre and the Foothills Hospital, where the two organizations were on the same site but operated independently.

The discussions included many different issues, such as the site that the Grace would occupy. Of concern was the ability to provide women's health services in a consistent, congruent manner, rather than in a disjointed manner. The North Tower of the Nursing school was suggested as a possible site but the Salvation Army was concerned that procedures that were inconsistent with their mission, vision, values and positional statements would be performed in the rest of the building. The Salvation

Army was assured that no procedures that were inconsistent with their mission, vision and values would be performed in the building. Other concerns included the status of the Grace Hospital physicians and their relationship with the Foothills Hospital and the maternity and obstetrics programs there. The Grace offered low-risk maternity and obstetrics, as did the Foothills. Both parties agreed that it was important to avoid duplication of services but the initial consensus was that the two groups could continue to provide services, with the Grace focusing on low-risk births and continuing their work to develop a Birthing Centre, and the Foothills continuing with all higher-risk births.

The discussions were successful and the Foothills and the Grace informed the Health Minster that moving the Grace operations to the Foothills site while maintaining the Grace name and Salvation Army involvement was their preferred option. In June 1994, the formation of the health authorities was announced. On July 14, 1994, the closure of the Grace site and the move to the Foothills site was announced.

2. Content and Implementation of the Agreement

On March 31, 1995, a transition agreement covering the operation of the Grace at the old site and the intention to move it to the Foothills Hospital site was signed by the CRHA and the Salvation Army. In August 1995, the formal legal agreement between the CRHA and the Salvation Army was signed. The agreement was for a term of three years, after which it would be renewed automatically. The current agreement was signed in May 1998. While the initial discussion took place between the Chair of the Grace and the Chair of the Foothills, the Territorial Headquarters of the Salvation Army for Bermuda and Canada and the CRHA signed the legal agreement. The document laid out

the agreement between the two parties with respect to the Salvation Army Grace Women's Health Centre.

The newly moved Grace would be known as the Salvation Army Grace Women's Health Centre and the continuing involvement of the Salvation Army would be formally recognized. The CRHA agreed to ensure that the North Tower in which the Grace is located would not be used for any procedure that is contrary to the mission, vision and values of the Salvation Army.

Currently, the Salvation Army Grace Women's Health Centre provides women-centred services to the Calgary region including day surgery, the Breast Health program, the Urodynamics program, a Colposcopy program, an Osteoporosis program, and the Grace Women's Health Resources Centre. The Resource Centre is likely the most well-known part of the Salvation Army Grace Women's Health Centre, providing health information and educational programs on a variety of women's health topics. The Nova/Grace Women's Health Express Van is part of the Women's Health Resource Centre, designed to make the resources of the centre available to women who may have difficulty accessing services at the Foothills site.

The day-to-day management of the Grace is the responsibility of the CRHA, via the program manager of the Grace, who is appointed with the approval of the both the Health Council and the CRHA. The program manager receives input from the Health Council with respect to the mission, vision and values of the Salvation Army, as well as reporting back to the Health Council. The program leader is responsible for ensuring that

all employees, volunteers and practitioners within the Grace are aware of, and comply with, the mission, visions and values of the Salvation Army.

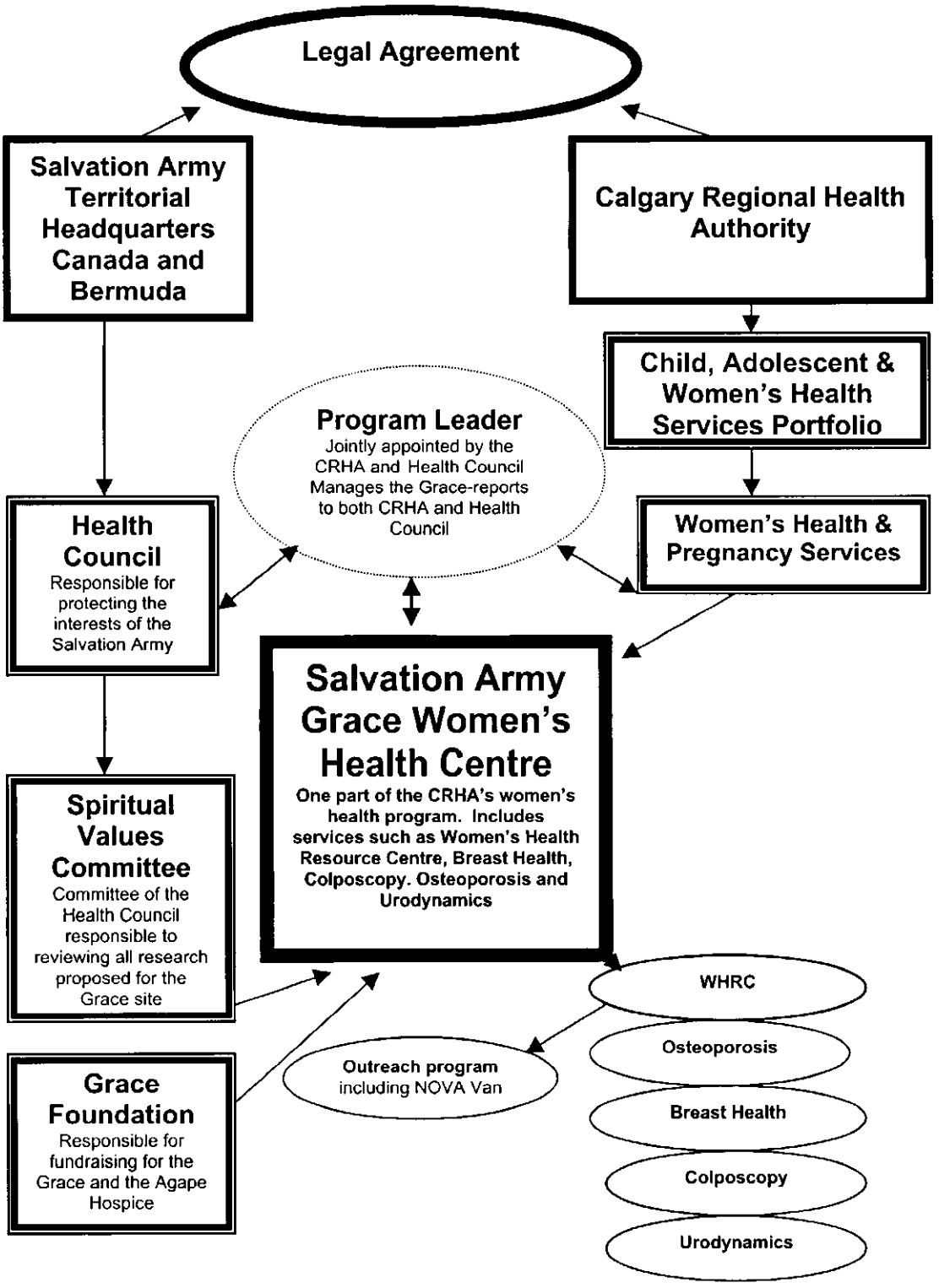
The Salvation Army Health Council remains in an advisory capacity, except in matters pertaining to the mission, vision and values of the Salvation Army, where the Health Council has a governance function. The Salvation Army has an option of terminating the agreement, if the CRHA makes a decision that makes it impossible for the management and operations of the Centre to remain true to the mission, vision and values of the Salvation Army. The Salvation Army Health Council also has an impact on research within the Grace, as the Spiritual Values committee of the Health Council reviews all research proposals.

Also included in the agreement is the role of the Grace Foundation, the fund-raising body associated with the Salvation Army health concerns in Calgary. The Grace Foundation continues to raise funds for women's health and the Agape Hospice, under the guidance of the Salvation Army Health Council.

The current organizational chart of the CRHA places the Salvation Army Grace Women's Health Centre under the Child, Adolescent & Women's Health Services Portfolio as part of Women's Health & Pregnancy Services. The current organizational chart was developed in 2000 but the Salvation Army Grace has been placed in several different parts of the organizational chart of the CRHA over the years since regionalization, including part of tertiary, academic and research services (TARS) from 1994-1996 and then part of acute care from 1996-2000. While the changes in the organizational structure of the CRHA have impacted the management of the Grace, the

services provided have not been noticeably affected by the changes to the organizational chart.

Figure 2. Major Elements of the Agreement between the Salvation Army and CRHA



CHAPTER 4: RESULTS II

I. FRAMING THE PUBLIC DISCOURSE

By examining the archives of a local newspaper, it was possible to examine the public discourse of the time and subsequently the journalists' and the readership's understanding of the agreement between the CRHA and the Salvation Army. Twenty newspaper articles, including editorials and letters to the editor were analysed. One thing that became apparent was that although the legal agreement between the CRHA and the Salvation Army was the subject of our research, the move of the Grace Women's Health Centre to the Foothills Hospital site dominated the discourse. For this reason, the examination of the public discourse has been organized around the announcement of the move of the Grace.

A. Before the Announcement of the Move (January 1994-June 1994)

The general tone of articles leading up to the move and the establishment of the CRHA was speculative. It had been made clear that changes were coming within the healthcare system and the general tone of the newspaper text was advocacy for the Grace. It was early in the process and a battle for public opinion was taking place in the media. The following excerpt shows the type of advocacy that was taking place.

> *Grace is an inviting target. It is a small facility with what might seem to be a small constituency. Therefore the potential political repercussions of closing it seem minimal.*
> *That could be proven wrong.*
>
> *Unless the decision to close the facility has already been made --which would be a slap in the face to the government's so-called public consultation process -- there is still time to make the case for the Grace.*
> *The Grace recently embarked on a public relations campaign to clear up some of those misconceptions. If Calgarians -- men and women --want to ensure there is a facility with a mandate to make women's health the institution's first priority, a*

> *place where treatment includes prevention and education they will have to take ownership of the issue and make it clear to the province that politics has no place in budget decisions.* ***Calgary Herald, Editorial. January 15, 1994 p A4***

1. Identity

A key theme that emerged was the identity of the Grace. The Grace identity included the physical site, the philosophy of care, the involvement of the Salvation Army and the focus on a women's health program. The identity of the Grace Hospital as a denominational or religious hospital was only briefly mentioned.

> *The boards will be set up throughout Alberta by June 1 and "will allow for the continued operation of (denominational) hospitals," said Health Minister Shirley McClellan.*
> *"These facilities would operate under agreement with, and be funded by, regional boards," she said.*
> *"This is great news," said Grace Hospital chairwoman Phyllis Kane "I'm impressed the government recognises the importance of denominational hospitals and the role they play, and that it wants to see them continue intact in the new regional system," said Kane.*
> *Alberta Health spokesman Gordon Turtle said the regional boards would eventually replace individual facility boards. "But there is some flexibility for regional boards to allow a hospital board to continue operating," he added. "They will certainly be allowed to continue to operate under the same philosophy and have a management group that adheres to that philosophy."* ***Calgary Herald, Robert Walker & Anthony Johnson. February 3, 1994, Final Edition, p.A1***

Although it had been made clear that denominational hospitals would be allowed to continue under their established philosophies, at no point were the particular philosophy, mission, vision and values of the Salvation Army discussed, let alone made clear.

2. Models of Women's Health

Early in the regionalization process, the Grace was most often identified as a site for women's health. A separate, holistic women's health program requiring experts was advocated for.

> *Holistic, comprehensive, integrated, multi-disciplinary and cost-effective are just some of the words the chairwoman of the hospital for women uses to explain what*

the Grace does. Women's health doesn't just mean some specialized out-patient programs, or preventive work in the area of breast cancer, Kane says. It means offering women the full range of services they might need in any situation, including surgery, the senior officials at the Grace believe.
``There is a general lack of understanding of women's health,'' Kane told reporters Wednesday.

But the holistic approach is something the Grace administration and staff will fight to preserve. Kane and Cheddie Kean, the hospital president, made it clear they want to try to maintain those ideals, no matter where the Grace ends up in the budget-cutting shuffle. ***Calgary Herald, Jim Cunningham. April 14, 1994, B1.***

The consideration of women's health as a top priority was a key topic in the public discourse. While advocating for women's health as a specialty, the Grace was put forth as the ideal model for providing women's health in Calgary.

But instead of having a hospital that makes women's health a top priority, Calgary would wind up with women's health programs offered by a larger institution with competing internal agendas. Women's health would not be the top priority. It would be one of many competing departments. The hospital's biggest hurdle may be the public impression that the Grace is a poor second-cousin to larger institutions, a cozy place to have babies. On the contrary, the exclusive focus Grace puts on women's health makes it a leading-edge institution. Its programs cover a wide range of women's health issues. If budget-cutting decisions were made simply on the needs of patients the Grace would not be in the rumor mill. ***Calgary Herald, Editorial. January 15, 1994 p. A4***

3. Resources

During this time, a key focus of media reports about the Grace was the fundraising success that the Grace had achieved. This approach is consistent with the advocacy approach, as budget concerns were thought to play a major role in decisions to close facilities.

Startling new figures show Calgary's smallest hospital is raising money almost faster than all the others combined despite growing pressure from them to close the facility down. The Salvation Army Grace Hospital for women has raised $4.1 million in the last 10 months, which is equivalent to almost half of its annual operating budget. Hospital chairwoman Phyllis Kane says the facility has raised

more money than the amount that would be saved if the Grace were closed. ***The Calgary Herald, Robert Walker. February 5, 1994, Final Edition, p.A1***

B. The Announcement and Move (June 1994 – March 1996)

Shortly after the CRHA was established, the announcement was made that the Grace would be moved to the Foothills Hospital site and the advocacy turned to a more emotional tone.

Talk to just about anybody who has had anything to do with the Salvation Army Grace Hospital for Women in the past 70 years and you'll hear the same words. A home. A family. A calm, caring place. A beloved old house the residents had simply outgrown. ***The Calgary Herald, Jim Cunningham. March 2, 1996, Final Edition, p.A1***

1. Services

One of the main emphases of the public discourse during this period was advocacy for a continuation of the Grace services provided by the original site. The closure of programs was described as heart-wrenching. This is consistent with the emotional tone that dominated the public discourse at this time.

So the decision was made to convert the hospital into a women's health centre. It would provide only day surgery, most of it in gynecology, Breast Health and colposcopy programs, and education. The first, difficult step was to shut down the maternity. That happened just over a year ago, Jan. 31, 1995, and it was ``heart-wrenching,'' Hadlow recalls ***The Calgary Herald, Jim Cunningham. March 2, 1996, Final Edition, p.A1***

2. Site Become Focus

During this period, the site of the Grace became a central issue. Time and again, the red brick building in which the Grace was housed was mentioned as a key factor in articles discussing the Grace.

> *Before it leaves its red brick home .....The centre is not disappearing. It will move in November with other Grace Hospital services to their new home in the north tower of the Foothills Hospital complex. I want to believe that the new regional plan for women's health will build and improve on what we have. My one worry is how far can women's health be absorbed into the giant regional health machine without losing the special quality of that little brick building next to the Grace Hospital?* ***The Calgary Herald, Susan Ruttan. July 12, 1995, Final Edition, p.B1***

It had already been made clear that the Grace programs and staff would generally remain untouched, as would the Salvation Army involvement. It was not clear from the press coverage why the site was framed as such an emotional symbol at this time.

During this period, there was little or no discussion about holistic models of women's health. The themes that had permeated the media leading up to regionalization had disappeared. There was no mention of women's health as a speciality or the status of a holistic women's health program at the new site.

Although identity was often mentioned in the media, it was the identity of the Grace that seemed to be the focus. The role the Salvation Army played in the identity of the Grace was rarely mentioned, instead the focus was on the Grace site.

> *A community hospital feel, and a focus on patients as people, were what made the Grace different, says former staffer Hadlow. She, like many others, feels something has been lost with the closure of the old brick building beside the hill. The fear ``is that we'll just be eaten up'' at the Foothills, the city's biggest hospital. ``I think there will be a lot of pressure on us to do things the Foothills way.''* ***The Calgary Herald, Jim Cunningham. March 2, 1996, Final Edition, p.A1***

Although the Grace was often identified as the Salvation Army Grace, there was no mention of the fact that the Salvation Army was a religious institution. Focus was the site, rather than the philosophy of the Salvation Army.

> *Colleen Wells, the Salvation Army hospital chaplin(sic), says the situation ``has been very, very hard.'' Staff are excited about moving, but find it hard to say goodbye to a building they have put so much work into keeping alive. ``They know the bricks and mortar and they know how much blood and sweat and tears have gone into it.'' Transferring the same feelings to the sparkling new home now being*

created in the old nursing school at Foothills, ``is not going to be easy,'' Wells predicts. ``It's going to be work. ***The Calgary Herald, Jim Cunningham. March 2, 1996, Final Edition, p.A1 /FRONT***

The Grace's identity as a denominational hospital and the continued involvement of the Salvation Army was not completely clear. The following excerpt refers to a "Salvation Army health unit" but it is not evident what is meant by this term. The description of the activities of the health unit does not match with the mandate of the Salvation Army Health Council. The inclusion of confusing information within the public discourse does not help clarify the situation for the public.

The Salvation Army didn't like giving up its hospital, remembers Caryl Miller, who chairs the Salvation Army health unit which will oversee the new Grace and women's programs in the region. But with the regional health authority paying the bills, there was no choice. ``I think that what we lost is that we are no longer our own boss,'' says Miller. ``We are a partner and probably a junior partner.'' But the Grace had something the health authority needed - a strong track record in women's health. ***The Calgary Herald, Jim Cunningham. March 2, 1996, Final Edition, p.A1 /FRONT***

When staff arrive at Foothills their first day, March 11, all will be expected to don the standard RHA plastic badge. But Ivey-Hobbs vows the Grace people won't let themselves be identified that way. Each of them will also get a special Grace pin to wear along with the badge. It will tell the world who they really are, what kind of work they do and what tradition they represent. ***The Calgary Herald, Jim Cunningham. March 2, 1996, Final Edition, p.A1 /FRONT***

3. Resources

During this period, the discussion of fundraising and budgetary concerns changed. After the decision had been made to move the Grace, the emphasis was on the cost-effectiveness of the move, rather than emphasizing the cost-effectiveness of the Grace.

The Salvation Army Grace Hospital shut its doors this week. It is the first major Alberta hospital, and the first of three in Calgary, to close as a result of the Klein government's cuts to health-care spending. The move to the Foothills Hospital is expected to save the Calgary Regional Health Authority $1.7 million next year. The changes have had the desired effect on the bottom line. The Grace cost $14 million to run in 1991-92, when maternity and surgery were part of its work. In 1995-96,

with maternity shut down, the budget was down to $4.5 million. Next year, the new Grace at the Foothills Hospital will have a budget of $2.8 million. ***The Calgary Herald, Jim Cunningham. Final Edition, p.A1 /FRONT***

C. Post-Move (March 1996 – December 2000)

After the Grace had moved to the Foothills site, the tone of the newspaper coverage turned to a much more matter of fact style. There was very little emphasis on women's health as a specialty. There was no mention of the legal agreement reached between the CRHA and the Salvation Army. The media merely reported on new fundraising initiatives and new programs.

1. Services

Despite earlier concerns about programs and services being dropped, little emphasis is put on services that have been dropped or eliminated, rather the focus is on programs that have expanded.

The Grace has dropped its obstetrics program, but has expanded in other areas. The Breast Health clinic, for example, now undertakes all breast biopsies for the Foothills. And the centre has expanded its library, as well as operating a healthmobile to outlying areas. The colposcopy clinic, which handles about 4,000 women a year, also has improved facilities, thanks to $3 million worth of renovations to what was formerly the Foothills Hospital nursing school. The Grace also offers diagnostic imaging, pastoral care, as well as support and counselling for parents who have lost a baby. ***The Calgary Herald, Susan Scott. May 12, 1996, Final Edition, p.A5***

The development of the outreach van and the osteoporosis programs were both reported during this time.

Plans to establish an osteoporosis program at the Grace Women's Health Centre are about to get a $1-million boost. An official announcement of the cash infusion by several corporate donors is expected Wednesday at the Heart of Grace Luncheon at the Palliser Hotel. The money will be used to help set up a multidisciplinary program that will include a team of physicians, nurses, physiotherapists, dietitians and pharmacists. ***The Calgary Herald, October 17, 1998, Final Edition, p.B14***

2. Identity

> *``It's the same services as at the old site and the same staff," said Mary Jane Cullen, program director of women's health. ``The (Salvation) Army is still involved, so the same philosophy is still there."* ***The Calgary Herald, Susan Scott. May 12, 1996, Final Edition, p.A5***

This comment clearly emphasizes the site move, although there is absolutely no mention of the role of the CRHA in the new facility. Although the Salvation Army philosophy is mentioned, a clear discussion of the impact that the Salvation Army philosophy might have on services offered at the Grace has never appeared in the public discourse.

3. Site Becomes Model of Women's Health

Although the previous emphasis had been on the old Grace site, after the move, there was still an emphasis on the physical site, this time at the Foothills.

> *There's tasteful, expensive-looking wallpaper on the walls of the recovery wards. Soft colors dapple the lino of the surgery area and natural light floods in through a large window in one of them. All six waiting areas are generous....The bulk of the more than $2.9 million being spent to develop the new Grace will make it an attractive place for patients, Cullen explained during a recent tour of the facility.* ***The Calgary Herald, Jim Cunningham. March 2, 1996, Final Edition, p.A7***

Prior to the announcement of the move, women's health was being described as a specialty requiring experts, now the Grace is being described in terms of the site's comfort and coziness rather than as a cutting edge institution. These descriptions place an emphasis on the physical environment, which is consistent with concerns that the Grace would be lost with the move to the new site. This emphasis served to downplay the emphasis placed on a holistic model of women's health.

> *``I wouldn't have any hesitation coming here,'' said Alison Glass, touring the airy rooms with her mother Mary. ``Look at the pads on the stirrups,'' she said in the colposcopy clinic for women with abnormal pap smears. ``Now that's a really nice touch.* ***The Calgary Herald, Susan Scott. May 12, 1996, Final Edition, p.A5***

Although some articles included a vague description of a place to treat the whole woman, the ultimate emphasis was on cozy surroundings.

> *``I felt like they saw all of me -- mother, daughter, caregiver, someone in need of care.'' Over four years, she has healed mentally, physically and spiritually. ``They started me on the process of self-help. '' The atmosphere at the Grace contributed to her ability to help herself. ``Warm chairs, lamps, flowers, books on the coffee tables. I felt like I'd walked into somebody's living room; and since I was scared, that's just what I needed. There was no clinical feel to it.''* ***The Calgary Herald, Sharon Adams. March 28, 1996, Final Edition, p.F5***

4. Resources

During this period, discussion of resources was generally limited to announcements of programs made possible by corporate donations.

> *For instance, the Grace will use part of Nova Corporation's $2 million Partners in Health donation for women's health to equip a mobile outreach unit to deliver education and services to women throughout the Calgary region. ``It's really a mobile women's health centre,'' said Cullen.* ***The Calgary Herald, Sharon Adams. March 28, 1996, Final Edition, p.F5***

When a fundraising campaign begins, the importance of women's health is once again emphasized, as well as an emphasis on women's health as a medical specialty.

> *``Well-informed women make good health-care decisions for themselves and their families,'' said Cullen. And because women ``are gatekeepers of family health,'' said Bobey, their knowledge is passed on and affects the health of others in their families, and the next generation.* ***The Calgary Herald, Sharon Adams. March 28, 1996, Final Edition, p.F5***

> *Partners in Health can help tear down the invisible walls separating education, prevention, treatment and research into women's health issues. ``We have the opportunity to look at women's health across the continuum from promotion through to tertiary care and across the life cycle,'' said Mary Jane Cullen, women's health program director at the Grace Women's Health Centre. ``Establishing a centre of excellence for women's health would promote the idea that it's a valid area to work in,'' said Mary Bobey, psychologist and director of women's health resources at the Grace.* ***The Calgary Herald, Sharon Adams. March 28, 1996, Final Edition, p.F5***

II. THE INTERNAL DISCOURSE

A document review provided another view of this particular case. Although some of these documents are currently part of the public record, via the CRHA archives, they would not have been available to the public at the time. Others were made available by the informants in this case study and would not normally be available to the public. For this reason, the term internal discourse is used. These documents track some of the emerging issues, known only to those involved at a managerial and decision-making level within the health system.

A. Pre-Announcement (September 1993 – June 1994)

Early in the process of regionalization, the Grace began a campaign to raise awareness and consolidate support for the Grace during the expected upheaval of the health system. This support for the Grace set the tone of many documents early in this period.

> *She reminded the Board that we still have 2-3 months left to make an impact, regardless of the milieu that surrounds us and encouraged each Board member to do their utmost to present women's health and the Grace Hospital to the public and politicians as a vital and necessary part of health care in this Province.* ***Board of Trustees, September 27,1993***

1. Services

During the period leading up the move, the minutes of the Salvation Army Grace repeatedly mentioned the importance of several services, including the low-risk maternity and obstetrics programs. Once it became clear that the changes would impact the Grace,

discussions began to explore a possible partnership with the Foothills Hospital. These discussions included the issues of what programs would be offered within a partnership.

> *Foothills Hospital recognizes the importance of the Grace and it women's Health programs, gynaecological surgery, and hospice program and also recognizes the need for Foothills to offload some of their low risk obstetrics because of their tertiary care mandate. A partnership would provide the opportunity for the Grace to enhance many aspects of its role and would present research opportunities and medical coverage that would otherwise be unavailable.* ***Board of Trustees Special Meeting, February 14, 1994***

The Grace disagreed with the Bow Valley proposal because of changes to the way women's health would be delivered, particularly the loss of services such as obstetrics and inpatient surgery.

> *Grace Hospital finds the option disturbing because the proposed configuration of ambulatory care programs at the Community Health Centre does not meet our philosophy of care which provides comprehensive, integrated women's health services and programs including obstetrics and inpatient surgery.* ***Joint Meeting – Grace Hospital Board of Trustees and Foothills Board, April 25, 1994***

However, the same program changes came about as a result of the Foothills partnership. It appears that it was not the loss of programs per se that was the primary concern but rather the loss of Salvation Army identity and control and an integrated women's health program.

2. Communication

One of the important themes during this period was the role of communication in maintaining and consolidating support for the Grace. The internal discourse included several discussions with respect to controlling the communication with the media and eventually the public.

> *It was suggested that another informational meeting be arranged with the Calgary Herald Editorial Board. Timing may be appropriate because Debra Cummings is*

planning several Lifestyle articles on health. ***Board of Trustees, February 28, 1994***

It was noted that further activities to promote publicity for the Grace Hospital by the Friends of the Grace should continue to be conducted within the realm of dignity associated with The Salvation Army. ***Board of Trustees, February 14, 1994***

On February 24, Mrs. Kane and Mrs. Kean met again with the Editorial Board of the Calgary Sun. During the course of this meeting they had an opportunity to speak about our discussions with the National Bureau of Health. ***Board of Trustees, February 14, 1994***

3. Identity

Within the internal discourse, identity emerged as a theme early on. In contrast to the public discourse, identity within the internal discourse seemed to refer to the Salvation Army identity as the mission, vision and values. There is no single document that contains the mission, vision and values of the Salvation Army. Rather, the Salvation Army has developed a series of positional statements to guide their worldwide operations. The Salvation Army Health Council is charged with interpreting and implementing those positional statements within the Salvation Army's Calgary health projects.

The Grace Hospital ... disagrees with the Hyndman Report recommendation to locate the Grace Hospital women's health programs to the Bow Valley site because of our holistic approach to women's health and the importance of The Salvation Army identity to us. ***Joint Meeting – Grace Hospital Board of Trustees and Foothills Board, April25, 1994***

She noted that Grace Hospital challenged the recommendation to move Grace Hospital to the Bow Valley site as part of a new Community Health Centre without any provision for inpatient services or Salvation Army identity. ***Board of Trustees, April 2, 1994***

The theme of identity came up many times, especially with respect to the proposal to move the Grace programs to the Bow Valley site as part of a community health centre.

4. Site

As it became apparent that the Grace was one of the facilities threatened with closure by the regionalization process, the emphasis shifted from maintaining the Grace on the original site to moving to a new site as part of a partnership.

The Foothills proposal was acceptable because it offered a separate building for the Grace, allowing it to remain distinct. This distinctness was described both in terms of identity and services. Part of the model of women's health espoused by the Grace included one site for women's healthcare.

> *We do, however, feel we could be flexible as to where we are located in Calgary as long as the services we provide are not fragmented; they must be comprehensive and integrated with obstetrics and gynaecological surgery services...The Grace Hospital feels that women's health services must include Obstetrics, Breast Health, Colposcopy, Gynecological Surgery, and Women's Health Resources.* ***Special Board Meeting, April 11, 1994***

Due to this vision, it was not seen to be acceptable to split the Grace programs among different locations. The separate site would also allow the Grace name and identity to continue. The Salvation Army would have control of the physical site.

> *The Grace needs to establish control of space at the new site in order to maintain The Salvation Army's Vision, Values, Philosophy, Mission and Goals. It was decided to take a strong approach and Mrs. Miller will propose to the CRHA and Dr. Bryan that Grace Hospital be the sole leasee of the School of Nursing and the North Tower with the right to sublet space.* ***Board of Trustees, November 28, 1994***

5. Models of Women's Health

A recurrent theme during this period was the need for a holistic model of women's health. There was no discussion within the minutes around what an ideal holistic women's health program might look like.

> *One of Grace Hospital's major concerns throughout this process has been the concept of women's health as expressed by most people. This concept of women's*

> *health programming would fragment women's health care delivery and Grace's concept would not be offered in the restructuring proposed by the Hyndman report. Grace Hospital has many unfunded innovative programs based on a holistic, integrated philosophy of delivering women's health.* ***Joint Meeting, Grace and Foothills Boards, April 25, 1994***

It was generally accepted within the internal discourse that the Salvation Army Grace Hospital represented a holistic model of women's health with no mention of those who believe that it is impossible to offer a holistic model of women's health without offering a full range of services that include contraception counselling and abortion services.

6. Partnership

In contrast to the public discourse, discussion around the possibility of a partnership was a key topic within the internal documents. Within the public discourse, the partnership was not mentioned, rather it was simply announced that the Grace would be moving. As a result, the public remains unaware of the complexities of the decision to move the Grace and the development of the agreement between the CRHA and the Salvation Army.

> *Preliminary discussions with Foothills Hospital representatives have centered around an interest in joint initiatives with Grace Hospital remaining on its current site - a voluntary alliance - each with its own mission statement and autonomous governing structure. A second option may be an onsite partnership on the Foothills site.* ***Board of Trustees, March 24, 1994***

The political climate of the time had pitted the hospitals against one another in an effort to survive. This environment impacted the way in which the partnership was discussed.

> *Some concern was expressed that we should be cautious because some of the benefits to this arrangement for Foothills Hospital include: image boost, enhanced fund raising opportunities; the role of The Salvation Army; opportunity for FHH hospital to fill empty space; family medicine physicians; limited governance by the Grace; and their desire for our programs. On the other hand, it was noted that,*

> *except for this offer from the Foothills, there is absolutely no support from the health care community to keep the Grace Hospital open.* ***Board of Trustees, February 14, 1994***

7. Resources

The role of the Salvation Army identity emerged as an important theme with respect to fundraising.

> *The Grace Hospital feels that if The Salvation Army identity is lost, the Community Health Centre would have difficulty raising funds for women's health the way the Grace Hospital has been able to because The Salvation Army is the largest fund raiser in Canada. The Grace Hospital has also never depended on or waited for government funding to start up women's health programs once the need for them has been identified.* ***Special Board Meeting, April 11, 1994***

The Grace Foundation was an effective fundraiser and was a resource that the Salvation Army brought to the table when discussing any partnership.

B. The Announcement and Move (June 1994 – March 1996)

Approximately eighteen months passed between the establishment of the CRHA and the Grace's move to the Foothills Hospital site. Many of the key aspects of the legal agreement were established during this time period.

1. Governance

During this time, the details of how the governance of the Grace would occur were being fleshed out. It wasn't until late 1994, that it was determined that denominational hospitals would continue to exist within the regionalized system via advisory boards in conjunction with the respective regional health authorities.

Once it was determined that the CRHA would be established, the Salvation Army Grace Hospital Board of Trustees was terminated and the Health Council was established.

> *Lt. -Colonel Luginbuhl advised that once the Board legally ceases to exist, the Governing Council would like to be assured that a local group which would represent The Salvation Army's health care interests in Calgary is in place to watch over the new and existing sites. It was agreed that Lt.-Colonel Luginbuhl would prepare draft Terms of Reference for Board approval based on similar models in place with other Salvation Army institutions across Canada who are now under regional authorities.* ***Special Board Meeting, July 18, 1994***

> *WHEREAS the Governing Council recognizes and acknowledges the right of the Government of Alberta to establish The Calgary Regional Health Authority to assume responsibilities for health care facilities in Calgary including The Salvation Army Grace Hospital. BE IT RESOLVED that the Governing Council shall dissolve THE SALVATION ARMY GRACE HOSPITAL BOARD OF MANAGEMENT effective 2400 hours March 31, 1995.* ***Termination of the Board of Trustees, March 31, 1995***

The Salvation Army was able to use its experience within the healthcare system and the process of regionalization to advocate for its needs when discussing the governance under the legal agreement.

Although much of the original negotiation was with the Board of the Foothills Hospital, the final legal agreement was established between the CRHA and the Salvation Army.

> *We need to remember that we are not negotiating with Foothills Hospital -we are negotiating with the Regional Health Authority, feel worst mistake we could make is to doubt the goodwill of those we are dealing with.* ***Special Board Meeting, July 18, 1994***

Once the CRHA was established and the Board of the Grace was dissolved, the role of the Salvation Army Health Council was established.

> *The role of the Grace Hospital within the Regional Health Authority and The Salvation Army's relationship to the CRHA was discussed..... A Salvation Army Health Council has been proposed. The council will ensure that the Women's*

> *Health Program operates within the ethical guidelines of The Salvation Army. The letter to the CRHA will include that The Salvation Army Governing Council will appoint Health Council members; that there be a lease agreement with the CRHA for the use of the North Tower and School of Nursing; that the council collaborate with the CRHA in appointing the Program Director, Women's Health; and that a separate Foundation be maintained for fund raising.* ***Board of Trustees, October 17, 1994***

The powerful role that the Salvation Army Health Council would play in the implementation of the agreement between the CRHA and the Salvation Army was established.

> *The Health Council shall be responsible for ensuring that the mission, philosophy and values of The Salvation Army are achieved to the fullest extent possible in the Grace Women's Health Centre.* ***Salvation Army Health Council Terms of Reference***

> *Ensure that the CRHA and the committees and officers of the CRHA in their decisions and actions affecting the Grace Women's Health Centre have due regard for the mission, philosophy and values of The Salvation Army;* ***Salvation Army Health Council Terms of Reference***

> *Ensure that the management and operations of the Grace Women's Health Centre are consistent with The Salvation Army Positional Statements issued by the authority of the Territorial Commander for Canada and Bermuda;* ***Salvation Army Health Council Terms of Reference***

The Salvation Army Health Council will have a major impact on how the Grace is run. There is no mention of the Health Council anywhere in the public discourse.

2. Services

> *... The Grace Hospital will give up its inpatient beds in maternity and surgery and there will not be LDRP's (sic) in the Women's Health Centre. Grace Hospital will become responsible for the Women's Health Program for Region 4. The Women's Health Centre will continue to deliver and house Women's Health Resources, Day Surgery, Breast Health, Colposcopy and Perinatal Loss. The Women's Health Program will be responsible for establishing a Birthing Centre; Grace Hospital and Foothills Hospital Childbirth Education and Breast Feeding Support services will likely consolidate.* ***Board of Trustees Meeting September 26, 1994***

The services for which the Grace would be responsible at the new site were very similar to those offered at the old site, without the surgery and maternity beds. This was clearly

not the "comprehensive, integrated women's health services" that the Grace had held to be so important; obviously compromises had been necessary to ensure the partnership.

3. Resources

The existence of the Grace Foundation and a separate mechanism for fundraising enables the Salvation Army to maintain some control over funds for the Grace, rather than be solely dependent on the funding decisions and priorities of the CRHA.

> *Mrs. Miller recently met with the Campaign Cabinet to discuss Capital Campaign contributions. It was decided at that meeting to issue a letter to all contributors and solicitors bringing them up to date on the issues regarding the transfer of Grace programs to Foothills Hospital site. Most responses to the letter from the Campaign Co-chairs are positive; however, some have cancelled their pledges. It was noted that if donors are willing to let their donations stand, it would be in the best interests of The Salvation Army to donate some of these funds for the 29th Street site renovations in order to retain some ownership and equity at the new site.* ***Special Board Meeting, July 18, 1994***

C. Post-Move (March 1996 – December 2000)

1. Identity

The identity of the Grace within the new CRHA and the Foothills site remained an emotional issue, affecting the signage, staffing and research. In accordance with the agreement, the Salvation Army was to be clearly identified on all Grace signage.

> *...Issue of signage on the GWHC first raised in Nov 1995 to request signs identifying the S. A. involvement on the North Tower of the Foothills site.* Dec 1998 – sign is finally complete almost 4 years after issue is first raised and more than 2 ½ years after GWHC is on site.* ***Summary of Issues – Salvation Army Health Council, 2000***

Consistent with pre-move sentiments, the identity issue became tied to the physical site and discussed in terms of the lack of signage.

Due to hospital closures and layoffs within the healthcare system, the issue of "bumping" of staff arose. Due to regulations of the nurses union, nurses are often "bumped" to new units, according to seniority, replacing more junior nurses. The Salvation Army mission, vision and values became a core part of maintaining and developing the identity of the Grace.

> *Health Council directs the Administrative Leader of GWHC to ensure that new nurses are aware of Salvation Army mission and values.* ***Summary of Issues – Salvation Army Health Council, 2000***

The Spiritual Values Advisory board was established to ensure that the Salvation Army perspective was included in all research proposals which involved the Grace. This board would require a review in addition to the regular CRHA ethics review.

> *The Spiritual Values committee makes recommendations and has them accepted as to research proposals as they have valuable insight and input not always apparent to the CRHA Ethics committee.* ***Summary of Issues – Salvation Army Health Council, 2000***

2. Services

The role of the Salvation Army in determining what services will be offered at the Grace is an ongoing issue. The Salvation Army Health Council has the continuing responsibility of ensuring that no procedures which violate the mission, vision and values of the Salvation Army are done at or seen to be associated with the Grace. This impacts not only the services provided at the Grace but the placement of the Grace within the CRHA organizational structure. The Health Council is responsible for ensuring that the CRHA respects the stance of the Grace when structuring the organization and planning services.

3. Resources

The Grace Foundation remained an important issue after the move. The Grace Foundation is a powerful fundraising body and the Salvation Army protects the independence of the Grace Foundation.

> ** Health Council decides that Grace Foundation will not become a part of the Calgary Health Trust, but will maintain itself as a separate foundation and be an affiliate of the CHT.*
> ** By April 1999 concerns arise as to slow handling of donations made to Agapé or the Grace Foundation, timely access to funds and as to the lack of reporting by the CHT to the Grace Foundation;*
> ** June 2000 - probationary period is ended and Grace Foundation agrees to remain an affiliate of the CHT as long as the original benchmarks are met.* ***Summary of Issues – Salvation Army Health Council, 2000***

III. PUBLIC PARTICIPATION STRATEGIES

This case revealed several strategies for public participation used and proposed by the Salvation Army Grace Women's Health Centre. We have attempted to place each of the strategies within the CRHA Public Participation Framework in order to examine what impact the framework might have when implemented.

A. Legal Agreement between the CRHA and the Salvation Army

The legal agreement between the CRHA and the Salvation Army resulting in the Salvation Army Health Council is an example of a partnership, a form of public participation described in the CRHA Public Participation Framework. In order to better understand this partnership, we have examined the relationship between the CRHA and the Salvation Army according to the community partnership framework proposed by Scott & Thurston (1997).

1. External Factors

a) Administrative

External factors have impacted the administration of the partnership. The political context of the time, with the move from individual boards to one regional health authority determined the administrative structure chosen by the partnership. The CRHA is responsible for the delivery of services, as mandated by the laws governing the regional health authorities, as well as responsibilities to the Minister of Health. The Health Council is responsible for protecting the interests of the Salvation Army in the operations of the Salvation Army Grace Women's Health Centre and the Agape Hospice.

b) Service Provision

Service provision was affected by the political environment. The move to regionalization brought with it a restructuring of the administration of the health system as well as budget cuts. The services offered by the Grace Women's Health Centre are different from the services provided by the old Grace. Maternity and obstetrics care were moved to the Foothills Hospital and new services have been added at the Grace.

2. Domain

a) Recognition

The domain of the partnership is women's health. Although it is clear that both partners consider women's health to be the domain where the partnership operates, there is no explicit statement within the legal agreement or supporting documents as to what women's health entails. Although many of the Salvation Army documents refer to

holistic women's health programs, whether the CRHA shares this vision of women's health is not clear.

b) Support

Women's health had been stated as a priority by both the CRHA and the Salvation Army. The Salvation Army has had a long history of involvement in women's health. The existence of a specific women's health program within the CRHA might be seen as evidence of support for women's health in the region and of a belief in the contribution of the Salvation Army in providing high quality service.

3. Partnership Characteristics

a) Groundwork

The substantial groundwork put into developing the partnership played a role in ensuring a workable relationship. The two organizations differed in that the CRHA was a completely new organization while the Salvation Army was a well-established, well-respected organization. The Salvation Army had experience dealing with health authorities in other provinces, as well as experience as a provider of healthcare. The desire to cultivate commitment was evident by the lengths to which both organizations went to establish the partnership.

b) Organizational Structure

The organizational structure of the partnership is clear and identified within the legal document. The CRHA is responsible for the day to day functioning of the Grace while the Salvation Army, through the Health Council, is responsible for ensuring that

the program is run in a fashion that is consistent with the mission, vision and values of the Salvation Army.

The Salvation Army Grace Women's Health Centre is managed by a program leader chosen jointly by the CRHA and Salvation Army. The program leader has a huge responsibility in terms of representing the views of the Salvation Army and the CRHA. The functioning of the partnership is very much contingent on a strong program leader who is able to balance both the CRHA and Salvation Army perspectives.

c) Representation

Representation is described in the legal agreement. The Grace program leader is responsible to both the Salvation Army Health Council and the CRHA. The reporting structure to the Salvation Army remains constant, while the structure of the CRHA underwent three major changes. Depending on where the Grace falls within the organizational chart of the CRHA, the program leader may report to lower levels of management within the CRHA. The depth and breadth of the organizational chart will impact where the Grace is situated with respect to the decision-making power of the CRHA. For example, a shallow organizational chart with fewer levels of power allows the Grace to remain near the decision-making, while a deeper chart leaves the Grace reporting to lower levels of CRHA management, further away from the locus of power.

d) Reputation

The partnership's reputation is not very clear, as the partnership itself is poorly understood outside of those directly involved. This has led to some speculation among community groups that may actually harm the partnership's reputation, for example one

community women's group was under the impression that the Salvation Army controlled the entire Women's Health Program within the CRHA, while the reality is that the Salvation Army Grace Women's Health Centre is just one part of the Women's Health Program of the CRHA. The partners may want to make their agreement more clear to the public in order to clarify some misconceptions.

4. Partner Characteristics

a) Organizational Structure

The organizational structure of the Salvation Army is a complex one, with world-wide connections. This complex organization is simplified with the existence of the Health Council, a group charged with representing the Salvation Army's interests within their health programs in Calgary. This sets up a clear line of command and reporting. Although the individual players may change, the support structure of the Salvation Army makes it possible for the Salvation Army to be seen as a stable organization. The Salvation Army is responsible to the hierarchy of the Salvation Army Territorial Headquarters and the tenants of the faith.

On the other hand, the CRHA is a complex organization which has undergone substantial changes since its inception. This culture of change makes it difficult to position the partnership within the CRHA. The individual players have changed many times along with the structure of the entire organization. The CRHA is responsible to the provincial government and is controlled by several pieces of legislation.

The terms of the agreement include a formal statement about the ownership of the buildings and the financial responsibilities of the partners. The legal agreement also

includes a clause which describes the procedure to terminate the agreement. The fact that both partners had the resources to allow them to develop a formal legal agreement means that the organizational structure, power and resources of the partnership are clearly outlined.

b) Resources

Both partners have access to extensive resources, including paid personnel, legal representation, and individuals with political connections. These factors made it possible for the partners to develop the partnership on fairly equal footing.

One of the most important resources of the partnership was the powerful women who adopted the cause of the Grace and women's health. These women were able to advocate for the Grace due to their political and personal connections. These women had access to leaders in the business world and healthcare system as well as media outlets. The personal connections of these women allowed them to build a web of support for the Grace in both the general public and the decision-makers in Calgary.

The role of women within the Salvation Army may have played a role in the resources available to the partnership. The Salvation Army has a history of supporting women in positions of power. This was the case in the Salvation Army Grace Hospital Board, where women held upper management positions. These powerful women had developed the skills and experience that would allow them to continue to hold positions of power and influence within the CRHA. These women and their passion for women's health are one of the major resources of the partnership.

The resources of the partnership include the Grace Foundation, operated by the Salvation Army for fundraising for the Grace and Agape hospice. The existence of this fundraising body means that the Salvation Army still pays a significant role with respect to fundraising for programs, which may give it some additional power in the partnership.

c) Representation

The representatives of each group are skilled professionals, making it possible for them to fully participate in all aspects of the partnership. The Salvation Army Health Council has community representatives on the council but it is not evident that the CRHA receives any community input specifically for women's health. According to the organizational chart of the CRHA, a women's health advisory council should exist and the legal agreement included a spot for the Salvation Army Health Council on that council. This opportunity for the CRHA to include community representation in women's health has yet to be adopted.

d) Reputation

The CRHA was a new organization, and as such did not have an established reputation when the agreement was signed. On the other side, the Salvation Army and the Grace enjoyed an extremely positive reputation in Calgary. It has been suggested that the good reputation of the Salvation Army was an asset for the CRHA.

5. Communication

Internal documents revealed that extensive communication occurred prior to the agreement. While this was formal communication between board chairs, there was also a substantial influence of personal relationships and informal communication. Once the

agreement was implemented the formal communication continued via the regular meetings of the Health Council. There was no explicit data to show us how information passes between the CRHA and the Salvation Army. It appears that the Grace program leader is responsible for conveying information between the two partners. This makes this role very important, as the success of the partnership is reliant on one person to maintain official communication between the partners. This person has a gate-keeping role, controlling access to higher levels on both the Salvation Army and CRHA sides. It is unknown how much informal communication takes place between the two partners.

6. Operations

Scott-Taplin (1993) described operations as the "activities performed on behalf of the partnership". In this case, the operations of the partnership are comprised of the administrative and service provision activities associated with the Salvation Army Grace Women's Health Centre.

The type of services provided are impacted by the domain of the partnership, resources of the partners, and partnership characteristics. Both partners are well-established organizations with access to ample resources. The existence of the Grace Foundation has allowed for targeted fundraising for Grace programs.

Characteristics of the partners, specifically the Salvation Army have impacted the types of services provided through the partnership. The Salvation Army has formal position statements on several procedures associated with the domain of women's health. The Salvation Army will not perform abortions or procedures associated with In Vitro fertilization and other fertility procedures. The women's health issue most clearly

affected by the partnership was abortion. The stance of the Salvation Army with respect to abortion is very clear:

> *"It's just that the Army can't be responsible for abortions being delivered ...there's a commitment from the CRHA to respect the Grace for that."* ***Salvation Army Representative***

Some people questioned whether a holistic model of women's health was being well represented by a CRHA program that did not provide comprehensive sexual health programs, including family planning and abortion. Others argued that the CRHA provides these services, just not in the Grace Women's Health Centre. This was an issue of interest to several women's groups. Many members of the Women's Health Express Advisory Committee said that their initial interest in joining the committee was to ensure that women were able to access a full-range of health information.

Maternity and obstetrics care has been affected by the agreement. Prior to the agreement, the Grace provided low-risk maternity care and was planning on developing a Birthing Centre, and other initiatives, such as midwifery, that limit the "medicalization" of birth. After regionalization, the Grace lost the maternity programs to the Foothills Hospital and with it, plans for the Birthing Centre. There continued to be pressure to include midwifery services within the region. Midwives were registered in July 1997 and currently there are 8 registered midwives working the Calgary region. Beginning August 1, 2000, registered midwives have been eligible for hospital privileges in Calgary, meaning that women have the choice of a midwife assisted birth at home, hospital or one of the private birthing centres. Midwifery services are not paid for by Alberta Health and Wellness and the $2500 cost must be covered privately.

In this case, the services provided by the partners outside the partnership had an impact on the services provided within the partnership. In an effort to avoid duplication of services, the Salvation Army gave up services which were highly valued by the organization. There may have been financial pressures to eliminate programs, as well as external pressures to avoid duplication of services.

The Osteoporosis program at the Grace has also been affected by the agreement. The osteoporosis program had been planned by the Salvation Army Grace prior to the agreement. The agreement has led to more bureaucracy and programs are slower to get implemented. The Osteoporosis program which had been planned and fundraised for and was then delayed is now running in the Grace Women's Health Centre.

The Urodynamics program was formerly on the Bow Valley site, under acute care. After the agreement, the program moved to the Grace site and received boosted funding through the Grace Foundation which has revitalized the program.

B. Focus Groups for Van Outreach program

A second public participation initiative identified was a series of focus groups to elicit input for the Grace Women's Health Resources outreach program. Community groups who serve women were invited by the Grace Community Outreach worker to a series of focus groups. Individuals from these groups who expressed an interest in the Outreach Van Project were invited to join the Women's Health Express advisory council.

Under the CRHA framework, this initiative falls under the planning and evaluation of services area. The minimum level of participation for this area is input, and the maximum is delegation. The stakeholders from the community were invited to give

input about an outreach project and then interested individuals were invited to continue with the advisory council.

C. Community Advisory Council for the Outreach Van

This public participation initiative grew out of a series of focus groups. The council was made up of various women from the community. Many were affiliated with women's groups but it was not known if they were formally representing these groups. The council worked to design and implement the van outreach program. The design phase was quite successful but the program monitoring and implementation phase was problematic. The community groups were able to impact the Van Outreach program by advocating for a wide variety of resources and supplies to be carried on the van.

This public participation initiative was discontinued in early 2001 after several members expressed their dissatisfaction with their failure to have their ideas implemented. Several of the community groups continue to meet on an ad hoc basis to develop community-based women's health projects. The Health Express Van continues to be operated by employees of the Grace and CRHA.

This initiative falls under the "planning and evaluation of services" area of the CRHA public participation framework. The level of participation was consultation, as the community groups felt they did not hold the power to implement plans. This particular initiative was impacted by the confusion over the agreement between the CRHA and the Salvation Army.

D. Women's Health Design Committee

During the early days of regionalization, health services were designed around a program approach. A women's health program planning committee was formed, including representatives from the CRHA, the University of Calgary and community members. There was an abrupt shift in CRHA management and the program approach was discontinued by the CRHA in 1997. The women's health group was disbanded and there was no further follow-up. This led to anger and frustration for some members, as a considerable amount of time and energy had been invested and then apparently dismissed. It is important to note that it was the CRHA and not the Salvation Army that stopped the planning committee.

Under the CRHA public participation framework, this committee would fall under the "setting direction" function, associated with little decision-making.

IV. UNDERSTANDING OF THE AGREEMENT AND PUBLIC PARTICIPATION

A. No Knowledge of Agreement

One of the key findings was the lack of knowledge of the legal agreement or partnership between the CRHA and the Salvation Army. Although some individuals, particularly managers and Health Council representatives were aware of the agreement and were able to clearly describe the agreement and its implementation, the remaining key informants were less clear.

Knowledge ranged from being unaware of the agreement to having some awareness but incorrectly describing the roles of the CRHA and Salvation Army.

Well I know there is an understanding that um the Grace is run by the Salvation Army Board. I'm imagining somewhere in that agreement that clarifies and protects the Army's position, and respects the Army's position for not providing abortions on site. As far as the details of the agreement I'm not too clear but it's very VERY clear working here that the Salvation Army still has a presence. ***Grace staff member***

You know and that that has been um with all that the community groups that got involved, has been um something that has been sort of talked around but never sort of been brought to the table, like ah, exactly what what the agreement is.
Community Member

This is similar to the findings from the public discourse which demonstrated that the agreement was not the key focus, rather the move to the new site was the focus of public discourse. Those key informants who did not have access to the internal discourse were unaware of the specifics of the agreement.

Without an awareness of the agreement, most informants were unable to identify how public participation had been impacted by the agreement. In addition, many showed some confusion about what public participation was, which further limited their discussion of the impact of the agreement.

B. Understanding of Public Participation

1. Role of Public Participation

It became clear through the interviews that the breadth of understanding of public participation was limited. Due to the number of times that public participation was mentioned in CRHA literature the researchers were expecting a greater understanding of public participation. The interview guide was designed to elicit information about strategies for public participation used and proposed by the Grace. Although many interviewees were unable to answer sections of questions, these patterns of response and non-response provided important data. Through these questions, it became apparent that

although several interviewees identified public participation as being important, very few could actually articulate what they understood public participation to be.

Some individuals were aware of public participation and how it might be used within the Grace. Although public participation was often identified as being important, it was unknown to many informants how public participation fit into the Grace. Many were confused about the differences between public participation and access to services. Some of the strategies for public participation identified by interviewees were actually issues with respect to access to service. For example, one staff member suggested that as long as women kept accessing services at the Grace, public participation strategies were working well.

Strategies for public participation were limited and it wasn't evident that the strategies identified included decision-making or went beyond strategies to control and manipulate the public. There was no linking of strategies to specific health issues.

As well as a general lack of understanding of public participation, the informants demonstrated confusion with respect to the process of public participation versus the outcomes of public participation. This confusion led to trouble with identifying outcomes and ways to evaluate public participation strategies, in that many staff identified the public participation process as being the outcome of choice. For example, one key informant suggested that the number of women attending focus groups was a way to gauge the effectiveness of public participation, ignoring outcomes such as decision-making by the public.

2. Needs

One of the areas where the lack of breadth became apparent was within a section of questions designed to elicit ideas about what the public and health professionals require to participate effectively. This section clearly demonstrated some of the misconceptions around public participation. One key informant mentioned the need for health professionals to "manage" public participation to ensure that the public didn't get distracted, while another key informant mentioned the difficulty of getting "good" people from the community involved.

The need for transparency in public participation processes became evident and appeared to be linked to the idea of having clear goals. Transparency will help both the public and health professional set boundaries. There was some confusion about the role of public participation, and some of the requirements suggested for health professionals seemed to be designed to facilitate the control of situations where people outside of the health system might be involved.

3. Women's Health Issues

The fourth objective of this thesis was to identify women's health issues affected by the agreement between the CRHA and Salvation Army and determine the current status of those issues. Due to the lack of knowledge about the agreement, key informants were unable to discuss how the agreement had affected women's health issues. However, key informants were able to discuss specific health services and how they had been affected since the move to the Foothills site. The services that were mentioned were discussed as part of the "operations" of the partnership earlier in this chapter.

In addition to the programs discussed earlier, are the programs of the Women's Health Resource Centre (WHRC). Started in 1986, the WHRC provides health information and education programs to women in the Calgary area. This program continued at the new site, including a new van to be used for outreach, made possible by a large corporate donation made through the Grace Foundation. The outreach van was designed to ensure that the resources of the WHRC, including library materials were available to all Calgary women, regardless of their location. Since the legal agreement, more women in Calgary are able to access health information in a convenient manner.

C. Lack of Organizational Coherence

We have used the term *organizational coherence* to describe the way that information and ideas are distributed within the organization. In this case, lack of organizational coherence became clear when interviewing employees of the Grace. The knowledge displayed by the interviewees about the terms of the agreement and partnership varied greatly. For instance, one key informant knew all the terms and the implications of the agreement, while another key informant believed that the Salvation Army controlled all the Women's Health Programs in Calgary. The understanding of the agreement was not consistent throughout the organization, although upper management consistently described it, front-line staff did not have a clear idea of the agreement and its implementation. This lack of consistency in turn led to confusion among community groups dealing with front-line staff.

In terms of public participation, knowledge and understanding of public participation was not organized among the staff interviewed. Although it was expected

that certain staff members might have better ideas about public participation than others might, it seemed to be an individual level variable. Some of the front-line staff were able to clearly identify public participation strategies and describe potential barriers. On the other hand, many members of upper management displayed understandings of public participation that limited it to Arnstein's (1969) first three steps of *therapy*, *manipulation* and *informing*. The understanding of public participation was not at all clear through out the levels of management nor was it organized vertically, rather it seemed to be dependent on the individual and his/her particular background. For instance, one particularly knowledgeable individual had had considerable experience with public participation in previous employment.

CHAPTER 5: DISCUSSION

I. OVERVIEW OF THE RESULTS

This case study was designed to examine the impact of the agreement between the Salvation Army and the CRHA on women's participation in health policy and planning.

A. The Agreement between the CRHA and the Salvation Army

Partnerships are becoming more common in the health arena as increasing responsibilities are shifted to regional health boards and available resources become limited (Kickbush & Quick, 1998). Partnerships may provide a means for organizations to share resources and expertise in order to provide health services in a more effective/efficient manner.

One of the research questions set out at the beginning of the study was to characterize the relationship between the CRHA and the Salvation Army. Using the Scott & Thurston (1997) partnership framework, the relationship is clearly an example of a partnership, although neither organization used the term partnership to refer to their relationship. It is unclear why the term partnership hasn't been applied to this relationship by the participants. This is even more puzzling because the term partnership is now used extensively in the health sector to cover relationships that Scott and Thurston would exclude. Participants mentioned the "special" relationship between the CRHA and the Salvation Army and often mentioned that the relationship was highly valued by both parties. However, participants referred to the legal agreement repeatedly, seemingly minimizing the positive personal, professional and organizational factors which have moved the relationship past a legal contract to a successful partnership.

Partnership is also a form of public participation described by both the CRHA public participation framework (CRHA, 1999) and Arnstein's (1969) ladder of citizen participation. Although the relationship meets the criteria for a partnership, neither organization referred to it as such when discussing public participation. It is clear that the Salvation Army as a public has substantial decision-making power within the relationship. The issue of representation may have impacted the failure to describe the Salvation Army as a public. The Salvation Army may act to represent their church members, members of churches with similar stances on moral issues as well as those citizens who donate to the Salvation Army. Ongoing public participation takes place via the Salvation Army Health Council including members of the community in addition to Salvation Army representatives.

The failure of the organizations to identify the relationship between the CRHA and the Salvation Army as a partnership may have been due to limited information. One of the major findings of this study was the lack of understanding and knowledge of the agreement between the CRHA and the Salvation Army outside those at the top level of administration. Women from the community and front-line staff were either unaware of the agreement, or had incorrect information and/or made false assumptions about the relationship. The failure of these women to identify the relationship as a partnership or as an example of public participation is not surprising given the lack of understanding and/or lack of knowledge of the agreement.

If women and community groups are unaware of the relationship between the CRHA and the Salvation Army, when they engage in public participation strategies with

the Grace, they may be unaware that they are interacting with both the Salvation Army and the CRHA. They may not be aware of the shared impact that the CRHA and the Salvation Army have on programs at the Grace. As a result, knowledge about the existence of the partnership and understanding the division of responsibilities within the partnership has implications for how women impact health policy. This lack of knowledge may result in women lobbying the wrong organization or directing their energies in areas that will not bring the desired results.

B. Public Participation and Women's Health Policy

The public participation initiatives identified in this case study correspond with a variety of levels of Arnstein's public participation ladder (1969). The Salvation Army and CRHA partnership characterized by decision-making by the public and the Women's Health Design committee with the power to advise on program design issues (CRHA, 1997) would be at the top of the ladder. The input provided by the focus groups for the outreach program and the advising found at the level of the Women's Health Express Advisory Council would be in the middle. Framing of the media discourse around the Grace closure is at the bottom of the ladder.

Although several public participation strategies were identified, these strategies were not accompanied by theorising about public participation. The breadth of knowledge associated with public participation was very limited. Individuals within the health care system, both management and health professionals, did not have the level of understanding with respect to the use of public participation strategies that the researchers expected. On the other hand, this level of understanding is consistent with the need for a

public participation framework. The question guide used during the key informant interviews included several very specific questions around the use of public participation within the health system. The patterns of non-response indicated gaps in knowledge about participation, particularly matching strategies to goals, the reciprocal nature of participation and possible barriers to participation.

Although public participation has been identified as an important strategy in the health promotion field (World Health Organization, 1984) there are many systemic barriers that minimize its impact. Participation is influenced by social, political, cultural, and economic factors, and imbalances in terms of power and control (Woelk, 1997).

Wiebe, MacKean & Thurston (1998) identified five categories of factors that determine if decision-making is an outcome of participation: characteristics of the setting; characteristics and support of public participants; characteristics of change; goals and objectives of public participation; and characteristics of participatory techniques.

The *characteristics of the setting* include: the structure and political context of the health systems; the historical impact of the bio-medical model of medicine on professional and public behaviour (Cron, 1981) and the mystique created and maintained around medicine. None of the participants in this project identified the setting as an issue that had affected women's participation, but this may be a result of the sample we achieved. Women who were truly intimidated or had difficulty accessing the healthcare system would not have been captured by our sample.

The culture of an organization and its history of involving the public is another aspect of the setting, highlighted by our findings, that will likely affect the beliefs about

participation and the behaviours of professionals working within the organization (Shisana & Versfeld, 1993). In this case, the difficulties experienced by the researcher in trying to get access to public information is an important indicator of the culture of the CRHA and its commitment to public information in practice compared to its publications such as the Public Participation Framework.

Setting may also be examined in the way that the stage of the health system or health program development may impact the receptiveness of an organization to consider community participation. This is evidenced by the use of public participation during the planning phase of CLSCs in Quebec, which was curtailed when the program began to function (O'Neill, 1992). In our case, the Women's Health Express Advisory committee was successful during the conception and design phases of the project but ran into difficulties with implementation and maintenance of the program.

The *characteristics and support of public participants* centres on the mandate from the community, the number of participants and the infrastructure behind them (Wiebe, MacKean & Thurston, 1998). Community is often defined geographically or in terms of shared interests (Bracht, 1991). If a public participant has no constituency to draw upon for ideas and support, the likelihood of being effective is reduced (Chesney, 1984). The Salvation Army has a world-wide constituency of church members as well as all those who donate to the fundraising efforts of the Salvation Army.

An important characteristic of the participants and their support, highlighted by our research, was available resources. The ability of the public to participate effectively is often limited by the resources available to the community (Shisana & Versfeld, 1993).

The Salvation Army, as one public, is well-supported with material and symbolic resources and personnel to draw upon for power and action, in addition to corporate experience dealing with health authorities in other provinces. The resources that the Salvation Army was able to invest in the partnership may be a factor that has impacted the success of the partnership. Starr (1980) asserted that the public needs complete and unbiased information in order to participate effectively within the complex medical system. As evidenced by the internal discourse, the Salvation Army had access to complete information that allowed them to participate on an equal footing with the CRHA.

Other public participation projects also included publics whose resources were well-matched to the needs of the project. For example, the Women's Health Express advisory council was made up of community groups, another public, who had the resources to maintain their involvement over time. These resources included the availability of a staff person, transportation and skills at an appropriate level to interact with the other participants. By varying the types of public participation projects, the CRHA will increase the likelihood that diverse publics will be able to participate.

Our findings highlighted another characteristic of public participants and their support, namely the particular groups of skills needed by citizens and stakeholders in order to maximize the effectiveness of public participation. The skills required by the public to effectively participate include mediating and negotiation skills, decision-making skills and knowledge of the health-care system (Pedalini, Dallari & Barber-Maden,

1993), skills which the Salvation Army representatives already possessed, having had experience as members of the Board of Trustees of the Salvation Army Grace Hospital.

Empowerment is a necessary antecedent to the use of public participation in health policy planning (Dwyer, 1989; Starr, 1980). It is critical to avoid recreating societal inequities within the health system (Berg, 1999). Those communities that experience the most barriers in accessing the health system, may also be those groups who face barriers to public participation (Armbruster, Gale, Brady & Thompson, 1999; Cohen, 1994). The Women's Health Express van was designed to ensure that all women in Calgary were able to access the programs of the Grace Women's Health Resource Centre.

Changes occurring both within and around the health system have implications for the use of public participation (Milewa, Valentine & Calnan, 1998). The Canadian movement towards regionalization has redirected health care planning and decision-making from a central point to a regional level (Sullivan & Scattolon, 1995). This decentralization may allow more opportunities for involvement, as decision-making takes place closer to the community. The direction of the change will have an impact on public participation. For example, regionalization may bring decision making closer to the community, while a move to centralize health administration may take decision-making power away from the community. One of the advantages of decentralized planning is the ability to allow for innovation and evaluation of policy changes on a small (e.g., regional, local) scale compared with the wide scale implementation demanded by a centralized planning system (e.g., provincial, national) (Walker, 1997). In terms of our study, the

changes associated with the regionalization process brought about an opportunity for a partnership between the CRHA and the Salvation Army.

The *goals* of the public participation activity should guide the type of public participation that is developed. The goals guide the characteristics of the techniques used to involve the public. Consumers prefer some techniques and others are favoured by health professionals (Koseki & Hayakawa, 1979). The CRHA framework doesn't introduce particular techniques for public participation (CRHA, 1999). Most of the staff interviewed had a very limited knowledge of public participation strategies. Having an arsenal of public participation strategies from which to choose will increase the probability of matching an appropriate strategy with the particular goal. A cookbook approach is not required but ensuring that CRHA staff are aware of the range of activities that can be considered public participation may help them choose appropriate strategies. The interviews revealed that knowledge of public participation strategies was limited and that the strategies chosen may have been chosen not because of their suitability but rather due to that fact that they were known to the user.

C. Strength of Religious Institutions

Religion is a social institution with many variables, including a complex set of patterns of beliefs, norms of behaviour, roles and power relationships and expectations of members. Kleinman (1980) describes the complex interactions between similar variables within the health care system. The role of a religious institution within the health care system brings into play some of the conflicts between these two powerful and well-established systems.

A key finding of this study was the concern expressed by community groups about the appropriateness of the Salvation Army being involved in women's health due to their stance on abortion and other women's health procedures and its effect on limiting the type of care that women were receiving in Calgary. Although the involvement of the Salvation Army does impact which services are offered through the Grace Women's Health Centre, the lack of abortion and contraceptive services at the Grace has not been changed by the legal agreement. Prior to the legal agreement, these services were not provided by the Grace, but were available to women in the Calgary region from other institutions. The current situation is very similar, as these services are offered by the CRHA but not at the Grace site. The information available to clients of the Grace has not been changed by the agreement. It appears that the partnership with a religious organization has not impacted the services available to women in the region

It is impossible to know what women's health services might look like in Calgary if the Salvation Army and the CRHA had not formed a partnership but it is possible that the very existence of a women's health program is due to the involvement of the Salvation Army. Horne, Donner & Thurston, (1999) found that women's health programs in Saskatchewan and Manitoba were rare. If the Salvation Army had not advocated so strongly for women's health, it can be speculated that women-centred programs such as the Breast Health Program and the Colposcopy program may not have continued or may have been smaller with the closure of the Grace hospital.

The role of denominational hospitals within the regionalized Alberta health care system seems to be unique, as shown by the opportunity for denominational hospitals to

retain some power by virtue of agreements such as the one between the Salvation Army and the CRHA. The data could not explain why the Salvation Army was allowed to maintain this level of control over the Grace, while the other boards operating in the Calgary area prior to regionalization were stripped of all their power, but it suggests that religious organizations are powerful institutions, acknowledged by the provincial government.

D. Power: Information and Other Resources

In 1993, Shisana and Versfeld identified that the culture of an organization and its history of involving the public will impact the beliefs about participation and the behaviour of professionals working in the organization. The CRHA has identified public participation as a key priority of its organization and the public participation framework was designed to address this. The ability of the CRHA to successfully incorporate public participation within its organization may be impacted by the ways information, resources and power are treated within their organization.

Chesney (1984) identified that many of the barriers to public participation in health policy are related to the imbalances of power which characterize the modern health system. One of the major findings of this study has been the role that knowledge has played in terms of the agreement between the Salvation Army and the CRHA and the use of public participation. By examining the public discourse and comparing it to the internal discourse, we can see that information was tightly controlled. Without access to the internal discourse, individuals have a limited knowledge of the agreement between

the CRHA and the Salvation Army. This limited knowledge may have backfired, as community groups may have assumed the worst (e.g., loss of services).

Power and knowledge are inextricably linked in organizations (Deetz & Mumby, 1990). Those groups with the knowledge have essentially controlled the discourse around the Salvation Army and CRHA partnership. Although it is clear that both partners value the partnership between the CRHA and the Salvation Army, the lack of information sharing has had an impact on the ability of the public to participate in a meaningful way. Access to information is a prerequisite for any public decision-making (Arnstein, 1969).

The willingness of the organizations to share information with the community will impact public participation efforts. The Salvation Army was quite forthcoming with information, while the CRHA, a public body, made it difficult (if not impossible) to access certain public records.

The culture of the CRHA where information is closely guarded and managed has set up a situation where members of the public have difficulty in accessing public documents. Without access to information, community groups are placed at a clear disadvantage. Community members do not have the power to force the CRHA to release information and so are immediately placed in a subordinate position. They have to first find out whom to contact; second, learn about the Freedom of Information and Privacy Act; third, complete the necessary forms and pay the application fee; and finally, follow up on the decision that is made regarding their application. Many individuals and groups don't have the time and energy that this requires. Valuable knowledge is exchanged

informally through networks and personal contact; however, this is sometimes neither official nor full knowledge upon which individuals and groups would be able to act.

Two issues that emerged were power and resources. This agreement takes place within the context of the health system, a context which has historically been rife with power imbalances. The success of the partnership between the CRHA and Salvation Army is impacted by the access to resources and power held by these two organizations. Any attempts to implement a public participation project within this context must take the power imbalances into account and take steps to ensure that some of the power imbalances are addressed. The CRHA public participation framework has not explicitly addressed the power imbalances.

When community groups are engaging in public participation activities associated with the Grace, they are dealing with both the CRHA and the Salvation Army. Any public participation initiatives specific to the Salvation Army Grace Women's Health Centre must make it explicit what role each organization has in the particular project.

II. FURTHER RESEARCH

This exploratory case study offered a first look at the partnership between the CRHA and the Salvation Army. As we came to understand the relationship between the Salvation Army and the CRHA, we began to wonder about how this partnership might compare to other partnerships within the healthcare sector. As Scott and Thurston (1997) identified, characteristics of the partners impact the success of partnerships. This was a partnership between a health authority and a faith community. Faith communities are organizations that are similar in many ways to other organizations but unique in others.

The Salvation Army has several strengths: a history in the Calgary healthcare system; experience with other health authorities in other provinces; access to financial resources via the Grace Foundation; a good reputation within the city; experience in women's health; and the support and resources of a world-wide church to sustain them. The role of faith communities as partners in health could be explored by examining other denominational hospitals within Alberta health regions. Several other denominational hospitals exist, although their religious affiliations are with the Catholic Church. It would be interesting to examine how two very different faith communities, the Salvation Army and the Catholic Church have established themselves within the Alberta healthcare system.

As it becomes clear that ensuring the health of populations requires input from multiple sectors and that faith communities may play a role in supporting the health of communities (Abuelouf, 1999; Connelly, 1999), further research into partnering with faith communities is necessary. Although religion as a factor in individual health has been examined, the role of religion as a social institution needs to be further explored. In particular, it will be necessary to determine if religious organizations function similarly to other voluntary organizations when it comes to increasing the health capacity of a community (Greeley, 1997).

Faith communities are just one of the many possible partners within the health care system. The success of this partnership between two very different institutions suggests the possibility of partnerships with different types of organizations. The

possibility of partnerships with private organizations is a topic which is emerging and is especially salient in the Alberta context.

The establishment of the Women's Health Advisory Council, which is mentioned in the legal agreement and is included in the current organizational chart of the CRHA will offer an excellent opportunity to examine a new public participation initiative within the CRHA. It will be important to document the process and to ensure that opportunities to learn from success and failures are built into the process.

This case study examined the use of public participation in women's health policy; it was limited to those who have participated. The literature suggests that women who have difficulty accessing the healthcare system may face barriers to participation (Armbruster, Gale, Brady & Thompson, 1999). In order to increase our understanding of women's participation in health planning, the barriers that keep women from participating need to be better understood. By focusing only on those groups and individuals that do participate, there is a risk of missing important information about why women do not participate.

Wiebe, MacKean and Thurston (1998) have described the skills and characteristics of participants as important variables that affect the success of public participation. One of the characteristics of the participants in the public participation strategies identified by this case study was the importance of personal contacts. The relationship between the CRHA and the Salvation Army was initiated by informal communication between two powerful individuals, the Board Chairs, and resulted in a formal legal agreement. The Women's Health Express Advisory Committee came about

as a result of contacts with community women's groups. In this case, the role of personal contacts and networks impacted public participation.

III. STRENGTHS AND LIMITATIONS OF THE STUDY

A. Scope

It is important to note that this was not an exhaustive review of all public participation strategies used within women's health in Calgary. The coverage is limited to those initiatives identified through the review of the documents or identified by key informants. The partnership between the Grace and NOVA, referred to in their publication (Grace, 2000), was not examined during this case study, as it was not identified by any informants as a key issue. That partnership may have been impacted by the agreement between the Salvation Army and the CRHA.

B. Sample

This case study used multiple data sources to examine the particular case. The multiple data sources makes it less likely that one particular viewpoint has overshadowed the understanding of the case. One data source was the interviews with key informants. Key informants to be interviewed were suggested by other key informants, meaning that personal relationships and particular networks within the community may have impacted who was suggested as key informants. As a result, all the individuals interviewed had been involved in at least one of the public participation strategies used by the Grace. It is possible that those individuals who had participated had a very different experience with public participation from those community members who have not been involved with the Grace, either by choice or circumstance.

It is possible that the health system does present barriers to certain groups of women, and those women were missed by virtue of the sampling strategy. Women involved with other community groups may have a very different view of the how the agreement between the CRHA and the Salvation Army has impacted their participation. The women that were interviewed may have a set of skills which allows them to interact effectively with the health system and develop the personal networks which can lead to their involvement in Grace projects. In addition, particular organizations may have sufficient resources to allow their staff the time to be involved with the Grace. By not interviewing women from groups who have not been involved with the Grace, we may have missed some important insights with respect to why groups do not participate.

C. Review of the Documents

Another limitation of this study is the lack of CRHA documents due to difficulties accessing CRHA documents. It was not possible to access minutes of public meetings of the CRHA board in a timely and affordable manner. Although the difficulties accessing these public documents provided important data with respect to the culture of the CRHA and the public's access to information, the lack of documents from the CRHA has narrowed the understanding that we have of the case. The absence of information has fuelled speculation. This pattern is quite similar to the reactions of community women who knew a little bit about the agreement but in the absence of clear, unbiased information speculated on their own.

D. Significance of the Study

This study is important for several reasons. Firstly, it is an opportunity to get a better understanding of the relationship between the CRHA and the Salvation Army. Their continued partnership through major changes in the health care system shows that their partnership is a robust one. This type of partnership is an interesting example of a relationship between a health authority and a faith community within the Canadian context.

Secondly, this study allowed us to look at the use of public participation within the area of women's health. Connell (1994) identifies the quasi-governmental sector (that is institutions operating outside the formal state structure), as being an area where women have had a key role in shaping policy. This quasi-governmental sector includes health care and education. The literature on women's involvement in health policy and planning is sparse but this study may add to it. This study also allows us to examine the role of non-governmental organizations within the healthcare systems. Combined with other research, it will contribute to the development of a theory of public participation in the health sector.

REFERENCES

Abuelouf, A. (1999). Evolution of a community health ministry: Parish-based efforts to promote health and wellness benefit the entire community. Health Progress, 80(2), 38-39.

Ahern, K. (1999). Ten tips for reflexive bracketing. Qualitative Health Research, 9(3), 407-411.

Armbruster, C., Gale, B., Brady, J., & Thompson, N. (1999). Perceived ownership in a community coalition. Public Health Nursing, 16(1), 17-22.

Arnstein, R. (1969). A ladder of citizen participation. American Institute of Planners Journal, 35(4), 216 –224.

Auerbach, J.D., & Figert, A.E. (1995). Women's health research: Public policy and sociology. Journal of Health & Social Behavior, Spec No, 115-131.

Berg, J. (1999). Gaining access to underresearched populations in women's health research. Health Care for Women International, 20, 237-243.

Bergqvist, C. & Findlay, S. (1999). Representing women's interests in the policy process: Women's organizing and state initiatives in Sweden and Canada, 1960s-1990s. In L. Briskin & M. Eliasson (Eds.), Women's organizing and public policy in Canada and Sweden. (pp. 119-146). Montreal: McGill-Queen's University Press.

Bogue, R. Antia, M., Harmata, R. & Hall, C. (1997). Community experiments in action: Developing community-defined models for reconfiguring health care delivery. Journal of Health Politics, Policy and Law, 22(4), 1051-1076.

Bowie, C., Richardson A.& Sykes, W. (1995). Consulting the public about health service priorities. British Medical Journal, 311, 1155-1158.

Bracht, N. (1991). Citizen participation in community health: Principles for effective partnerships. In B. Bandura & I. Kickbush (Eds.), Health promotion research: Towards a new social epidemiology, (pp. 477-496). Copenhagen: World Health Organization.

Briskin, L. (1999). Mapping women's organizing in Sweden and Canada: Some thematic considerations. In L. Briskin & M. Eliasson (Eds.), Women's organizing and public policy in Canada and Sweden. (pp. 3-47). Montreal: McGill-Queen's University Press.

Brodie, J. (1995). Politics on the margins: Restructuring and the Canadian women's movement. Halifax, Nova Scotia: Fernwood Publishing.

Calgary Regional Health Authority. (1999). Public Participation Framework. The author.

Carpenter, E. S. (1999). Consumer participation in local health planning: The beginning of the end or the end of the beginning? Medical Care, 20(12), 1163-1165.

Casebeer, A. (1996). The process of change related to health policy shift. Unpublished doctoral dissertation, University of Calgary, Calgary, Alberta, Canada.

Chesney, J. (1984). Citizen participation on regulatory boards. Journal of Health Politics, Policy and Law, 9(1), 125-135.

Cochran, C. (1999). The common good and healthcare policy: Healthcare is a social construction for the good of all. Health Progress, 80(3), 41-44.

Cohen, M. (1994). Impact of poverty on women's health. Canadian Family Physician, 40, 949-957.

Connell, R. (1994). The state, gender and sexual politics: Theory and appraisal. In H.L. Radtke & H.J. Stam (Eds.), Power/gender: Social relations in theory and practice. (pp. 136-173). Thousand Oaks, CA.: Sage Publications.

Connelly, M.D. (1999). Together we can do more. Health Progress, 80(4), 80

Coyne-Beasley, T. & Schoenbach, V. (2000). The African American church: a potential forum for adolescent comprehensive sexuality education. Journal of Adolescent Health, 26(4), 289-294

Cron, T. (1981). The nature of "consumer health" as a public health concept. Public Health Reports, 96(3), 274-278.

Davis, D., Bustamante, A, Brown, C, Wolde-Tsadik, G., Savage, E., Cheng, X. & Howland, L. (1994). The urban church and cancer control: A source of social influence in minority communities. Public Health Reports, 109(4), 500-506.

Deetz, S. & Mumby, D. (1990). Power, discourse and the workplace: Reclaiming the critical tradition. In J. A. Anderson (Ed.), Communication Yearbook 13. (pp. 18-47). Thousand Oaks, CA: Sage Publications.

Doyal, L. (1995). What makes women sick: Gender and the political economy of health. New Brunswick, NJ: Rutgers University Press.

Dwyer, J. (1989). The politics of participation. Community Health Studies, 13(1), 59-65.

Ellison, C., & Levin, J. (1998). The religion-health connection: Evidence, theory and future directions. Health Education & Behavior, 25(6), 700-719.

Fox, S., Pitkin, K., Paul, C., Carson, S. & Duan, N. (1998). Breast cancer screening adherence: Does church attendance matter? Health Education and Behavior, 25(6), 742-758.

Gallagher, J. (1997). Religious freedom, reproductive health care and hospital mergers. Journal of the Medical Women's Association, 52(2), 65-68.

Glaser, B. & Strauss, A. (1967). The discovery of ground theory: Strategies for qualitative research. Chicago: Aldine.

Government of Alberta. A better way: A plan for securing Alberta's future. (1994). Edmonton, Alberta: Government of Alberta.

Government of Alberta. The Regional Health Authorities Act. (1994). Edmonton, Alberta: Government of Alberta.

Gray, G . (1998). How Australia came to have a National Women's Health Policy. International Journal of Health Services, 28(1), 107-125.

Greeley, A. (1997). The other civic America: Religion and social capital. The American Prospect, 32, 68-73.

Griffin, A. (1994). Women's health and the articulation of policy preferences. Setting the terms of discussion. Annals of the New York Academy of Sciences, 736, 205-216.

Hardwick, E., Jameson, E. & Tregillus, E. (1975). The science, the art and the spirit: Hospitals, medicine and nursing in Calgary. Calgary, AB: Century Calgary Publications.

Havighurst, C. (1986). The changing locus of decision making in the health care sector. Journal of Health Politics, Policy and Law, 11(4), 697-735.

Horne, T., Donner, L., & Thurston, W. (1999). Invisible women: Gender and health planning in Manitoba and Saskatchewan and models for progress. Winnipeg, Manitoba: Prairie Women's Health Centre of Excellence.

Hughes, T. & Larson, L. (1991). Patient involvement in health care: a procedural justice viewpoint. Medical Care, 29(3), 297-303.

Jarvis, G. & Northcott, H. (1987). Religion and differences in morbidity and mortality. Social Science and Medicine, 25, 813-824.

Kickbusch., I. & Quick, J. (1998). Partnerships for health in the 21st century. World Health Statistics Quarterly, 51, 68-74.

Kleinman, A. (1980). Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry. Berkely, CA: University of California Press.

Kome, P. (1983). The taking of twenty-eight: Women challenge the constitution. Toronto, Canada: The Women's Educational Press.

Koseki, L. & Hayakawa, J. (1979). Consumer participation and community organization practice: Implications of National Health Legislation. Medical Care, 17(3), 244-254.

Levin, J. (1984). The role of the black church in community medicine. JAMA, 76, 477-483.

Levin, L. (1995). Public participation in health care quality. Journal of Epidemiology and Community Health, 49, 344-347.

Lewis, S., Kouri, D., Estabrooks, C, Dickinson, H., Dutchak, J., Williams, J., Mustard, C & Hurley, J. (2001). Devolution to democratic health authorities in Saskatchewan: An interim report. Canadian Medical Association Journal, 164 (3), 337-342.

Lincoln, Y & Guba, E. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage Publications.

Little, J. (1994). Gender, planning and the policy process. Oxford, Engalnd: Elsevier Science Ltd.

Lovenduski, J. & Hills, J. (Eds.). (1981). The politics of the second electorate: Women and public participation. London: Routledge & Kegan Paul.

Maloff, B., Bilan, D. & Thurston, W. (2000). Key elements of community health advocacy - enhancing public input into decision making: Development of the Calgary Regional Health Authority Public Participation Framework. Family & Community Health, 23(1), 66-79.

Marshall, C., & Rossman, G. (1995). Designing qualitative research. (2nd ed.). Thousand Oaks: Sage Publications.

Milewa, T. Valentine J. & Calnan M. (1998). Managerialism and active citizenship in Britain's reformed health service: Power and community in an era of decentralization. Social Science and Medicine, 47(4), 507-517.

Mirola, W. (1999). A refuge for some: Gender differences in the relationship between religious involvement and depression. Sociology of Religion, 60, 419-437.

Moyles, R. (1977). The blood and fire in Canada: A history of the Salvation Army in the Dominion. Toronto: Peter Martin Associates.

O'Neill, M. (1992). Community participation in Quebec's health system: A strategy to curtail community empowerment? International Journal of Health Services, 22(2), 287-301.

Pan American Health Organization. (1993). Gender, women and health in the Americas. Washington, DC: Author.

Pedalini, L., Dallari, S., & Barber-Madden, R. (1993). Public health advocacy on behalf of women in Sao Paulo: Learning to participate in the planning process. Journal of Public Health Policy, summer, 183-197.

Place, M. (1999). How faith and public policy intersect. Health Progress, 80(1), 10-13.

Preston, T. (1982). The need for public involvement in medicine. Biomedical Communications, November/December, 9-28.

Prohaska, T., Peters, K. & Warren, J. (2000). Sources of attrition in a church-based exercise program for older African-Americans. American Journal of Health Promotion, 14(6), 380-385.

Qualitative Solutions and Research. (1997). NUD*IST Release V 4.0. Melbourne: Qualitative Solutions and Research Pty Ltd.

The Rainbow Report: Our Vision of Health. (1989). Edmonton, Alberta: Premier's Commission on Future Health Care for Albertans.

Ransdell, L. (1995). Church-based health promotion: An untapped resource for women 65 and older. American Journal of Health Promotion, 9, 333-336.

Rogow, D. (1994). Women's health policy: where lie the interests of physicians? International Journal of Gynaecology & Obstetrics, 46(2), 237-243.

Rothwell, A. (1976). Love and good sense : the first half-century of the Salvation Army Grace Hospital, Calgary, 1926-1976. Unpublished manuscript. (Available from University of Calgary library, (Call number: FC3697.4 .R66 1976), Calgary, Alberta.

Scheufele, D. (1999). Framing as a theory of media effects. Journal of Communication, winter, 103-122.

Scott, C. & Thurston, W.E. (1997). A framework for the development of community health agency partnerships. Canadian Journal of Public Health, 88(6), 416-420.

Scott-Taplin, C. (1993). Development of community partnerships. Unpublished Masters Thesis. Department of Community Health Sciences, The University of Calgary, Calgary, Alberta, Canada.

Shisana, O. & Versfeld, P. (1993). Community participation in health service institutions. South African Medical Journal, 83 , 5-6.

Starr, P. (1980). Changing the balance of power in medicine. Milbank Memorial Fund Quarterly, 58(1), 166-172.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research. Thousand Oaks, CA: Sage.

Strogatz, D., James, S., Elliott, D., Ramsey, D., Cutchin, L. & Ibrahim, M. (1985). Community coverage in a rural, church-based, hypertension screening program in Edgecombe County, North Carolina. American Journal of Public Health, 75(4), 401-402.

Sullivan, M. & Scattolon, Y. (1995). Health policy planning: A look at consumer involvement in Nova Scotia. Canadian Journal of Public Health, 86(5), 317-320.

Thomas, S. Quinn, S., Billingsely, A & Caldwell, C. (1994). The characteristics of Northern Black churches with community health outreach programs. American Journal of Public Health, 84(4), 575-579.

Troyer, H. (1988). Review of cancer among four religious sects: Evidence that lifestyles are distinctive sets of risk factors. Social Science and Medicine, 26, 1007-1017.

Vicker, J. & Brodie, M.J. (1981). Canada. In J. Lovenduski & J. Hills (Eds.), The politics of the second electorate: Women and public participation. (pp. 52-82). London: Routledge & Kegan Paul.

Walker, R. (1997). Public policy evaluation in a centralized state: A case-study of social assistance in the United Kingdom. Evaluation. (pp. 261-279). Thousand Oaks: Sage Publications.

Watson, S. (1999). City A/genders. In S. Watson & L. Doyal (Eds.), Engendering social policy. Buckinham, UK: Open University Press.

Weis D. Matheus R. & Schank. (1997). Health care delivery in faith communities: The parish nurse model. Public Health Nursing, 14(6), 368-72.

Weisman, C. (1999). The implications of affiliation between Catholic and non-Catholic health care organizations for availability of reproductive health services. Womens Health Issues, 9(3), 121-134.

Wiebe, V.J., MacKean, G., & Thurston, W.E. (1998). Public participation in health promotion program planning: A conceptual model. In W.E. Thurston, J.D. Sieppert, V.J. Wiebe, (Eds.), Doing health promotion research: The science of action, (pp.161-176). Calgary, AB: University of Calgary Health Promotion Research Group.

Woelk, G. B. (1992). Cultural and structural influences in the creation of and participation in community health programs. Social Science and Medicine, 35(4), 419-424.

World Health Organization. (1986). Ottawa Charter for Health Promotion. Copenhagen: Author.

Wuest, J. (1993). Institutionalizing women's oppression: the inherent risk in health policy that fosters community participation. Health Care for Women International, 14(5), 407-417.

Yin, R. (1993). Applications of case study research. Thousand Oaks: Sage Publications.

APPENDIX A: INTERVIEW GUIDE

Characterize the relationship between the CRHA and the Salvation Army.

1. *Are you aware of the agreement between the Salvation Army and the CRHA to provide women's health services?*
2. *Could you describe the relationship between the CRHA and the Salvation Army?*

Describe the implementation of the agreement between the CRHA and the Salvation Army.

1. *Are there any differences between the agreement on paper and how the relationship is implemented?*
2. *Are there factors that have impacted the implementation of the agreement? Factors outside the agreement? Communications? Operations? Characteristics of the partners?*

Identify and assess strategies for public participation used and proposed by the Salvation Army Grace Women's Health Centre.

1. *In your experience, what strategies are used to encourage public input for policy makers at the Grace Women's Health Centre?*
2. *Could you tell me how these strategies have worked in the past?*
3. *How would you know that a strategy was working well?*
4. *What happens if the strategies don't work?*
5. *Are there unanticipated outcomes, positive and negative of public participation?*
6. *Under what circumstances and for what issues are strategies most successful?*
7. *What do the public require in order to participate effectively?*
8. *What do health professionals need in order to participate effective with the public?*
9. *How is conflicting public input handles in each strategy?*
10. *How doe the agreement impact on public participation and vice-versa?*
11. *Are you aware of the CRHA's Public Participation Framework?*
12. *What is your understanding of the framework?*
13. *How are the principles of the CRHA Public Participation Framework implemented?*

Identify women's health issues affected by this agreement and the current status of these issues.

1. Can you think of specific women's health issues that have been affected by the agreement?
2. What has happened?
3. What is the current status of those issues?
4. Have women's groups been involved? What was their role?
5. Is there decision-making by the public?
6. Do you have any other comments that you would like to add?

APPENDIX B: CONSENT FORM

Research Project: THE INFLUENCE OF THE AGREEMENT BETWEEN THE CALGARY REGIONAL HEALTH AUTHORITY AND THE SALVATION ARMY ON WOMEN"S PARTICIPATION IN HEALTH POLICY.

Researcher: Erin Rutherford
Research Supervisor: Dr. W. E. Thurston

Agency: Department of Community Health Sciences
University of Calgary

Date:_____

Dear_____;

This consent form, a copy of which will be given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

This project is intended to explore the influence of the agreement between the Salvation Army and the Calgary Regional Health Authority on public participation in the development and implementation of women's health policy.

No individual, neither employees nor volunteers will be identified in reports without their written consent. All individual will be assigned a code and their names will be stored separately from the data collected. Only the researcher and the research supervisor will have access to identifying data. We will also ensure that tape-recorded dialogues and transcripts of the interview are protected.

It will take about one hour for your interview. Based upon data analysis, you may be asked to participate in one or two additional ½ hour interview sessions. While you may not gain directly from participating, it is hoped that the results of this project will benefit the health care system. We guarantee that we will not tell anyone whether you decided to participate, or not, or the extent of your participation.

In the event that you suffer injury as a result of participating in this research, no compensation (or treatment) will be provided for you by the University of Calgary.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal right nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your healthcare. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have further questions concerning matters related to this research, please contact:

Researcher: Erin Rutherford
Phone Number: 245-9033
Email: esruther@ucalgary.ca

Research Supervisor: Dr. W.E. Thurston
Phone Number: 220-6940

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, The University of Calgary, at 220-7990.

(Printed name of participant)	(Signature of participant)
(Printed name of witness)	(Signature of witness)
(Printed name of researcher or delegate)	(Signature of researcher or delegate)
(Date)	(Date)

A copy of this consent form will be given to you. Please keep it for your records and future reference.

APPENDIX C: PLEDGE OF CONFIDENTIALITY

I, _____, agree not to discuss or disclose

(PRINTED NAME OF CLERICAL ASSISTANT)

respondent or organizational information learned as a result of my work as Clerical Assistant for the study of " The Influence of the Agreement between the Calgary Regional Health Authority and the Salvation Army on Women's Participation in Health Policy".

I also pledge myself to continue to observe strict confidentiality on this information when I cease to be involved with this research project.

_____	_____
(PRINTED NAME OF CLERICAL ASSISTANT)	(PRINTED NAME OF WITNESS)
_____	_____
(SIGNATURE OF CLERICAL ASSISTANT)	(SIGNATURE OF WITNESS)
_____	_____
(DATE)	(DATE)