The Role of the Media in Public Participation: Framing and Leading?

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ABSTRACT. This article focuses on the framing of women’s health services in the context of restructuring dictated by health system regionalization. By examining the archives of a local newspaper and the minutes and documents of one of the key organizations involved in re-
structuring after regionalization, it was possible to examine the public discourse of the time and subsequently the journalists’ and the readerships’ understandings of women’s health.

The evidence suggests that the Salvation Army was instrumental in setting the tone that was taken by the media in framing the issues around the closure and move of its Grace Women’s Health Centre. While the Calgary Health Region was successful in bringing the Grace under its mandate and organizational control, it was the Salvation Army, with its highly visible and powerful fundraising arm and its advocacy for holistic women’s health, that caught the public’s attention. The internal discourse tracked some of the emerging issues, known only to those involved at managerial levels within the health system, but the public discourse kept women centered in decisions regarding the partnership. Women from many constituencies must continue to participate in the public policy realm to ensure that women’s health remains an issue in health reform.

KEYWORDS. Women’s health, public participation, media, discourse, policy, health reform

INTRODUCTION

Regionalization of health services in Alberta, Canada occurred in 1994, a process wherein 200 separate boards of hospitals, health units, and health service institutions were dismantled and a single health authority board in each of 17 regions was appointed by the provincial government (Casebeer & Hannah, 1998). Some would argue that regionalization reduced opportunity for public participation in health policy because of the loss of board positions (Veenstra & Lomas, 1999).

In one urban health region, presently called the Calgary Health Region (CHR), seven boards governing eight hospitals and two public health units were replaced by one board composed of 15 members. Regionalization also brought with it hospital closures including the Salvation Army Grace Women’s Health Centre (the Grace), a publicly funded hospital operated by the Salvation Army (SA) (Moyle, 1977; Thurston, Rutherford, Vollman, & Meadows, 2005). The closure of the Grace site and the move to the Foothills Hospital site was announced on
July 14, 1994. On March 31, 1995, the CHR and the SA signed a transition agreement covering the operation of the Grace and the intention to move it. A formal legal agreement for partnership was signed in August 1995 by the CHR and the Territorial Headquarters of the Salvation Army for Bermuda and Canada. Between November 11, 1995 and March 11, 1996, the old site was closed, and the move to the new site was completed. It continued to be known as the Salvation Army Grace Women’s Health Centre, and the continuing involvement of the governing council of the SA was recognized. The governing council includes the leader of women’s health for the CHR and advises on programs and oversees respect of the SA mission, vision, and values. The CHR agreed to ensure that the physical space in which the Grace was located would not be used for any procedure that was contrary to the mission, vision, and values of the SA (SA Health Council summary of meetings 1995-2000).

The Grace programs included an important number of regional women’s health services: day surgery; breast health; colposcopy; obstetrics and gynecology; osteoporosis; health information outreach; urodynamics; and an education resource center. These programs serve approximately one million people. The resource center alone sees approximately 22,000 women annually, and breast health sees 6,500 women.

In the development of policy, policy communities, networks, and advocacy coalitions play a key role (Howlett & Ramesh, 1995; Bacchi, 1999). The women’s health policy community in a given region comprises all those people concerned about the promotion of women’s health and well-being. Given a determinants model of health (Health Canada, 2004), this may include people from government, health services, feminist organizations, and the general public. Networks, often formed around special topics (e.g., breast cancer, violence, poverty), are composed of members of the policy community who interact on a regular basis (Howlett et al., 1995). Advocacy coalitions include “actors from a variety of public and private institutions at all levels of government who share a basic set of beliefs (policy goals plus causal and other perceptions) and who seek to manipulate the rules, budgets and personnel of governmental institutions in order to achieve these goals over time” (Howlett et al., 1995, p. 126).

These varied members of policy networks and advocacy coalitions may have several sources of information upon which to draw when formulating their positions on a given policy matter. They also have the opportunity to exchange information with other members and to participate in discussion and debate. Members of the policy community who
are not involved in networks and coalitions would have fewer opportunities for information exchange. As researchers from different disciplines have argued (Keller, 1989; Harding, 1986; Smith, 1987), knowledge and facts are not neutral; information is not a value-free commodity. In his introduction to *The History of Sexuality*, Foucault (1978) stated, “Repression operated as a sentence to disappear, but also as an injunction to silence, an affirmation of non existence, and, by implication, an admission that there was nothing to say about such things, nothing to see, and nothing to know” (p. 4). Women’s groups have actively worked to bring repressed issues, such as family violence, into the public policy realm (Eliasson & Lundy, 1999; Sherwin, 1992). These women’s health discussions have “the power to make visible what has been invisible” (Webster, 1994, p. 378).

Policy communities and the public in general receive much information from the media. Indeed, “[m]edia discourse is part of the process by which individuals construct meaning” (Scheufele, 1999, p. 105), providing a frame in which social issues are understood. In the case of seemingly sensitive problems, such as violence against women, the media may screen out feminist perspectives or analyses that reflect an understanding of the gendered nature of power relations (Eliasson et al., 1999). We take the position that journalism is neither fact nor fiction but a co-mingling of the two as part of “the creation of an expansive, complex public discourse” (Denzin, 1997, p. 127). This is not without practical and material consequences, with implications for individual behavior, organizational structures, and social policies (Ashcraft & Mumby, 2004; Fairclough, 1992; Krieger & Gruskin, 2001). Frames may be deliberately constructed to promote certain policies despite lack of scientific data supporting a claim (Herek, 1998) or may preclude the identification of research gaps and alternative policy approaches (Krieger et al., 2001).

This article focuses on the framing of women’s health services in the context of restructuring dictated by regionalization. Gamson and Modigliani (1987), as quoted in Scheufele (1999, p. 106), defined media frames as “a central organizing idea or story line that provides meaning to an unfolding story.” How the media frames an event can affect how the public understands and reacts to it. Media frames may be influenced by how other social groups frame or provide meaning to an issue (Scheufele, 1999). The framing of issues affects how those not actively involved in the framing respond to an issue and can sustain or deflate groups organized for change (Woliver, 1996). However, rhetorical health policy frames may not affect how issues actually unfold in some political cul-
Atkinson’s (2002) discussion of political cultures or the social context is related to the concept of political space. Political space is shaped by mechanisms available to the public to influence policy, by prominent discourses that create willingness to address policy issues, and by the capacity of groups to access policy processes (Webster & Engberg-Pederson, 2002). A public participation process may seek to change the political space within which policy is shaped, and the process is mutually affected by that political space (Frankish et al., 2002; Webster & Engberg-Pederson, 2002).

The present research project posed the question: how was women’s health framed when a major reorganization of health services was underway and whether the framing of issues by the media differed from that of key members of the policy communities, networks, or advocacy coalitions. Did the players differ in what they wanted the broader public to understand?

## METHOD

### Design

A case study design was used to examine the closure of the Grace. Minutes of the Grace Board of Trustees from 1993 until the termination of the board in 1995 were reviewed. These included regular board meetings, special board meetings, and joint board meetings with the Board of the Foothills Hospital. The SA Health Council also provided a copy of the legal partnership agreement between the SA and the CHR for the SA to provide women’s health services to the region’s population (see Thurston, Rutherford et al., 2005), excerpts from the Health Council by-laws, and a summary of issues arising during Health Council meetings from 1995 to 2000. The Grace staff supplied the terms of reference for the Women’s Health Express Advisory Committee. Efforts were made to obtain the minutes of the CHR Board meetings for the years from 1994 to 2000, but they were not made available (see Thurston, Rutherford et al., 2005).

The electronic archives of a local newspaper, the *Calgary Herald*, were searched for articles referring to the Grace, women’s health, the CHR, and the SA during the period from September 1993 to December 2000. Articles which pertained to the subjects of interest, that is, the closure of the Grace hospital site and the opening of a new center, were chosen for analysis.
Data Management and Analysis

Data were imported into a qualitative analysis software program (QSR NU*IST 4) to facilitate analysis (Meadows & Dodendorf, 1999). One researcher coded all of the material, and the others reviewed codes and participated in team analysis meetings.

The constant comparative method (Glaser & Strauss, 1967) was used for analysis. Data were initially broken down by asking simple questions such as what, where, when, how, 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. As categories emerged, the researchers searched for those that had internal convergence and external divergence (Lincoln & Guba, 1985). Public and internal documents were compared within and between groups. Separation of data by source was maintained throughout the analysis, allowing the researchers to track changes in tone, differences in information availability between the public and private discourse, and differences in focus. The analysis process was an iterative one, with the researchers moving among data sources as questions emerged, to build a clear picture. These approaches contributed to the trustworthiness of the analysis (Morse & Field, 1995).

Ethics

The SA Spiritual Values Committee and the Conjoint Medical Research Ethics Board reviewed and approved the research proposal. Since few individuals were 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 CHR or SA perspective” without saying where in the organization the data were collected. For newspaper articles, however, if the identity of the respondent was provided, this was included in the data and reports.

RESULTS

The newspaper search resulted in nearly 200 articles. Twenty-five articles were related to the closure of the Grace site and/or the opening of a new center for women’s health and were included in the analysis de-
scribed here. The time period from Fall 1993 to December 2000 was selected to reflect the availability of electronic archives and the desire to take a snapshot from before, during, and the early days following health care regionalization.

The review of internal documents provided by the CHR and the SA, specifically minutes from the Grace Board of Trustees from 1993 through to the termination of the board in 1995, provided evidence of the internal discourse and tracked some of the emerging issues, known only to those involved at managerial and decision-making levels within the health system.

We have organized our report according to time periods around the move of the Grace (i.e., before, during, and after), with a focus on three key overlapping themes that were repeated in the data: identity; women’s health; and resources.

**Before the Announcement of a Move–January to June 1994**

The general tone of articles leading up to the establishment of the CHR and the move of the Grace was speculative and involved advocacy for the Grace. It was early in the process of regionalization and a battle for public opinion was taking place in the media.

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. ([Calgary Herald, January 15, 1994, p. A4](#))

*Identity.* The Grace identity included the physical site, the philosophy of care, the involvement of the SA, and the focus on a women’s health program. The Health Minister at the time noted that the new health boards “will allow for the continued operation of (denominational) hospitals,” to which the Grace chairwoman responded, “This is great news. . . . I’m impressed the government recognizes the importance of denominational hospitals and the role they play, and that it wants to see them continue intact in the new regional system. . . .” ([Calgary Herald, February 3, 1994, p. A1](#)). While denominational hospitals would be allowed to continue under their established philosophies, the nature of these philosophies, including that of the SA, were never articulated or questioned by the media.

In concert with the public discourse, the internal discourse focused on consolidating on-going support for the Grace during the expected
upheaval of the health system. Typical of the tone of board minutes is the following excerpt:

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)

The Grace began a campaign, early in the process of regionalization, to raise awareness of its role, function, and services. It was noted in the media:

The Grace recently embarked on a public relations campaign. . . . 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, January 15, 1994, p. A4)

Internally the board discussed that what was said to the media and how the Grace was represented must be consistent with its historical values and approaches.

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)

Additionally, board members were encouraged to seek and take advantage of opportunities to promote the Grace within the media and eventually the public.

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. . . . 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)

Women’s Health. In this early stage, the Grace was most often identified as a site for women’s health, with support often taking the form of emphasis on advocacy for women’s health as a specialty and unique to the city as practiced by the Grace.

In today’s economic climate it’s certain that women’s health would not get the attention it receives at the Grace. The risk of fragmentation of care would increase and, more importantly, the hospital’s unique approach to women’s health—a holistic, program-based approach with a strong emphasis on preventative medicine and health management—would be compromised. . . . Women’s health has historically taken a back seat. (Calgary Herald, January 15, 1994, p. A4)

The value of the Grace as a model for providing women’s health services in Calgary was promoted.

. . . 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 [closure of] Grace would not be in the rumor mill. (Calgary Herald, January 15, 1994, p. A4)

However, with closure becoming more of a real threat, the emphasis in the internal discourse shifted from maintaining the Grace on the original site to moving to a new site as part of a partnership to retain services to women. During the period leading up to the move, the minutes of the Grace Board of Trustees repeatedly mentioned the importance of several programs, including the low-risk maternity and obstetrics programs. Discussions began to explore a possible partnership with the Foothills Hospital to ensure that as services were consolidated in regionalization, the Grace and its focus on women’s health programs would not be lost.

Foothills Hospital recognizes the importance of the Grace and its women’s health programs, gynecological 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)

Going forth in the partnership was as much about maintaining a program of women’s health services as it was about delivering them in a cost-effective and non-duplicative manner.

Resources. During this time, a key focus of media reports was the successful fundraising of the Grace Foundation, deemed a clear signal of widespread advocacy for the Grace among influential people. It was used to counter budget concerns that 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. (Calgary Herald, February 5, 1994, p. A1)

Members of the general public, the media, and influential people with dollars to donate were champions of women’s health and supportive of a special program in women’s health.

“We have found there are not too many occasions where you can make a donation that is specifically directed towards women.” . . . A large part of the Norcen workforce are women, and “we thought it would be a positive statement about how we regard the women in our company and in general.” (Calgary Herald, February 5, 1994, p. A1)

The public remained unaware of the complexities of the decision to move the Grace and the development of the partnership agreement between the CHR and the SA. The political climate of regionalization had pitted the hospitals against one another in an effort to survive. This environment impacted the way in which the partnership was discussed and
there was a shift from issues of women’s health services to competition around fiscal resources and efficiencies.

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 Foothills 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)


The establishment of the CHR was soon followed by the announcement that the Grace would be moved to the Foothills Hospital site. The public discourse took on 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. (Calgary Herald, March 2, 1996, p. A1)

The Grace was becoming less identified as the purveyor of women’s health and more identified as a physical presence in the community.

Identity–Site Becomes Focus. It was not clear why the site was such an emotional symbol at this time except that people felt that the Grace was losing its autonomy and identity as a separate, special service. The fear of being subsumed by a large teaching hospital may have also tinged regret for the move.

The centre is not disappearing. It will move in November . . . 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 [emphasis added] . . . ? (Calgary Herald, July 12, 1995, p. B1)
The discussion about the Grace identity extended to the people who worked there, and their “fear . . . that we’ll just be eaten up” at the Foothills” (Calgary Herald, March 2, 1996, p. A1). It was made clear that the Grace identity would be maintained.

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. (Calgary Herald, March 2, 1996, p. A1)

Characterization of the identity of the Grace by the media focused on the site and its character whereas the internal discourse around identity centered on the SA affiliation and the meaning of that tradition.

Proposals for a new regional structure included more than one option for women’s health services; however, the proposal to move the Grace to the Foothills Hospital site was most acceptable to the Grace Board of Trustees because it offered a separate building which would allow it to remain somewhat distinct. While accepting the inevitability of relocation, the importance of the SA philosophy remained steady.

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 [regional CEO] that Grace Hospital be the sole leasee [sic] of the School of Nursing and the North Tower with the right to sublet space. (Board of Trustees, November 28, 1994)

The continued use of the mission, vision, and values of the SA as the guiding principles for the Grace was critical during the negotiation of the agreement with the Foothills Hospital; concerns were raised about the use of the building for procedures that would be in conflict. Specific issues that contradicted the SA mission, vision, and values, such as abortion and homosexuality, were never mentioned in the public discourse and also never referred to directly in the internal discourse.

Women’s Health—From Models to Programs. The theme of holistic models of women’s health that had permeated the media leading up to regionalization had disappeared, along with the view of having
women’s health as a specialty within a holistic women’s health program at the Foothills Hospital site. In the public discourse during this period, the focus moved to services offered by the Grace and advocacy for the continuation of programs as provided at the original site, with the emotional tone evident again. The closure of the Grace maternity ward was portrayed as a difficult loss.

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. *(Calgary Herald, March 2, 1996, p. A1)*

Little of the internal discourse came to light in this period. Much time and effort was spent in negotiating the best possible move of the Grace and integration of the services they had been delivering in women’s health programs. The Grace Board of Trustees had disagreed with a recommendation to be moved to the Bow Valley Centre because of the way women’s health would be delivered in that model.

Grace Hospital finds the option disturbing because the proposed configuration of ambulatory care programs at the [Bow Valley] 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 Board of Trustees and Foothills Board, April 25, 1994)*

Ironically, the same program changes came about as a result of the partnership with the Foothills Hospital. It appears that it was not the loss of programs *per se* that was the primary concern but rather the loss of SA identity and control and an integrated women’s health program.

... The Grace Hospital will give up its inpatient beds in maternity and surgery and there will not be LDRPs [labor, delivery, recovery, post-partum] in the Women’s Health Centre. Grace Hospital will become responsible for the Women’s Health Program for Region 4 [Calgary]. 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, September 26, 1994)

Some compromise on the “comprehensive, integrated women’s health services” that the Grace held to be so important was permitted by this agreement.

Throughout the process, dialogue continued to use the term ‘women’s health’ and the need for programs to be holistic. However, few articulations of the meanings of those terms occurred. This is illustrated in the following excerpt from the internal discourse.

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 Board of Trustees and Foothills Board, April 25, 1994)

Consensus characterized the internal documents, with no mention of possible opposition from those who believed that it was impossible to offer a holistic model of women’s health without offering a full range of services that include contraception counseling and abortion services.

**Resources–Shift in Emphasis.** With the decision to move the Grace came a shift in emphasis from the cost-effectiveness of the Grace to the cost-savings of the changes.

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 . . . 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. *(Calgary Herald, March 2, 1996, p. A1)*
Once the decision to move had been made the internal discourse became less critical and if discussions about whether the reduction in budget represented a reduction in services to women or not took place, they were not recorded.

**Post-Move–March 1996 to December 2000**

As the process of regionalization progressed and negotiations went behind closed doors, public debate on the issues was quieted and the internal discourse provided more data. Once the move was completed, however, and the Grace Board of Trustees disbanded, the internal discourse of the CHR could not be captured. Public discourse faded as the topic was no longer the spotlight of the media. Newspaper reporting turned to a much more matter of fact style, with a diminished rhetorical focus on the importance of women’s health.

Identity. Public discourse in this period gave no evidence of the difficulties of the transition forced by regionalization, and the role of the CHR in the new facility was not mentioned.

“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.” (*Calgary Herald*, May 12, 1996, p. A5)

Again, although the SA philosophy was mentioned, a clear discussion of the impact that the SA philosophy might have on services overall was missing in the public discourse. No distinction between CHR Women’s Health and SA services was made explicit. Women’s health within the CHR was synonymous with the Grace.

The physical site was still emphasized, but now the improvements of the new facility at the Foothills Hospital were the focus.

There’s tasteful, expensive-looking wallpaper on the walls of the recovery wards. Soft colors dapple the linoleum 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. (*Calgary Herald*, March 2, 1996, p. A7)
In describing the ‘new’ Grace reporters emphasized form over function, drawing attention away from the institution as a health facility toward the idea it was an ideal destination for a friendly visit.

“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.” (Calgary Herald, March 28, 1996, p. F5)

Women’s Health. The Grace was described in terms of the site’s comfort and coziness, rather than as an institution leading the way in women’s health care and services. The emphasis on the physical environment was consistent with concerns that the focus on a holistic approach to women’s health at the Grace would be lost with the move to the new site.

“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.” (Calgary Herald, May 12, 1996, p. A5)

However, the importance of women’s health was once again emphasized when a new fundraising campaign began.

“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. (Calgary Herald, March 28, 1996, p. F5)

Despite earlier concerns about programs and services being cut, the focus turned to programs that had expanded.

The breast health clinic . . . 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 counsel-
ling for parents who have lost a baby. (Calgary Herald, May 12, 1996, p. A5)

It was apparent that the SA felt comfortable in its position as lead organization for women’s health and, with the power of the Grace Foundation, well it might.

**Resources.** During this period, discussion of resources was generally limited to announcements of programs made possible by corporate donations, reflecting the continuing role of fundraising by the Grace Foundation as a source of funding.

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. (Calgary Herald, March 28, 1996, p. F5)

These announcements generally emphasized the need for specific women’s health programs and allowed corporations to make donations to programs or projects that helped women.

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, dieticians and pharmacists. (Calgary Herald, October 17, 1998, p. B14)

The Grace Foundation was undeniably an effective fundraiser and the SA identity had an important role with respect to this. This had been recognized and was a resource that the SA had brought to the table in partnership negotiations and in the publicity surrounding it.

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. (Board of Trustees Special Meeting, April 11, 1994)

DISCUSSION

In the three periods—pre-announcement, announcement and move, and post-move—represented in this six-year period of investigation, the three key themes of identity, women’s health, and resources were evident in the discourse. The amount of information and degree of emotion around each of those themes evidenced in the public and internal discourses differed at each stage.

The evidence in this case study suggested that the SA was instrumental in setting the tone that was taken by the media in framing the issues around the closure and move of the Grace resulting from the process of regionalization. The SA organizational discourse became societal (Ashcraft et al., 2004) because the SA as an organization was better organized, had more power than the CHR, and promoted a discourse that moved beyond the entity that was the bricks and mortar of the Grace to encompass a philosophy of holistic women’s health. The media could accept the SA frames because it was an organization that garnered widespread public support as evidenced by money raised. The latter also suggested support for the women’s health agenda alluded to in Grace discourse. Supporting the CHR, on the other hand, was a more risky business when public sentiment against hospital closures was so strong. The SA chose not to emphasize that it had entered a legal partnership with the CHR but maintained its identity through shifting frames as needed. Other organizations that may have had a different frame for women’s health did not have similar access to the media, and the media chose not to identify when or why the SA hold on a women’s health agenda might be questioned.

An epidemiologic, more conservative, perspective on women’s health dominated in the discourses, both public and private, around the move of the Grace programs. Standing (1997) characterized thinking about gender in health reform as resulting from two approaches. In the epidemiologic, the concern is about the disease and health service needs of women. In the second, the role of gender in the production of health and in the creation of facilitators or barriers to access and utilization is central; therefore, power relations are more of a concern. It is the first type of thinking that predominated in Canadian and Alberta public doc-
uments focused on women’s health during the period of this study. This lack of gender analysis in women’s health policy is common (Thurston, Horne, & Donner, 2002). Thus, the SA framing was in keeping with general mainstream policy and never suggested conflict or power struggles. In a sense, the approach made women’s health fit the available political space and agendas, for example, cost cutting.

The SA may well have served as a comfortable buffer between the CHR and the smaller women’s organizations that have a much more explicit feminist health agenda. As Bergqvist and Findlay (1999) noted in a comparison of Swedish and Canadian women’s participation in policy processes: “These organizations are still active in the ongoing struggle for government policies to promote women’s equality. Today, however, their voices have little impact on the conservative governments, which have insulated themselves against the ‘special interest groups,’ including organized feminists” (p. 141). The framing of women’s health as holistic left the door open for many collaborations with the SA and for actions on health determinants other than health services. As we concluded in a related study (Thurston, Rutherford et al., 2005), feminist organizations may strategically partner with the SA to achieve some steps towards equality on issues where mutual goals can be set (e.g., equal access for poor women). Indeed, the Women’s Health Resources program of the Grace added a community outreach worker to its staff to address such access.

If groups focus on “struggles about identity and representation” (Bergqvist et al., 1999, p. 142), however, opportunities for social change may be missed. Our theoretical framework for understanding public participation (Thurston, MacKean et al., 2005) suggests that the most that may be gained in some initiatives is the ability to bring a feminist analytic lens to the table. Some will object to this as siding with a moral stance that is incompatible with equality for women; that is, the mission, vision, and values of the SA that influence its position on abortion and reproductive choice. Sherwin (1992), however, offers a perspective that allows for collaboration:

“Community” in this sense is not just any gathering of people in some sort of socio-political structure but a group with shared concern for one another and governed by democratic structures. To be confident about the moral worth of a community’s standards then, we need to evaluate moral decision-making within the community itself and be assured that it is not achieved through oppressive forces. (p. 69)
Sherwin goes on to stress assessing the process through which moral standards are upheld and whether force is used to obtain compliance. Sherwin’s call for both conservatives and liberals to engage the actual women affected by their policies in order to give the positions “full moral force” (p. 73) is another call for women’s participation in the health system.

Similarly, Ashcraft and Mumby (2004) argue that as different as the approaches to setting frames around gender and organization may be they share certain characteristics. “Such projects suggest fluid borders between frames, as well as possibilities for collaboration and productive tension across frames albeit within limits” (p. 23). The strategic choices of frames taken by the spokespeople for the Grace did not include marginalizing or disparaging other women’s health organizations. Doors were not closed to feminist NGOs; nevertheless, decisions were made to keep a conservative press and health sector engaged in the subject of women’s health. The possibility of collaboration among what Mills (2003) identified as feminist and non-feminist communities of practice remained a possibility.

**CONCLUSION**

Clearly the SA has been and continues to be committed to women’s health, and carries with it a philosophical position that influences the care it delivers and partnerships it allows. While the CHR was successful in bringing the Grace under its mandate and organizational control, it was the SA, with its highly visible and powerful fundraising arm and its advocacy for holistic women’s health, which caught the public’s attention. The internal discourse moved the bricks, but the public discourse kept women centered in decisions regarding the delivery structure that evolved. The future will no doubt provide further opportunities for increasingly evident feminist advocacy, while we continue strategically to ensure that women’s health remains an issue in health reform. Thus women from many constituencies must continue to participate in the health system, beyond their roles in administration and health care services.

**REFERENCES**


