

WOMEN IN DECISION MAKING:
DOES IT MAKE A DIFFERENCE?
CASE STUDIES OF NEWFOUNDLAND AND
LABRADOR HEART HEALTH PROJECT SITES

CENTRE FOR NEWFOUNDLAND STUDIES

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WOMEN IN DECISION MAKING: DOES IT MAKE A DIFFERENCE?
CASE STUDIES OF NEWFOUNDLAND AND LABRADOR HEART
HEALTH PROJECT SITES

By

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School of Graduate Studies
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ABSTRACT

The overall goal was to explore whether the policies and programs developed by women decision makers in three community-based heart health projects were gender sensitive. The research objectives were (1) to determine whether the fact that women comprised the majority of decision makers in three of the community-based projects funded under the Newfoundland and Labrador Heart Health Project allowed for development of programs and policies that were gender sensitive; and (2) to identify factors that contributed to the development of gender sensitive policies and programs in the three community-based projects. Case studies were done on three community-based heart health projects in the Newfoundland and Labrador Heart health Project. These community-based projects produced some gender sensitive programs and policies. Gender sensitive programming was more likely to be developed when women learned about cardiovascular disease through a family history, became involved in the heart health project with a desire to improve their family's or their own health, the heart health committee was a cohesive group, and decision makers learned about the differences in women's and men's experience of CVD through their professional education. Even though some gender sensitive programming was delivered, decision makers had little understanding of why women but not men participated in their activities. If health promotion activities are to benefit both women and men then organizers will have to receive education on the different needs of men and women. This education is often called gender sensitive training. Organizations dominated by men will need to be encouraged to become involved in health promotion programs if men are to benefit.

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CHAPTER 1: INTRODUCTION

This study reports results from three case studies in which the researcher sought to investigate the impact of having women as decision makers in community health promotion initiatives. In the late 1990s, I worked as a research assistant in a project titled “What are the key factors and processes associated with sustained environmental change supportive of health promotion?”(Neville, Potvin , & MacDonald, 1995), here referred to as the sustainability study. The goals of that project were:

1. To identify the factors and processes that contributed to the sustainability of community-based health promotion initiatives;
2. To describe the outcomes of health promotion programs at the community level;
3. To identify key factors and processes associated with the selected indicators of sustained environmental change at the community level;
4. To explore the extent to which the factors suggested by the research model are associated with sustainability at the community level.

In conjunction with the sustainability study, I explored what women involved with community-based health decision-making did, why they did it and what, if any difference it made. Both the larger research project and the thesis research, whose results are reported here, were undertaken in relation to the Canadian Heart Health Initiative (Canadian Heart Health Initiative: Process Evaluation of the Demonstration Phase, 2001; Health and Welfare Canada, 1992).

CONCEPTUAL FRAMEWORK

I develop my conceptual framework by providing an overview of how I came to

investigate the topic explored in this study. I begin with my personal experience, which I use as a starting point for tracing the emergence of my interest in this topic. After outlining how my experiences contributed to the formation of the research objectives pursued here, I briefly discuss how my study is related to a larger health promotion research project called the sustainability study (Neville et. al., 2000), followed by a review of relevant literatures about women and cardiovascular disease, and women and decision- making. Gendered-based analysis is documented. In the following sections I document the research literature I used to develop my conceptual framework. As the nature of qualitative research is exploratory my conceptual framework is broad. This literature, combined with my personal experiences, formed the conceptual framework that lead to the development of my research objectives

Overview of Relevant Experience

My decision to explore the influence of the presence of women in decision-making roles had on policies and programs developed within a community health initiative had roots in observations about the public policy process. These observations emerged from diverse personal and professional experiences, combined with a feminist perspective. Early in my life, I became aware of the importance of public policies, which, at their best, did not support women and, at worst, discriminated against them. My mother's experience in the paid labour force provided me with an early introduction to the importance of public policy in shaping women's lives. My mother's experiences also illustrate how public policies including legislation have often failed to support women.

Laws in Newfoundland (Kealey, 1993) and Canada (Status of Women Canada, 1979) forbade married women from working in the civil service in both countries. My

mother worked as a bank teller before her marriage in 1948. Despite her love of numbers and bookkeeping, she was forced to quit her job at the Newfoundland Savings Bank when she got married. Although this law was changed in Canada in 1956 (in areas under federal jurisdiction), in Newfoundland the provincial legislation was not altered until 1979 when it was repealed by the Human Rights Anti-Discrimination Act. This meant that until 1979, in Newfoundland, married women were still legally unable to work in areas under provincial jurisdiction. In practice, this law was often ignored by the late 1960s.

My awareness that public policies often did not work for women grew as I started my nursing career. I was confronted by the inadequacies of public policy in meeting women's needs, first, as a nursing student, in the late 60s, in relation to wages and, subsequently, in a nursing job in relation to women's unmet needs for contraception.

As a fourth year nursing student, in 1970, I asked my fellow students to sign a petition to eliminate the two tiered wages paid to nurses based on the gender of the nurse, where men were paid more than women. These laws reflected a minimum wage structure that guaranteed that men were paid more than women (Provincial Advisory Council on the Status of Women, Newfoundland and Labrador, 1988). To my surprise, many female students did not sign the petition because they felt they were not worth as much as male nurses.

Upon graduation from nursing school in 1971, I became a public health nurse in rural Newfoundland. The provision of birth control devices and services had been legalized in Canada in 1969, but many contraceptive services were not available to women who needed them. I attended the first in-service educational program about

contraception for public health nurses organized by the Department of Health in Newfoundland. My rural nursing practice included visiting new mothers within 72 hours of their discharge from the local cottage hospital. One of my post-natal visits was to a woman who had just had her tenth baby. She lived in a house with only cold running water. The United Church minister's wife had done the laundry for this mother while she was in the hospital giving birth. During my post-natal visit, this mother of ten told me that having her laundry done was the nicest thing anyone had ever done for her. This woman asked for my help. Her husband had not had "it" in the five days she was in the hospital. By it, she meant sexual intercourse. This mother of ten did not want to get pregnant again. Yet there were no method of birth control available to her. The doctor had refused her a tubal ligation, because she was a poor surgical risk. Her physician had said she was not a candidate for the birth control pill. No one, including me, fitted diaphragms. Her husband did not take responsibility for birth control, and he was not interested in abstinence. Even if he wanted to use condoms he could not buy them in my nursing district. As none of the four physicians in the area did vasectomies, this was not an option for her husband. For religious reasons, none of the community's physicians inserted intrauterine devices. I could not provide this woman with a method of birth control.

Through this experience, I became aware that when public policy existed, as was the case with the 1969 birth control legislation, programs consistent with policy objectives as well as people with skills to deliver those programs must also be provided. At the time, I understood my inability to help the mother of ten as a lack of skill on my part, which left me resolved to work to change the situation by increasing my skills. If my

nursing skills had included fitting diaphragms that woman would have had a method of birth control.

An opportunity to increase my nursing skills arose in 1974, when I was accepted into a research project that explored the feasibility of an expanded role for nurses. This pilot program, undertaken at Memorial University of Newfoundland, required that I spend nine months in school, followed by twelve months working with a physician in his office. Six female nurses and six male physicians were involved in this research, which ended in 1976. Results of this study (Chambers, Bruce-Lockhart, Black, Sampson, & Burke, 1977; Chambers, Burke, Ross, & Cantwell, 1978) showed that nurses gave effective care and that patients, allied health professionals, and physicians accepted the new, expanded role that nurses filled after completion of the pilot program.

In spite of these positive findings, the educational program stopped when the research dollars ended and no jobs were created for nurses prepared to assume expanded roles. Because policy makers had not changed policies, nurses were not granted expanded roles in spite of research that demonstrated their abilities to perform in these roles, and despite the benefits that would accrue to patients and practitioners alike from a re-definition of nursing care. From this experience, I learned that it was not enough that I increase my skills. I had to be allowed to use those skills, and it became clear to me that legislation and policies had to change in order for this to happen.

From my mother's experience of being forced to leave the paid labour force upon marriage, and my own efforts as a young nurse to secure a wage equal to that of male nurses, I learned that public policies often work actively against women; I also learned that, in the absence of public policy explicitly requiring fair treatment of women, women

are often disadvantaged. My experience as a rural public health nurse left me aware of the necessity for skilled people to carry out programs that reflected public policy, once new public policies were introduced. My subsequent experience with a research project that explored the feasibility of expanding the roles of nurses working with physicians in family practices, and clinics left me aware that gaining skills would not necessarily, on its own, lead to change. This experience left me aware of the importance of public policy in supporting change.

My understanding of policy making continued to develop in the intervening years, which included a term as a city councillor in St. John's, Newfoundland, during which I worked in a variety of contexts to improve the lives of women. As I began work on the project outlined here, I believed that public policy in health required leadership to set up new programs, and the cooperation of health care professionals to implement change. Further, by the beginning of the project, I had come to believe that policy making requires information about possible policies, and the impact of alternatives on interested parties or those with a stake in the policy process. Increasingly, I came to believe that those at the decision-making table that lack the lived experience relevant to understanding the decision are as important as the information used to make the decisions. My work as both an activist and an elected official left me aware that decision makers use both the information presented to them, and their personal experiences to make a decision. This suggested to me that if those at the decision-making table lack experience relevant to the decision under consideration, they are less likely to support a decision.

Many people do not understand the extent to which their experiences influence

the way they perceive the world. The best way I have found to illustrate how our experiences influence our perceptions, and how we draw on those perceptions is through a simple experiment. Fill a bowl with cold water, a second with hot water, and a third with warm water. First place your right hand in the cold water, and your left hand in the hot water, and then place both hands in the bowl with the warm water; your right hand will experience the warm water as hot while your left hand will experience it as cold. Just as one's experience of warm water is relative to whether ambient conditions are hot or cold, the same policy (warm water) is experienced differently by people whose experiences differ.

If, as my little experiment suggests, our understanding of the world is developed relative to our experiences, and if my assertion that decision makers draw on personal experiences (often unknowingly) in making policy and programming decisions, then the development of policies and programs that reflect heterogeneous and broad interests will require that we consider the perspectives of people with different experiences. Many examples of the differences among people can be found in the differences between women and men's lives. Women, generally, are poorer than men (Statistics Canada, 1995). Women live longer than men and often carry multiple workloads of paid labourer, wife, mother, and housekeeper (Working Group on Women's Health, 1990). In spite of changes to traditional sex roles, women still have primary responsibility for child care (Working Group on Women's Health, 1990; Heller, 1986). These different experiences give women and men different perspectives toward the world, perspectives on which they rely in formulating public policy. Because women and men have different experiences of the world, I believed that having more women in decision-making positions would result

in more decisions supportive of women. A great deal of my energy has gone into encouraging women to become policy makers, and into lobbying for increases in the number of women in policy making positions. At the same time that I was directing my energies towards increasing women's participation in public policy decision-making, the formal health care system was encouraging public involvement in decision-making about health. This encouragement came from the health promotion field. It was hoped that increased involvement of the public in decision-making about health would lead to both a strengthening of health services that met diverse community needs (including women's health needs), and contribute to empowerment of the public. My research was designed to look at whether increased public participation particularly women's participation, would lead to heart-health services that better met women's needs.

Emergence of this Study

The Heart Health Project (HHP) in Newfoundland presented me with an opportunity to scratch beneath the surface of anecdotal stories that suggested women's involvement in public policy arenas could lead to public policy that better met the needs of women. The HHP had nine community projects and I looked at three of them. The HHP provided me with an opportunity to engage in a systematic, in depth investigation of what women involved with community-based health decision-making did, why they did it, and what, if any, difference it made. I chose to limit my study of public policy to healthy public policy for two reasons. First, the HHP had a provincial committee that focussed on healthy public policy. Committee members facilitated the production of a booklet titled Making Public Policy Healthy: A Vision for Our Community's Health (Hanrahan, 1994) that the provincial coordinators of the HHP developed, and delivered to

senior public servants a workshop based on the booklet. Second, the sustainability study used the existence of healthy public policy as an indicator of sustainability.

In conjunction with the sustainability study, I studied the impact of having women as the majority of decision makers in three community health initiatives in Newfoundland and specifically, to determine if this allowed for the development of programs and policies that were gender sensitive. In the next section, I discuss the formation of my research objectives in relation to relevant literature, which includes literature about women and cardiovascular disease, and women in decision-making.

Overview of Relevant Literature

In exploring the impact of women in decision-making roles in the context of the three Heart Health Projects in Newfoundland and Labrador, several bodies of literature serve as points of reference for the inquiry. Here, I provide an overview of literature relevant to my study of women's roles in decision-making in community-based health initiatives.

As a means of contextualizing the study, an overview of research on women's health is appropriate. I show that both human biology and the cultural institutions in which individuals live influence women's health. Next, I discuss the prevalence of cardiovascular disease (CVD) in both Newfoundland and Canada. Literature about CVD outlines the significance of CVD in Newfoundland in general and points to its significance for women in particular. Among the findings that surface from a review of this literature is that differences exist in women's and men's experience of CVD in the diagnosis, treatment, and rehabilitation phases of the disease.

Researchers and reviewers (American Medical Association Council on Ethical

and Judicial Affairs, 1991; Giacomini, 1996; McLaughlin, et al. 1996; World Health Organization, 1998) report that women have been under-represented in both the diagnosis and treatment of CVD. Unfortunately, these medical studies do not address the potential role of women in the reduction of CVD among women. For such research, one has to look to those writing in the social sciences literature. Some researchers (Thurston & O'Connor 1996; Writing Group of the 1996 ANN Expert Panel on Women's Health, 1997) suggest that women in decision-making are likely to improve women's health. play an important role in the reduction of CVD among women. Other researchers (Kar, Pascual, & Chickering, 1999) said that women when empowered and involved are effective partners in health promotion programs.

In Canada, senior civil servants in both the federal and provincial governments developed the Canadian Heart Health Initiative (CHHI), (Health and Welfare Canada, 1992; Canadian Heart Health Initiative: Process Evaluation of the Demonstration Phase, 2001) in response to high morbidity and mortality associated with CVD. The Canadian Heart Health Initiative started in 1986 and was on going as of December 2002. The Initiative, a population health approach to a major chronic disease, represents a systemic approach to implementing a countrywide policy at the national, provincial, and community levels. The CHHI had the following long term goals; to improve the heart health of Canadians, to reduce premature cardiovascular morbidity and mortality, to reduce the prevalence of preventable or controllable risk factors for CVD (smoking, high blood pressure, elevated blood cholesterol, diabetes, obesity, and sedentary life style), to improve lifestyle behaviours associated with heart health, and to improve working conditions, social, and physical supportive of citizens in making heart-healthy

behavioural choices. The CHHI also had the following health system goals, to maintain the provincial heart health programs and the coalitions, to entrance heart health in the agendas of governments, community, voluntary, professional, and private sector organizations at all levels, to disseminate the knowledge, and know-how gained to provincial health departments, community coalitions, private, and voluntary sector organizations, and Health Canada; and to determine the feasibility of employing a public health approach for initiating and delivering integrated heart health programs at the community level.

These goals were to be met through six strategies, public education, community mobilization, healthy public policy, strengthening preventive health services, research, evaluation, and public health leadership. The CHHI had five phases, the policy development phase, the provincial heart health risk factors surveys, the demonstration phase, evaluation phase, and the dissemination phase. In the policy development phase, a federal provincial working group developed a policy framework that identified the scope of the problem and suggested a public health approach as the solution. In the survey phase that lasted from 1986 to 1992 all ten provinces conducted heart health surveys. While the timing of demonstration phase varied from province to province they were started no earlier than April 1989 and were all completed by December 1997. Provinces used the information from the provincial surveys to develop provincial goals consistent with the national goals. This research was carried out during the demonstration phase of the Newfoundland and Labrador project.

In Newfoundland, the members of the Newfoundland and Labrador Heart Health Project took a community-based approach to CVD and worked with community groups

to help the public understand what they could do to reduce their risk of CVD.

Activists from the women's health movement suggest that efforts to improve women's health will require the promotion of women into decision-making positions (Federal/Provincial/Territorial Working Group on Women's Health, 1990; Health Canada, Medical Research Council of Canada, National Cancer Institute of Canada, Canadian Cancer Society, & Canadian Breast Cancer Foundation, 1994). A review of literature about gender differences in decision-making suggests that women and men sometimes make different policy decisions. Women judges are more likely to incarcerate and impose longer sentences. (Steffensmeier & Hebert, 1999). Little research in the health literature explored the impact of women in decision-making. The health care literature confined itself to identifying differences in male and female physician's practices (Calder, 1997; Williams, Domnick-Pierre, Vayda, Stevenson, & Burke, 1990). Within the health promotion literature, fostering public participation in health decision-making has been identified as a possible means for improved health outcomes (Lalonde, 1974). Although this view leaves open the possibility for increased participation of women in health decision-making, the health promotion literature has fallen short of advocating increased involvement of women in health decision-making. The research on the different decisions men and women make combined with the goal of increased public participation suggest that increasing the involvement of women in community-based decision-making concerned with health could result in the development and delivery of gender sensitive programs and policies suited to women's needs.

Women's Health

Women's health is linked to women's status in society. Manderson and Mark

(1997) suggest that a woman's health is influenced by both biology and cultural institutions that, in turn, define gender and power relations, determine household responsibilities and priorities, and influence access to knowledge and resources. The significance of inequalities in health outcomes is further articulated in The World Health Report 1998 (World Health Organization, 1998). The authors argue that the health of women benefits from equality and suffers from discrimination. This acknowledgment of the role that discrimination and lack of equality play in women's health suggests that decisions to improve women's health must also include work aimed at bringing about women's equality.

Lefebvre (1996) reviewed the state of women's health research in Canada. She drew on the work undertaken by the Medical Research Council of Canada which concerned the disproportionate allocation of funding to women and men's health issues. Pregnancy, reproduction, cancer, and infections accounted for more than 70% of research activities in which women were the subjects, while social and mental components accounted for only 16% of the research. The disproportionately high proportion of resources allocated to women's reproductive capacities reinforces the existing narrow perception of women's health. Lefebvre reports that the MRC Committee found that approximately 5% of Canadian health research funding for 1993-1994 was on women's health while that related to men's health was estimated to be 7% of funding. This is important because these figures, of course, imply that the remainder of the research funded is gender-neutral, which is probably inaccurate (Lefebvre, 1996).

In her 1996 paper, Lefebvre states that funding records for 1994-1995 do not show any major changes from those figures, although she detected a trend to allocate

more research funding to studies with clearly designated gender differences in the titles of the projects. A major lesson to be drawn from this review does not arise from the comparison itself, but from the fact that a small proportion of funding is given to areas directly related to the major health needs of Canadian women and men. Thus, the analysis served to emphasize that an increase in the proportion of research funding directly related to health needs of both women and men is required.

Much medical research continues to be based on the assumption that men and women are physiologically similar in all respects apart from their reproductive systems (Lefebvre, 1996; Pederson, 2002). Other biological and social differences that have such a major impact on health are ignored. The consequence of an approach which focus on reproductive biology the generation of biased evidence that is biased. (Armstrong, 1999). In the context of routine data collection, statistics are not always disaggregated by sex, making it difficult to plan for the specific and unique needs of men and women. Similarly, many clinical studies leave women out altogether or fail to treat sex as an important variable in the analysis (American Medical Association Council on Ethical and Judicial Affairs, 1991).

Research (Gijsbers Van Wijk, Van Vliet & Kolk, 1996; Manderson & Mark, 1997; World Health Organization, 1998) concerned with women's health have brought cultural institutions, power relations, and inequality as determinants of women's health to the forefront. It also has highlighted how medical research funding patterns have helped to reinforce the view that women's health is identified with reproductive health. These observations suggest that existing power relations and gender inequalities have an adverse affect on women's health. In the context of this research project, these ideas are

important because they imply that gender-based inequality may adversely affect women's health. In addition, equating women's health with reproductive health may mean that other health concerns of women, such as CVD, receive inadequate attention.

Cardiovascular Disease in Canada and Newfoundland

Cardiovascular disease (CVD) is the major cause of death, disability, and illness in Canada (Heart and Stroke Foundation of Canada, 1997). In their 1992 editorial in the Canadian Medical Association Journal (Balram, et al. 1992) the Canadian Heart Health Survey's Research Group indicated that that two in three Canadians have one or more of the major risk factors for CVD--smoking, high blood pressure and elevated blood cholesterol level.

The 1989 Newfoundland Heart Health Survey (Newfoundland Department of Health & Department of National Health and Welfare, 1990) found that the risk factors for heart disease are widespread among women in Newfoundland and Labrador. The four risk factors for CVD studied in the 1989 survey were smoking, lack of exercise, high blood pressure, and high cholesterol levels. The survey found that:

1. Forty-four percent of women aged 18-34 and 32% of women aged 35-64 smoked at least one cigarette per day;
2. Forty-eight percent of the women aged 35-64 participated in physical activity at least once per week;
3. Seventy-five percent of women between ages 35-64 had high blood pressure;
4. Forty-two per cent of women aged 35-64 were defined as high risk based on cholesterol levels.

As a result, we know that Newfoundlanders have a higher death rate from heart

disease than the Canadian average (Neville, Buehler, James, & Edwards, 1994). This information was the reason that the Newfoundland Government invested in the Heart Health project. My research can help determine if the HHP allowed women to get their heart health needs met.

Differences in Men's and Women's Experiences of CVD

Many differences in men and women's experience of heart disease have been reported. In 1990, Johansen, Nargundkar, Nair, Neutel, and Wiegosz reported that although CVD is a major cause of death for both men and women, differences between men and women in how CVD is experienced, how it is diagnosed and treated are well documented. Heart disease in women is likely to present initially as angina pectoris whereas men are more likely to experience a heart attack or sudden cardiac death. Differences in diagnosis are also recorded. Men are three times more likely than women to be referred for coronary arteriography. The treadmill exercise test gives excessive false positive tests in women. Johansen et al. (1990) highlight the need for women to know the importance of chest pain so that appropriate diagnosis, and treatment strategies are started early.

In 1988 the American Heart Association (Eaker, Chesebro, Sacks, Wenger, Whisnant, Winston, 1988) published a paper on CVD in women. This paper marked the emergence of a concern among health researchers that women with CVD are different from men. The National Heart Lung and Blood Institute in the United States in 1992 held an invitational conference about cardiovascular health and disease in women (Wenger, Speroff, and Packard, 1993). Wenger et al. (1993) looked at CVD prevention, diagnosis, management and prognosis, hormone replacement therapy, oral contraceptives and CVD,

behavioural and psychosocial aspects of CVD, CVD in pregnancy, and non-coronary CVD in women and provided recommendations for research. Among the findings reported was that information about appropriate dosages of heart medications for women is scarce because most research has been done on men. Therefore, it is important for women and their health care providers to pay special attention to side effects of medications taken for the treatment of CVD.

The American Heart Association published a medical/scientific statement about CVD in women (Eaker, Chesebro, Sacks, Wenger, Whisnant, & Winston, 1993) in which they identified the education of health care providers as essential to the improvement of women's cardiovascular health. The statement says, "providers must understand the risks associated with CVD in women as well as the importance of a) prevention or control of risk factors, b) recognition of symptoms by women themselves and health care providers and c) timely referral with appropriate diagnosis and intensive treatment" (p. 2000). The role of gender bias by a health care provider is often not mentioned in the research literature as an area where change has to happen to improve the health of women.

Women do not usually attend cardiac rehabilitation programs even when referred for several reasons. For example, women resume care-taking activities of others soon after returning from the hospital, making attendance at rehabilitation programs problematic. In addition, programs are often scheduled at times that are not convenient for women and exercise regimes are often designed for men and are too rigorous for women (Eaker, et al. 1993).

McLaughlin et al. (1996) found that women were less likely than men or the elderly to receive life saving drugs for heart attacks. Medications recommended by the

American Heart Association for treating heart disease are underused in elderly patients and women. After adjusting for age and hospital type, women were less likely than men to be treated with aspirin, thrombolytic agents, beta blockers, or lidocaine.

Iezzoni, Ash, Shwartz and Mackiernan (1997) found that women are treated less aggressively than men after a heart attack and are more likely to die while in the hospital. The researchers examined the treatment and outcomes of more than 14,000 patients admitted for a heart attack to 100 hospitals in the United States of America during 1991 and found that women lag behind men in both treatment received and outcomes. Differences in age and severity of illness did not explain the variations in use of procedures and women's higher in-hospital mortality rate found in this study.

Malenka et al. (1996) examined data from 12,232 angioplasty patients treated between 1989 and 1993, and reported that women are more apt to die than men or more often require follow up bypass surgery after coronary angioplasty. Although angioplasty is nearly 90% successful in opening blocked arteries for both men and women, women have a 1.6 times greater risk of dying than men and more women (5.3%) than men (4.5%) undergo bypass surgery or suffer a heart attack following angioplasty. After acknowledging that women undergoing this procedure are older and have a higher incidence of diabetes and hypertension than men, they conclude that being a female remains a risk factor for death.

O'Connor et al. (1993) reported that female heart bypass patients were twice as likely as males to die in the hospital. This prospective study of 3,055 patients undergoing coronary bypass surgery between 1987 and 1989 found a mortality rate of 7.1% for women versus 3.3% for men. The mortality rate was higher for women in all age groups

and for women undergoing emergency, urgent and elective surgeries.

In this literature review, I have documented that women with CVD are different from men. Women present with different symptoms, they are under diagnosed by their physicians, receive less aggressive treatment and less cardiac rehabilitation. The literature about differences in men and women's experiences of CVD clearly indicates that differences in the needs of women and men with respect to CVD exist and that the health care delivery system meets the needs of men with CVD better than it meets those of women with CVD. This information, together with limited information on gender differences in decision-making, suggests that including women in health decision-making about CVD may lead to the development of more effective policies and programs.

I have included this degree of documentation on the differences in men and women's diagnosis, treatment, and rehabilitation because many people do not believe there is widespread discrimination against women, within health care in particular. However, things have been changing as women demand change. Legislative changes from the time the vote was granted to women up to the legalization of birth control have come from years of advocacy work by many women with the support of men in power. If women's experience of heart disease is going to change, changes must occur in both policies and programs. Women have to be educated about the difference in their experience of heart disease so they can demand better care for themselves and be better participants in deciding on their care.

Need for Policy Change to Address Gender Differences in CVD

Awareness of the need to address women's different experience of CVD at the policy level is increasing. In 1992, the first International Heart Health conference was

held in Victoria, Canada, under the sponsorship of Health and Welfare Canada, the British Columbia Ministry of Health, the Heart and Stroke Foundation of Canada, the World Health Organization and the World Hypertension League. At this conference the Victoria Declaration on Heart Health (Advisory Board of the International Heart Health Conference, 1992) was released, which included three recommendations for women: (a) programs dealing with the prevention of CVD should address the risk reduction needs of both women and men; (b) public health and clinical guidelines should identify and manage women at high risk for CVD and recognize the risk factors that particularly affect women and (c) governments and all others concerned with anti-smoking programs should direct special efforts to the prevention and cessation of smoking by women, particularly young women. As well, the 1993 Canadian Task Force for Cardiovascular Science recommended that a national symposium be organized to highlight the impact of CVD in women, support the dissemination of public health information concerning CVD prevention and recruit scientists with an interest in women's health and the prevention of CVD (Heart and Stroke Foundation of Canada, 1997).

In spite of a growing awareness of the need to address gender issues in CVD at a policy level, to date existing literature concerned with policy change has fallen short of calling for the increased involvement of women in decision-making. For example, the Canadian Heart and Stroke Foundation, acting on the recommendations from the International Heart Health conference in 1992 and the 1993 Canadian Task Force for Cardiovascular Science, released a booklet called Women, Heart Disease and Stroke in Canada: Issues and Options (Heart and Stroke Foundation of Canada, 1997). This publication has many strengths. For example, it reviewed the research documenting

women's experience of heart disease, outlined what is being done about women and CVD and made thirteen recommendations. Nonetheless, the report did not identify the need for the increased involvement of women in making change. The only recommendation that suggested explicitly that women must be involved in activities related to women and CVD stated that "women must be included appropriately in all heart and stroke research studies: any exclusion of women must be justified" (Heart and Stroke Foundation of Canada, 1997).

Women and Decision-making.

Kanter (1977) studied proportional gender representation in decision-making groups in her now classic book Men and Women of the Corporation. This study was the first to document group behaviour based on proportional membership in the group. Her research showed that the composition of the group and the proportion of people having particular characteristics made a difference to how individuals were treated, whether their ideas and concepts were listened to and then incorporated into the work of the group. For example, a study by Kanter has implications for understanding the importance of significant involvement by women in decision-making groups.

Kanter (1977) wrote about four types of groups that can be identified by the proportional representation of people having particular characteristics. A uniform group has people with one predominant set of characteristics (e.g., people who are all one race). The ratio of a uniform group is 100:0. A skewed group has a large preponderance of people who share characteristics. The numerically dominant group controls the group and its culture. The few who differ from the norm in a skewed group are called tokens. The ratio of dominants to tokens in a skewed group can be as high as 85:15. In contrast, in the

tilted group the ratio of dominant to non-dominant populations is closer to 65:35. In this situation, the dominants are just a majority and the tokens become a minority. The potential for the creation of allies and coalitions exists in a tilted group and thus the minority can affect the culture of the group. The final type of group is a balanced group and has a ratio of dominant to non-dominant individuals ranging from 60:40 to 50:50. The culture and interactions of the group reflect this balance. Outcomes for individuals in such balanced peer groups will depend more on other structural and personal factors, including formation of subgroups or differentiated roles and abilities (Kanter, 1977). Her research was one of the first to document the need to have diverse people in decision-making positions to produce policies and programs reflective of the needs of the people affected by those decisions.

Since the feminist movement of the late sixties and early seventies, women have advocated for increased participation in decision-making (Thurston & O'Connor, 1996; United Nations, 1985; Writing Group of the 1996 AAN Expert Panel on Women's Health, 1997). Thurston and O'Connor called for increased women's involvement in decision-making, arguing that it would result in policies that would serve women better. Although ample literature exists that calls for women's increased participation in policy processes, (e.g., Department of the Secretary of State, 1988; Federal/Provincial/Territorial Working Group on Women's Health, 1990; Thurston & O'Connor, 1996), little published research documents the impact of women's increased participation in policy arenas on the type of decisions that have evolved since women became involved in decision-making. A great deal of anecdotal information suggests that women's presence at the table when policy decisions are made makes a difference in that

it leads to policies that better meet women's needs, but this has not been confirmed in a systematic way.

In spite of a dearth of studies concerned with documenting what impact increasing the number of women in decision-making has had, the concept of proportional representation in decision-making groups has been incorporated into many strategies developed to improve women's health. At the federal level, Canada has taken an active role in looking at women's health and the concept of women as decision makers has been included in the principles of many health documents. For example, the lack of women in decision-making positions in health is addressed in Working together for women's health: A framework for the development of policies and programs (Federal/Provincial/Territorial Working Group on Women's Health, 1990).

This document made four recommendations; first, that each jurisdiction should adopt five guiding principles in the development of policies and programs on women's health. One of the guiding principles recommended greater participation of women in health decision and policy making. The second recommendation spoke to the need to facilitate the development, coordination, and implementation of policies and programs to improve women's health. The third recommendation of the report also spoke to the need to involve women in decision-making in health. It advocated that each jurisdiction recognize women's groups and voluntary organizations as essential partners and collaborate with them in planning and providing services to women. The last of the report's recommendations was that each jurisdiction ensure continuing representation and commitment to inter-jurisdictional collaboration in addressing women's health concerns and monitoring the implementation of the strategies and recommendations in the report

(Federal/Provincial/Territorial Working Group on Women's Health, 1990).

Subsequent to the release of this report, the Newfoundland member of the Federal/ Provincial/Territorial Working Group, Joanne MacKinnon, continued the process begun in this working group in her home province. She asked Dr. Bob Williams, the Deputy Minister of Health at the time, to convene a provincial working group on women's health, which he did in 1991. Their report, titled A Profile of Women's Health in Newfoundland and Labrador (Working Group on Women's Health, 1994) was released in 1994.

The framework for this report was the health promotion framework developed by Health and Welfare Canada (Epp, 1986; Pinder, 1988). Three of the strategies for carrying out the health promotion framework outlined in the Health and Welfare Canada paper are (a) fostering public participation, (b) strengthening community health services, and (c) coordinating healthy public policy. The Federal/Provincial/Territorial Working Group on Women's Health (1990) paper refined the strategy of public participation by advocating that women be active partners in all decision-making related to their health care. At the same time that policy makers and health practitioners were calling for the increased involvement of women in health decision-making, a paradigm shift was occurring in decision-making models in health care, that could (in theory) help pave the way for the movement of more women into health decision-making. Because this research was about policy and programs change I have included these reports in my literature review to document the adoption of this strategy to increase the number of women in decision-making in Newfoundland health care.

In this literature review I have documented why research on women's health is

appropriate. As well, I have reviewed the influence of biology and cultural institutions on women's health. I discussed the extent to which Canadians are at risk for CVD and how this risk translates into CVD being the major cause of disability and death in Canada. Newfoundlanders' death rate from CVD is higher than the Canadian average. Because many people do not believe there is any discrimination against women, next I documented women's risk of CVD and the discrimination that women face to get diagnosis and treatment. Women have different presenting symptoms than men but neither women nor their health care providers are aware of these differences. This results in women delaying going to physicians, who then delay treatment. The standards of care were developed for men. Women do not get access to treatment or rehabilitation at the same rate as men. Then I traced the literature of policy changes needed to get research on women's experience of CVD translated into health services designed for women needs. I have chosen to research the impact of the increasing of the numbers of women in decision-making positions. I traced the development of this idea from Kanter's work (1977) on proportional group representation through the work of international organizations such as the United Nations (1985), national organizations (Federal/Provincial/Territorial Working Group on Women's Health, 1990; Thurston & O'Connor, 1996) and finally provincial organizations (Working Group on Women's Health, 1994). My research will provide an opportunity to document the transition from research into policy and then into programming, i.e. moving from the established differences in men's and women's experience of CVD to determining whether having the majority of decision makers being women allowed for gender sensitive programming. I now turn to a documentation of a lack of women in decision-making in health care

specifically in the province of Newfoundland and Labrador.

Lack of Women in Decision-making in Health Care.

Women are the majority of workers in the publicly funded health care agencies in Newfoundland and Labrador and women use more health care services than men (Muzychka, 1995; Sherwin, 1992). However, they are underrepresented at the decision making level. In 1998 women comprised 44% of the decision makers on the fourteen Newfoundland health boards. This varied from a low of 23% of women on one board to a high of 66% women on another. However, women chaired only four of the fourteen boards. The Newfoundland and Labrador Health Care Association Board, which bargains with the unions for all these boards, has 26% women. Kanter's work indicates that at least 33% of like-minded people are required to influence decisions. My research took place in this overall decision-making environment in the Newfoundland health care system.

The research on female decision makers is very limited. Some research has been done on the patterns of practice of female and male physicians (Calder, 1997; Williams, Domnick-Pierre Vayda, Stevenson and Burke, 1990). I did find research done in Newfoundland on nursing and decision-making. In February 1993, the Association of Nurses of Newfoundland released their Report of a Survey on Nursing Input into Decision-making and Committee Work (Andrews, 1993). The purpose of the survey was to describe nursing involvement in decision-making and committee work. In spite of the predominance of women in the nursing profession, in this report gender is not mentioned. The awareness of the need to look at gender as a factor when decisions are made in health care was not present in the Newfoundland health care system.

The example I found in the Canadian health care system that used Kanter's research was the work of women breast cancer survivors. Women with breast cancer have used many strategies to make sure their experience is included when decisions are made about research and treatment. They have written letters and articles, lobbied politicians, and held conferences. Their voices were heard at the 1994 National Forum on Breast Cancer in Montreal (Health Canada, Medical Research Council of Canada, National Cancer Institute of Canada, Canadian Cancer Society, & Canadian Breast Cancer Foundation, 1994). The delegates to the conference included one-third survivors, one-third caregivers, and one-third researchers. This provides an example of Kanter's (1977) ideas put into use. The policy for the conference was that each meeting would have 30% of each type of delegate and thus 30% would be like-minded people. This conference resulted in programming and policy suggestions that take the perspectives of all three groups. Unfortunately there has been neither documented follow up reports of the Breast Cancer Forum nor an evaluation of the process. But I have spoken with Sharon Batt (personal communication, July 29, 2002) the Chair of the Forum's Support Advocacy and Networking Subcommittee, which was mandated to ensure that women with breast cancer participated in the Forum. She (Batt, 1994) holds the Elizabeth May Chair in Women's Health and the Environment at Dalhousie University for 2001-2003.

I believe it did make a difference, on a psychological level, to many, many people. People who attended still approach me to say they were at the Forum and it changed forever the way they think about breast cancer research and/or women with breast cancer. I believe that's partly because of the fact that we had critical mass. The planning process was set up so

that structurally we had real power. There were four subcommittees involved in the planning, one of which was made up of women with breast cancer and the people we chose to support us. We were integrated into the program in a way that put us on an equal footing with researchers, doctors/nurses and policy makers.

Decision-making Models in Health Care: Making Space for Women.

Although the women's health movement has been working to change how decisions are made, the health care field has been undergoing a shift in understanding the effectiveness of including a diversity of voices in decision-making. Health Canada (previously called Health and Welfare Canada) have been working to develop a framework to change the illness care system to one promoting health while still caring for the sick. Canada has taken a lead role in developing an understanding of what makes people healthy. In 1974, the Federal Minister of Health, Marc Lalonde released A New Perspective on the Health of Canadians (Lalonde, 1974). This report evaluated how factors other than health care services contribute to the health of a population. Although the document contained many innovative ideas, it contained no discussion about who, beyond health care professionals, should be involved in health-care decision-making and health policy arenas.

In the Kazakhstan city of Alma Alta in 1978, at a joint World Health Organization and UNICEF Conference, the World Health Organization adopted what became known as the Alma Alta Declaration (Morley, Rhode, & Williams, 1983). This proclaimed that primary health care was the way to achieve the goal of "Health for All by the Year 2000." The World Health Organization identified six overlapping approaches, including the use

of appropriate technologies, the generation of employment, the development of integrated rural services, the inclusion of women in the development process, the promotion of community participation in decision-making and the provision of services for basic human needs (Morley, Rohde, & Williams, 1983). Manderson and Mark (1997) believe that the Alma Alta declaration was the first reference to community participation as part of the strategy to improve health.

In 1986, Canada hosted the first international conference on health promotion where the Ottawa Charter for Health Promotion (World Health Organization Health, Health and Welfare Canada, & Canadian Public Health Association, 1986) and Achieving Health for All: A Framework for Health Promotion (Epp, 1986) were released. Both documents addressed the need to foster public participation in health decision-making as a strategy for promoting health. Although these ideas represented a significant shift in how health decision-making might be carried out, they neglected to address the important issue of just what the term public meant in calling for increased “public” participation in health-care decision-making.

Typically, to be considered a member of the public one must be neither a civil servant nor a politician. Although this view of public participation does not explicitly exclude women, it also does not ensure that the diversity of the public (in terms of differences such as class, gender, culture and sexual orientation) is reflected in public participation. Any discussion on public participation must explicitly include the diverse nature of the public. Much research evidence suggests that even when public participation is sought, many barriers to participation are encountered (Wharf-Higgins, 1997).

The Ottawa Charter (World Health Organization Health, Health and Welfare Canada, & Canadian Public Health Association, 1986) defines health promotion action as building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. In the discussion of strengthening community action, it says “at the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies” (World Health Organization Health and Welfare Canada, & Canadian Public Health Association, 1986).

In the years since the Ottawa Charter was released, the concept of community empowerment has continued to receive attention. Harris (1992) says some concepts most tenaciously held in community development are the most underdeveloped in research. These concepts include empowerment, participation, citizen involvement, and social change. An opportunity appears to clarify the concept of empowering the community by defining community in terms of several characteristics including gender and an increasing involvement of community members in decision-making. In spite of the rhetoric on the inclusion of women, implied in documents such as the Ottawa Charter that specifically address public involvement in health decision-making as a means of public empowerment, this is not the reality. The authors of the health literature concerned with public involvement fall short of specifically advocating proportional representation of women or any less powerful group.

Gender Lens

I will use a gendered-based analysis to examine the decisions made i.e. the policies or program that are developed. The actual tool is called a gender lens. The liberal

feminist perspective was that women could achieve equality by giving women and men the same opportunities. This perspective was based on the assumption that equal opportunity would bring sameness of results (Tong, 1989). However, the same opportunities did not necessarily yield equal results (Government of Newfoundland and Labrador, 1985; Torjman, 1988). Today the concept of equality (Status of Women Canada, 1996) acknowledges that different treatment of women and men may sometimes be required to achieve sameness of results, because of different life conditions or to compensate for past discriminations. This notion of equality is embedded in the Canadian Charter of Rights and Freedoms. Thus, gender equality should be understood as the equal valuing by society of both the similarities and differences between women and men, and the varying roles that they play, rather than merely the equal treatment of women and men. The process by which gender equality is achieved is called gender equity.

In all levels of government, the process of policy development has many steps. But the policy developers have not looked at the impact of gender at any step in the process (Status of Women Canada, 1979; Williams, 1996). The Canadian Government has decided that the way to achieve equality in the Charter is through the adoption of gender equity tools such as a gender lens. Gender equity tools have been developed to help policy makers assess whether or not policies are likely to benefit women, which, in turn, it is hoped, will contribute to the achievement of more equitable social relations. Tools such as the gender lens employed here have been developed to assist policy makers in working with women to effect change, and to ensure that policies will be beneficial for and not harmful to women. Gender lenses are relatively new.

Even where protocols require a gender analysis, often a lack of consistency occurs

in their application. Because women often have not been viewed as stakeholders in the policy process, women's specific views about policy issues have not often been sought, and/or have been either marginalized or disregarded. As a result policies have a differential impact on women relative to men. Moreover, policies developed without special reference to their impact on women are likely to have more adverse effects on women depending on their race, class, ethnicity, ability, and age. (Women's Policy Office, 1998).

Conceptual Framework and its Relation to Research Objectives

Research about women's health has documented that women and men experience disease differently, and has suggested that a singular emphasis on women's reproductive health may be detrimental to developing an understanding of other health issues affecting women, such as CVD. Research about CVD demonstrates that not only is CVD prevalent in Canada and Newfoundland, but that high rates of CVD are found among women in Newfoundland. Research concerned with women in decision making, particularly Kanter's (1977) work suggests that increasing the involvement of women in health decision making can lead to improvements in women's health outcomes.

Policy makers in women's health continue to recommend that the number of women in decision-making positions be increased as a means for improving the responsiveness of the health system to women (Thurston & O'Connor, 1996; United Nations, 1985; Writing Group of the American Academy of Nurses, 1997). However, in spite of ample literature that suggests that women's and men's experiences of disease differ, and despite repeated calls to involve more women in health decision-making, I was unable to find any literature that had explored the impact of women in decision-

making in the health field. My experiences led me to believe that public policies can work against women, and, in the absence of public policies specifically aimed at improving the lives of women, that women are likely to experience discrimination.

Goals and Objectives

The literature review combined with insights gained from experience, led me to formulate the following overall goal and research objectives in conducting research about the Newfoundland and Labrador Heart Health Project. The overall goal was to explore whether the policies and programs developed by women decision makers in three community-based heart health projects were gender sensitive. The research objectives were (1) to determine whether the fact that women comprised the majority of decision makers in three of the community-based projects funded under the Newfoundland and Labrador Heart Health Project allowed for development of programs and policies that were gender sensitive; and (2) to identify factors that contributed to the development of gender sensitive policies and programs in the three community-based projects.

The focal point of the research reported here is what, if any, impact the involvement of women in health decision-making has had on program and policy development in health. Although this research investigates women's involvement in health decision-making in three settings that were part of one project, the insights gained from such an investigation may yield results that will contribute to the broader development of knowledge about women's involvement in decision-making. First, given that the community-based health initiatives explored here were amongst the earliest undertaken in Newfoundland and Labrador, findings from this study will shed light on the little understood phenomenon of community involvement in health decision-making.

The findings also may yield information useful in the development of future community-based initiatives in the health sector. Second, these findings add to the small body of literature about policy and program development designed to address the health needs of women, and as such, should prove relevant in formulating future policies and programs designed to respond to the health needs of women. Third, the study here allows us to evaluate whether Kanter's (1977) framework can explain the dynamics of community-based decision-making in health.

CHAPTER 2: RESEARCH METHODOLOGY

INTRODUCTION

In this chapter I review the objectives of this research, preparatory to a discussion of why a case study approach was adopted in conducting this work. Following this, I discuss the development of the interview instrument used to collect data for this study. The basis for selection of case study sites in this study and the sustainability study is presented along with the methods used to enroll research subjects. I describe the ethical guidelines that guided the research process.

In discussing data analysis, I outline the methods used to analyze data including the gender lens. Research rigour is addressed in a discussion of how the concepts of trustworthiness, credibility, transferability, and dependability were applied in this study. This sets the stage for a presentation of my findings in Chapter Three, and in Chapter Four, a discussion of those findings and their implications for the HHP, and community health practice.

RESEARCH OBJECTIVES AND CHOICE OF QUALITATIVE APPROACH

The two main objectives of this study were (a) to determine whether the fact that women comprised the majority of decision makers in three of the community-based projects, funded under the Newfoundland and Labrador Heart Health Project, allowed for development of programs and policies that were gender sensitive; and (b) to identify factors that contributed to the development of gender sensitive policies and programs in the three community-based projects.

As discussed in Chapter One, the impact of women in decision-making positions in health has not been well researched, as evidenced by the absence of scholarly literature

on this phenomenon. Qualitative methodologies are often used to explore topics that have not been well researched (Marshall & Rossman, 1995). Because of the paucity of research on the impact of women decision makers, particularly in relation to health, a qualitative, exploratory study of decision-making by women in a community-based health promotion research project will make a useful contribution to knowledge development.

My involvement in the sustainability study provided the opportunity for me to collect data for this study within the context of that larger project. At the time I was to begin my own research, a qualitative study was initiated by a team of researchers led by Dr. Doreen Neville to explore factors that influenced the sustainability of health promotion processes in nine communities that had participated in the provincial Heart Health Projects in British Columbia, Quebec, and Newfoundland and Labrador. Neville et al. (2000) investigated three outcome measures: healthy public policy, community empowerment, and the integration of health promotion agendas into existing infrastructures. Three aspects of the sustainability study made it possible for my study to be easily accommodated within its context: (a) the location of three study communities within Newfoundland, (b) the focus on healthy public policy, and (c) the qualitative case study design.

The Case Study Approach

Case studies are empirical studies that investigate contemporary phenomena in real life contexts. Typically, the boundaries of the phenomenon and its context are not evident (Yin, 1989). Rather than focusing on hypothesis testing, which is one of the main purposes of traditional research, case studies strive for holistic description, explanation,

and interpretation. Case studies are distinguished from other approaches to research by their focus on interpretation in context (Cronbach, 1975). A case study method requires gathering extensive material from multiple sources to provide an in depth picture of the case (Marshall & Rossman, 1995).

Classic case studies often involved single cases. However, multiple case studies are becoming more common. Although generalizability is not the goal in qualitative research, qualitative researchers typically address the relevance or applicability of findings to other similar settings (Miles & Huberman, 1994). Some authors (Guba & Lincoln, 1987; Sandelowski, 1986) refer to this as transferability, and suggest that transferability is one criterion by which qualitative research demonstrates its trustworthiness or rigour.

The inclusion of more than one case in a study enhances transferability. Analysis across cases can deepen understanding and explanation. Glaser and Strauss (1967) argue that the use of multiple comparison groups to determine the structural conditions under which specific propositions hold true can increase the transferability of case study results. Multiple cases also help researchers find enough variability in the phenomenon of interest to strengthen theory, which is built through examining similarities and differences across cases. The analyst is also able to develop more general categories that explain how different concepts or conditions may be related when multiple cases are used (Miles & Huberman, 1994).

One of the features of a case is that it is bounded or has boundaries (Yin, 1989). The boundaries of a case study can include the topic, time, and/or place. The three case studies reported here were bounded by topic, time, and place. All three projects

investigated were concerned with heart health (topic), occurred within the same time period (between 1991 and 1996), and occurred within very specific geographic boundaries and communities.

Case and Participant Selection

Early in the larger research project, the team identified which of 25 potential Canadian heart health projects would be invited to participate. Nine of the 25 potential projects were community-based projects in Newfoundland. The research team sampled the 25 available communities to provide variation, both in terms of the characteristics of the community, and the success of program implementation. Three communities were selected for further investigation in Newfoundland. These varied according to the following characteristics: urban/rural location, socio-economic status of community members, and degree of implementation success of project activities (Neville, et al. 2000).

I collected my data at the same time that data were collected in the three Newfoundland sites selected for the larger research project (Neville, et al. 2000). From my work as a community member on the provincial coordinating committee of the Newfoundland and Labrador Heart Health Project from 1991 to 1996, I knew that most of the people involved at these three sites were women, and that they could serve as suitable key informants for my research. To preserve anonymity and confidentiality, I gave the pseudonyms of Beard, Top, and Cove to these three communities.

I planned to interview five participants from each of the three sites, for a total of 15 informants. Conversations with the Project Coordinator for the Newfoundland and Labrador Heart Health Project revealed that approximately 10 people were involved as

key decision makers in each site. Therefore, my plan to select five informants per site meant that half of the decision makers would be involved.

Recruitment of Interview Participants

Participants recruited for my study were the same as those who participated in the sustainability study. Interviewees were recruited for the sustainability study by mail. Likewise, in my study, potential participants were sent a letter from Dr C. Donovan describing the project and seeking their participation (see Appendix B) as well as refusal and consent forms (see Appendices C and D).

The Principal Investigator of the Newfoundland and Labrador Heart Health Project (NLHHP), Dr. Catherine Donovan, gave permission for me, in my capacity as research assistant for the larger project, to obtain a list of people who could serve as key informants in each of the three communities. Categories of key informants included project chairs, paid staff, and steering committee members. I was provided with a list of women and men involved with projects in the three communities selected as study sites for the larger project. Dr. Donovan asked the provincial coordinator for the NLHHP to help find these key informants.

I subsequently sent letters of introduction to all those who had been involved with the projects for whom I could locate addresses. I arranged to interview the first five people in each community who responded positively to the letter of introduction or who did not return a refusal form within three weeks.

Five women in Beard were sent the letter of invitation and the refusal form. One woman returned the refusal form although she did not state a reason. Phone calls were made to book interviews if the participant did not return a refusal form. In Beard, many

women said they were unable to book an appointment until I arrived in the community, and I was asked to call when I arrived. I was told that if the women were not too busy at that time, they would meet with me. Therefore, the interviews were scheduled after I arrived in the community. In each site, the key informants named additional persons who should be interviewed because they were knowledgeable about the project. Whenever possible, I interviewed these people. This process was repeated in Cove and Top. Three women in Cove were unable to attend an interview due to a death in the community. One person declined an interview when I phoned her.

Twenty two people were sent letters of invitation. One person mailed back the letter of refusal. After three weeks I phoned to schedule appointments for the week I was in their community. At the time of the phone call I received four more refusals, three due to a death, and one where the reason is unknown. When I arrived in the community I phoned to confirm my appointment. At this point I had two more refusals one due to the same death, and the second for shyness. Table 2.1 provides details for each of the three communities about the number of potential interview respondents in each community, the number of letters of introduction that were sent out, numbers of refusals, interviews conducted, and interviews taped. In my study, only those individuals who had been directly involved in the HHP were included. At the end of interviews for the sustainability study, informants were once again asked if they would be willing to answer additional questions for my study related to women and heart health. All people who were asked to participate in my study agreed to be interviewed and questions were asked on the spot.

Table 2.1: ENROLLMENT OF KEY INFORMANTS

SITE	BEARD	COVE	TOP
Dates	Nov. 97 Feb. 98	Jan. 98	Feb. 98
Potential key informants, by sex	9 women	12 women	19 women 1 man
# of letters of invitation sent	5	9	8
# of refusals by letter	1	Nil	Nil
Reason for refusal	Unknown	Not applicable	Not applicable
# of refusals by phone and reason	Nil	3 death in social network	1
# not found	Nil	Nil	1
# of refusals on site and reason	2	1 death	1 shyness
# of interviews added on a site	3	3	2
# of interviews done	7	8	8
# of interviews taped	6	7	8
Total # used as data	7	7	8

Instrument Development

The interview instrument used in the sustainability study is provided in Appendix E. The majority of the questions contained in that interview instrument involved assessment of the sustainability of the heart health projects in the selected communities. The topics addressed by Neville et al. included community characteristics, program champions, leadership skills, expectations, resources, access to information, network, early success, attention and notice paid to project activities, participation, healthy public policy, community empowerment, and integration of the heart health agenda into community-based organizations.

Additional questions were developed for my study that addressed topics such as why participants got involved in the project; what (if anything) they knew about the specifics of women's heart health and differences in women and men's experience of heart disease, strategies used to ensure community participation in the project,

particularly involvement on the part of women and any activities that did not work.

The research instrument used to collect data for the sustainability study was pre-tested by interviewing people who would not be interviewed as part of the sustainability study (by virtue of their involvement with projects or communities that were not to be included in the Neville et al. study). Because the study by Neville et al. included sites in Quebec, a colleague there pre-tested the research instrument in Quebec, which had been translated into French. No changes to the research instrument were required subsequent to pre-testing.

The full set of interview questions that were asked of participants in my study can be found in Appendix F. Questions were designed to explore the research objectives identified previously in this chapter. However, before asking questions related specifically to women as decision makers and to the existence of gender sensitive policies, I explored whether those involved in policy and program decision-making in the projects were aware of differences in women and men's experiences of heart disease. My assumption was that awareness of differences would be a pre-condition for the design of programs and policies responsive to women's needs. This was explored through the following interview questions

1. Can you recall any discussions about women's heart health?
2. While both women and men get heart disease, differences in their experience of heart disease have recently been noted. Can you tell me anything about those differences?
3. Some heart health projects have undertaken specific activities to make sure women could get involved in their programs. Did you ever undertake any strategies especially for women?

As a means of providing a context for those questions and in order to find out more about how the women involved in these projects had become involved, I also asked the following questions:

(1) Why did you get involved in the heart health project?

(2)) How did you learn about heart disease?

To be able to answer the question, “Does the involvement of women in decision-making lead to programs and policies that are more responsive to women’s needs?,” first I had to identify the programs and policies developed through the projects studied here and second, to determine whether they responded to women’s needs. Because the sustainability study asked about policies, I was able to use the information about policies and programs that the heart health project had produced. In addition, I asked about activities in each site and how they chose those activities to obtain information about women’s’ participation in decision-making. I asked two direct questions about women (see above) that addressed women's heart health and whether or not respondents had done any specific work to involve women. The need to document the programs and policies that had been implemented was addressed by asking the following interview questions

1. I would like to find out something about how you got people involved in your project. What sorts of activities did you do in your community?

Then for each activity, I asked for the following details:

2. Were you involved in the coalition when you decided to do (name activity)?

3. Where did this idea come from?

4. Did you talk about it at a meeting?

5. Why did you decide to do this?

6. Who was involved in deciding to do this?
7. How was decision made? A vote, discussion, or consensus?
8. Why do you think this activity worked?
9. Can you tell me about any projects that you tried that did not work, that is, that did not get people involved? What are your ideas about why this did not work?

In my design of this research, I wondered what role personal experience with CVD played in producing gender sensitive policies. I wanted to know if an interview respondent had personal experience with CVD, including whether or not a family member had CVD. This issue was partially addressed by asking how respondents had learned about heart disease, or if they had become involved with a CVD program for their own health.

ETHICAL CONSIDERATIONS

All participants provided written informed consent, as described above. The Human Investigation Committee at Memorial University of Newfoundland provided approval for both the larger health promotion sustainability study and for this research project. Participants names and all proper names were changed to protect their privacy. The tapes were destroyed in 2000 and an electronic copy of the data is on my computer until the research is finished.

DATA COLLECTION

In the fall of 1997 and the winter of 1998, I spent a week in each of the three communities, Cove, Beard and Top. I carried out structured interviews for the health promotion sustainability study, each lasting approximately 30 to 60 minutes. Responding to my set of additional interview questions required about 15 minutes of the total

interview time. All but two interviews were taped and subsequently transcribed. One woman in Cove and one in Beard did not want to be taped so I took notes during those interviews instead. In Beard, one interview did not tape on the second side of the tape and some information was lost. One interview was done by phone but, unfortunately, the technologist did not turn over the tape, which meant that only the first part of the interview (for Dr. Neville's study) was taped and responses to questions asked as part of my study were not taped.

The interviews were conducted in a variety of settings, including participants' homes, workplaces, and in hotel rooms. Because the people had already agreed to do something for me, a commitment existed on my part to do something for them. This meant that in one or two instances I was asked to follow up on questions when I returned to St. John's, which I did. Many asked for information about other heart health projects after I turned off the tape recorder.

In each site, I added people to be interviewed after I arrived in the community. This was done for two reasons. The first is that in each site, key informants identified people with project expertise that they thought I needed to interview. This is called snowball sampling (Patton, 1990). The second reason is that many of the key informants were unable to commit to being interviewed before I arrived in their community and were, for a variety of reasons, unavailable for interviews. Thus, in order to interview the most appropriate informants and to meet my goal of interviewing at least five people involved with each project, I added interview respondents after arriving in each community.

Twenty three interviews were completed in the fall of 1997 and the winter of

1998 (twenty two in person and one by phone). The twenty two interviews conducted in person were used in the analysis. The one telephone interview could not be used because, as noted above, technology failed and the interview was not recorded.

DATA ANALYSIS

After the interviews were completed, they were transcribed. Transcription was a very long process. I listened to each tape as I reviewed the transcription and made corrections. Every person was sent a copy of her or his interview. A stamped addressed envelope was included with the transcript so the key informants could mail back any corrections to their transcribed interviews. Although all interview participants were given the opportunity to edit their transcripts, only one person from Cove sent in changes, subsequently incorporated into the interview transcript.

After all identifying information was removed from the transcribed interviews and code names substituted, the textual data were imported into a qualitative computer program called QSR NUD*IST (Richards & Richards, 1991). Notes from the interviews that had not been taped were typed up and were imported into QSR NUD*IST. In addition to facilitating qualitative data analysis, this program tracks the analytic process on screen, allowing the researcher to visualize the evolving coding structure. The immediate accessibility of all existing data and the associated coding allows the analyst to build progressively on the existing coding structure and to modify it as necessary. The database is also available for an external audit, if required.

I coded all of the data imported into NUD*IST by going through each interview line-by-line and allocating a relevant code to a "chunk" of text. A coding system of 206 nodes and sub-nodes developed. Major coding categories included demographic

attributes, policies and programs that were developed in each site, participation of informant in decision-making, programs that did not work, strategies to encourage the public's participation, strategies to encourage men's participation, how people learned about heart disease and the reason they became involved.

Gender Lens

In the research reported here, I used a gender lens presented in Women Matter (Muzychka, 1995) to evaluate whether policies and programs developed in my case studies were gender sensitive. This tool consists of five questions:

1. Does this program, policy, regulation, or law affect women predominantly?
2. Does it create a barrier to women's equality?
3. Does it have no effect on women's equality?
4. Does it promote women's equality?
5. What changes would you have to make to promote women's equality?

Once policies and programs had been identified in the interview data, the degree to which they were gender sensitive was subsequently assessed according to Muzychka's (1995) gender lens. I examined the data on programs and policies identified by interview respondents by posing the questions in the gender lens about each program and policy. The results of this analysis are summarized in Table 3.8. Through this method, I was able to assess whether or not policies and programs developed in each of the case study communities was or was not gender sensitive. In addition, once a determination had been made about each of the programs, I was able to explore the factors that contributed to the existence of gender sensitive programs and policies. The results of these efforts are explored in the remaining chapters of this thesis. Before turning to research findings

however, I address the integrity of my data analysis.

Integrity of Findings: Trustworthiness

Meadows and Morse (2001) say that qualitative researchers need to ensure that their work explains a phenomenon, adds to the methods used in qualitative research, or adds to existing knowledge through its contribution to theory. They argue that good and valuable research does all three but that at least one of these objectives must be met. To do this, research has to meet criterion for rigour in the qualitative paradigm. A review of the literature on qualitative methodology reveals that the terms used to describe the scientific rigour of qualitative research and the processes used to assess it are issues of ongoing discussion and debate among qualitative researchers (Marshall & Rossman, 1995; Morse, Swanson, & Kuzel, 2001).

In quantitative research, terms such as validity and reliability are used to describe the tests of scientific rigour. Researchers must assess the validity and reliability of their work. In contrast, these terms are seldom used by qualitative researchers who prefer to employ concepts more in keeping with a qualitative epistemology to assess the rigour of qualitative research. Here I have chosen to use the term trustworthiness (coined by Lincoln & Guba, 1985) to address the integrity of my findings. Marshall and Rossman (1995), citing the work of Lincoln and Guba (1985), identify four criteria to be met if a piece of research is to be trustworthy. These criteria, which are widely accepted by qualitative researchers, are credibility, transferability, dependability, and confirmability. Each is outlined briefly below in relation to the research process in the study reported here.

Credibility

The term credibility focuses on demonstrating that research is conducted in such a way as to ensure that the phenomenon is accurately identified and described. Several techniques have been proposed for establishing credibility: (a) prolonged engagement in the field, (b) persistent observation, (c) peer debriefing, (d) negative case analysis, (e) progressive subjectivity (or self-reflexivity) and (f) member checks. Prolonged engagement in the field was not possible in this study as I conducted my interviews in each site over a one-week period. The criterion of persistent observation was met through my previous knowledge of the Heart Health Program, through my work on the provincial coordinating committee, and through my three-year involvement in the larger sustainability study. The coordinating committee held several workshops and conferences where I had met some of the key informants before undertaking this research project.

Some peer debriefing was undertaken. Initial findings were presented at a graduate seminar in the Department of Community Health at Memorial University and at a talk sponsored by the Canadian Research Institute for the Advancement of Women. Additionally, progressive subjectivity was used in that I monitored my prior and emerging concepts of the ideas in the study and discussed these with members of my thesis committee. I also worked closely with members of the sustainability study. My initial analysis found very few examples that women made a difference, but as I refined my analysis, I was able to see that the fact that women attended programs planned and organized by other women suggested that those programs met their need in some ways. I then returned to the data to examine those concepts and relationships further.

Member checks involve the process of testing hypotheses, data, preliminary

categories and interpretations with participants. Member checks were used in a limited way in this research, in that all participants were sent a transcribed copy of their interview and their comments and editorial changes were sought. For the purposes of the sustainability study, the principal investigator and I returned to the sites to report the findings to participants, who agreed with the outcomes of the analysis. Although member checks did not focus specifically on the role of women in decision-making, the positive reaction of the participants to the overall findings lends support to the validity of the conclusions in my study.

Transferability, Dependability, and Confirmability

Transferability refers to how transferable research findings are to another setting or program. Transferability is a judgment made by those who examine the study after its completion. I have endeavoured to provide enough descriptive detail to allow other researchers to judge the transferability of my findings to their situations.

Dependability and confirmability parallel (to a certain extent) the concepts of reliability and objectivity in quantitative research. We must acknowledge that the world in which the researcher works is constantly changing. It cannot be held constant. By dependability, I mean that the researcher attempts to account for any changes in the phenomena being studied. In this work, I did record any changes in the phenomena being studied. Confirmability is the work done to make sure that the findings of the study could be confirmed by another researcher. The use of NUD*IST provides an audit trail that allows confirmation of the researcher's analytic process. Members of my committee, who participated in the sustainability study and who confirmed my interpretations, also reviewed the data.

SUMMARY

To outline the research design employed in this study, I have described and justified my choice of a qualitative approach and specifically of a case study approach. I described the case sites and participants, and presented information on the method for recruiting interviewees. A rationale for development of the questions that guided data collection in this study was presented. The study fell within the ethical guidelines of Memorial University of Newfoundland. I detailed data collection and analysis procedures including the use of the gender lens. I now turn to the findings from my analysis.

CHAPTER 3: CASE STUDY FINDINGS

In this chapter, I present my findings from the case studies undertaken for this research. Initially, findings are organized by case, including information about each of the three sites, demographics that provide a sketch of the three sites and information about the heart health projects undertaken at each site. Then I discuss programs that did not work.

After the demographic material, I present findings by research objectives in order to: (1) determine whether the fact that women comprised the majority of decision makers in three of the community-based projects funded under the Newfoundland and Labrador Heart Health Project allowed for development of programs and policies that were gender sensitive; and (2) identify factors that contributed to the development of gender sensitive policies and programs in the three community-based projects. First I address whether people in the three community projects of the Newfoundland And Labrador Heart Health Project were aware of the differences in women's and men's experience of heart disease. Then I turn to programs or policies that reflected ideas about differences in women and men's lives. Subsequently, I use a gender lens (Muzychka, 1995) to identify which gender sensitive programs. Finally, I point out some factors that might have facilitated the development of gender sensitive Heart Health Programs.

FINDINGS BY CASE

Below, I present a description of each of the communities where the case studies took place, followed by the demographic information on the key informants and a description of the programs offered in each case. First, is the material from Beard, second from Cove, and finally Top.

Beard Case Study

The Beard Heart Health Project took place in five rural communities. The communities were an incorporated town and four unincorporated communities within a 15-mile radius. The incorporated town boasts most of the amenities in the region, such as a hotel, the high school, and the major grocery store. The Beard Heart Health Project had one paid staff position, which was held sequentially by two married female registered nurses over the life of the Beard project.

Seven interviews (see Table 3.1) were conducted and analyzed. All interview respondents in Beard were female. According to Kanter's (1977) work, this is a uniform group because all the members are similar (i.e., female). Thus, according to Kanter's analysis, women's ideas would be listened to and then incorporated into the work of the group. The only unmarried person from this site interviewed was a health professional with the public health agency. The other six women interviewed were married.

TABLE 3.1: MARITAL STATUS OF KEY INFORMANTS IN BEARD

KEY INFORMANTS	MARITAL STATUS
Volunteers	4 married women
Public Health Agency	1 lone woman
Project staff	2 married women
Total	7 women

Description of Heart Health Programs in Beard

The Beard Heart Health Programs included exercise classes, guest speakers who spoke about aspects of food purchasing, nutrition, and smoking cessation programs. It also ran cross-country skiing events, health fairs in the schools, a walking club, and piloted the life style clinic for the provincial heart health project. Volunteers in the life style clinic were taught how to record blood pressure and how to determine a person's

body mass index. The volunteers provided information about good health practices such as exercise and healthy eating. Although the life style clinic had a permanent site, the volunteers also took the clinic to community events. The Heart and Stroke Foundation developed the Heart Smart Restaurant program. The provincial Heart Health Project encouraged the community projects to get restaurants in their areas to adopt this program. The HHP facilitated local restaurants adopting the Heart and Stroke Foundation Heart Smart Restaurant Program. A school milk program was developed to allow the sale of milk in one elementary school.

Cove Case Study

The Heart Health Project in Cove was located in a rural incorporated town where the entire town was the focus of the project. No paid staff members were associated with the Cove Heart Health Project. Of the seven key informants (see Table 3.2), six were married women. This is a uniform group according to Kanter (1977), as all the key informants were female. The one lone woman worked for the public health agency.

TABLE 3.2: MARITAL STATUS OF KEY INFORMANTS IN COVE

KEY INFORMANTS	MARITAL STATUS
Volunteers	5 married women
Public Health Agency	1 married woman 1 lone women
Project staff	No staff
Total	7 women

Description of Heart Health Programs in Cove

The Cove project included exercise classes, guest speakers who spoke about aspects of food purchasing and nutrition, programs to encourage people to stop smoking, and a walking club. The Cove Heart Health Project also ran cross-country skiing events

and held health fairs in the schools, as well as several all-day community events. One such event was a Winter Carnival, with sports such as skating and tug of wars held on the frozen bay. The HHP helped several restaurants to adopt the Heart Smart Restaurant Program.

When asked if any of the Cove programs specifically addressed women's needs, the key informants in Cove identified one program targeted towards women. An afternoon session was held using a program called "Women and Heart Health: Women Take Time to Care for Yourselves." Twenty-five women attended an afternoon session about women and heart disease. The initiative for the session came from two committee members. One was a community member with a family history of CVD and the other was a health professional. The health professional had received a flyer about a provincial Heart Health Program (Squires, 1997). With Canada Health Day approaching, the public health nurse saw an opportunity to present this provincial program on Women and Heart Health program as a Canada Health Day event.

Heart health committee members, who each phoned six women to tell them about the event, undertook recruitment for this event. Subsequently a personal invitation was mailed to each woman who had been called. Twenty-five women attended the session. The session was held in the elementary school, which donated the use of the space, the TV, and the VCR. The ninety-minute information session on women and heart health included information on: heart disease, the Newfoundland heart health survey, and issues in diagnosis and treatment. It ended with a video on women and heart disease, and an opportunity for discussion in which women gave examples of heart healthy choices they made in their everyday lives. Suggestions were provided for reducing their risk of heart

disease and strokes. This program met the criterion of the health professional who wanted to do something for Canada Health Day and the personal need of at least one of the community women. Unfortunately, the community volunteer did not get to attend the session as she was called to work that day.

Top Case Study

The Top Heart Health Project took place in a social housing unit in an urban setting. As Table 3.3, shows Top had a paid married project coordinator. In this case study, as in the other two, all of the volunteers were married women. This site had the only male key informant. The male key informant worked for one summer in the community garden. As was the case with the Cove and Beard case studies, the only lone woman was an employee of the public health agency.

In Kanter's (1977) terms, this group is skewed. A skewed group has a large preponderance of one type of member. Kanter argues that the numerically dominant members (in this case, women), control the group and its culture enough to be called dominants. The few who differ from the norm in a skewed group (in this case, the one man) are tokens. The ratio of dominants to tokens in a skewed group can be as high as 85:15. Because this male worked only one summer, the amount of influence he could have had on the project seems likely to have been small. The Heart Health Committee might be more accurately described as a uniform group over the life of the project, because all the decision makers were female.

TABLE 3.3: MARITAL STATUS OF KEY INFORMANTS IN TOP

KEY INFORMANTS	MARITAL STATUS	
Volunteers	4 married women	
Public Health Agency	1 married woman 1 lone woman	
Project staff	1 married woman	1 lone man
Total	8	

Description of the Heart Health Programs in Top

Top held exercise classes and hosted guest speakers who spoke about aspects of food purchasing, nutrition, and women's health. The Top Heart Health Program organized a focus group about smoking. The purpose of the focus group was two fold. The criteria develop by provincial HHP required the community programs to address the risk factors identified in the provincial survey. Smoking was one risk factor. At the same time there was an Atlantic Canada health promotion program to gather data on women who smoked. The focus group held in Top was part of this data gathering. In Top, members of the heart health project also developed a community garden where people grew vegetables and a community kitchen which was in the community centre. The community kitchen consisted of a series of four sessions that allowed four women to expand their meal planning and food preparation skills. Each session lasted three hours, during which time family meals were planned, the ingredients purchased, and the meals cooked. The women had to provide the money to purchase the food. After preparing meals in the community kitchen, they were able to take home the meals they prepared. In another part of the same building, their young children attended a childcare program, although the Heart Health Project did not cover the cost of childcare as this was covered by other funding sources. Restaurants in the urban center also adopted the Heart Smart Restaurant program. Key informants identified one program as targeted towards women,

the focus group held to discuss smoking.

Differences and Similarities

Differences and similarities can be found among the three case studies. The similarities were often based on the criteria of the Newfoundland And Labrador Heart Health Project. The provincial project required that the community projects address at least three of the four risks factors for heart disease identified in the 1989 provincial Heart Health Survey, including the lack of exercise, the high rate of smoking, high cholesterol levels, or high blood pressure.

The projects were required to have both community members and staff from the public health agency on the coordinating committees. Because the majority of workers in the health care delivery system are women, it is not surprising that all the people from the public health system were women. The community women in all the sites were married. The lone people interviewed all came to the project through their paid work either in the public health agency or for the heart health project.

The differences in the three case studies reflect the differences in the three communities. The Top project had all their programs in their community center with all the participants coming from one housing project in an urban setting. Since no school was located in this area, no programs took place in schools. The people in the Top HHP had worked together before in a Tenant Association and in an advocacy group trying to get childcare services. In both Cove and Beard, programs were delivered in a variety of settings, including schools. The last two projects were organized in rural communities, where the members had no experience working together.

Cove was the community with the best financial basis because some people were

employed in the nearby national park. Employment was almost unknown in Top since, by definition, one had to live in subsidized housing to be involved in the project. Beard had had a fishing-based economy but many had left the community after the 1992 cod moratorium.

Programs That Did Not Work

The research protocol asked specifically about programs that did not work because I was looking to see if there was any difference in the decision making process in programs that worked and ones that did not. When asked which of the activities undertaken by the heart health project did not work, the answer was uniform across all projects. The respondents identified the antismoking programs as unsuccessful. Key informants were not asked to comment on how well other programs worked. Activities designed to tell people about smoking with a goal of reducing smoking were seen as failures.

Smoking is a complex behaviour. Greaves (1989) reports on why women say they smoke. Some women use tobacco as an appetite suppressant to keep off weight. Others say they use tobacco as a way to cope with stress. Some reward themselves with a cigarette for completing work or getting through a day. It can be difficult to replace smoking with healthier forms of relaxation. Healthy activities such as physical exercise and relaxation take time, money, and social support as well as a determination to put oneself first. Many women do not have these resources.

FINDINGS RELATED TO AWARENESS OF THE DIFFERENCES IN WOMEN'S AND MEN'S EXPERIENCES OF HEART DISEASE

In undertaking this research, one of my assumptions at the onset was that people

in community projects of the Newfoundland And Labrador Heart Health Project needed to be aware of the differences in women and men's experience of heart disease in order to design gender sensitive policies or programs. My assumption was based on my experience that when policies were developed for women it was because the policy developers were aware that women required different policies than men. To check this assumption, I asked if any discussion of women's health had occurred in each of the communities where I interviewed heart health project participants. Given that the key informants said that it was primarily women who participated in Heart Health Project programs, it was surprising how limited the discussions on women's health had been either in committee meetings or during activities. Of the three communities where heart health projects were investigated, the greatest amount of discussion about women's health took place in Cove. In Cove, all of the key informants interviewed were able to give examples of what aspects of women's heart health were discussed in committee meetings (e.g., smoking and its impact on heart disease in women). The Cove project held a session about women and CVD. Discussion also took place about women's roles in meal preparation and cooking and their link to CVD prevention.

Some limited discussion about women's health took place in Beard during the Heart Health Programs organized for that community. Key informants said women raised questions about weight, menopause, and tobacco at the Life Style Clinics. One informant noted that Beard's programs did not address women's health in any formal way.

Not in a formal sense. In our Life Style Clinic, many participants were women. We had a question and answer period where many questions dealt with women's health, menopause and how other factors influenced their

heart.

In Top, comments about women's health emerged when key informants talked about the focus groups held for women about smoking. The other issue concerning women that was raised in Top was that knew women need childcare to attend programs so they had organized childcare so that women could attend Heart Health Programs. The community centre policy to provide childcare pre-dated the Heart Health Program.

Given the limited discussion about women's health, it is not surprising to find little awareness of the differences in men and women's experience of heart disease in the three communities. The data suggest that understanding the differences in men and women's experience of heart disease was limited to health professionals. In Cove, two women educated as health professionals (one was a volunteer and one worked at the public health agency) answered the questions about the differences in women and men's experience of heart disease, indicating an awareness of those differences. In Top, a health professional said that women's heart disease was a new topic and that they would be doing something about it in the future. In Beard, a health professional said: "We talked about why it is higher in women than the men and why men are paid more attention when they get chest pain than women. Those are the topics that we discussed." In all three cases, key informants who had not been educated as health professionals were unable to identify any differences in men's and women's experience of heart disease.

Any information geared to women's particular health needs had to be provided by the health professionals or by the provincial heart health project. The provincial project did produce a kit, Women and Heart Health: Women Take Time for Yourself which was used by Cove heart health project. When asked if their project had any programming

targeting women, all the key informants spoke about being open to everyone. Targeting programs was seen as excluding others.

FINDINGS RELATED TO IDENTIFICATION OF HEALTHY PUBLIC POLICIES ADAPTED TO THE DIFFERENCES IN WOMEN AND MEN'S LIVES

When I designed this research, I had anticipated examining policies that were gender sensitive. Here, I document the list of “policies” key informants identified when asked if the heart health project had developed any policies. I then introduce a definition of healthy public policy, and subsequently discuss whether the policies that participants named in response to my query were, in fact, healthy public policies. This sets the stage for presentation of the results of an analysis of the extent to which policies developed by the three communities investigated were gender sensitive. During analysis of data, only one gender sensitive policy was implemented in any of the sites investigated.

The Identification of Healthy Public Policies

Key informants indicated that none of the projects had planned to develop public policies about health. When specifically asked if any public policies had been developed during the heart health project, key informants identified six:

1. The introduction of the Heart and Stroke Foundation restaurant program, called Heart Smart (Beard, Cove, & Top).
2. The organization of walking club (Beard & Cove).
3. The establishment of a basketball court (Cove).
4. The redesign of the Healthy Baby Club (Top).
5. The introduction of a milk program in an elementary school (Beard).
6. Efforts to make buildings smoke free (Beard & Top).

Heart Smart Restaurant program. The Canadian Heart and Stroke Foundation developed the Heart Smart Restaurant Program. The Newfoundland And Labrador Heart Health Project facilitated its adoption around the province. Under the program, restaurants used a variety of means to identify menu items that are Heart Smart.

Walking Clubs. Walking clubs had minimal structure. When women walked, they signed in at a site such as the town hall and indicated how far they had walked. Most of the walking was done on community streets. In Beard, walking club participants walked in the school gym during the winter months. Individuals paid no fees and required no equipment other than shoes. The majority of participants were women who walked with other women.

Basketball Court. The setting up of a basketball court in Cove was named as a public policy. The Heart Health Committee bought basketball equipment and installed a basketball net on public land. In the past, the town council's recreation committee had sponsored a basketball court, but it had not been maintained after the recreation committee stopped work. No data had been kept on who used the facility so it is unknown whether men or women used the basketball court.

Healthy Baby Club. In Top, a key informant within a community health agency spoke about the change in the way they delivered the Healthy Baby Club. The Healthy Baby Club program was developed in Newfoundland as a strategy to reduce the number of low birth weight infants (who have a higher rate of health problems than do higher birth weight infants). This change in delivery allowed the exchange of information between the facilitator and the participants, as opposed to the usual method of prenatal classes in which an expert tells women what the expert thinks women need to know. The sessions

were also changed to include a time to eat together and to have small gifts or prizes. One key informant described how she became aware of the need for change in how the healthy baby program was delivered:

Some things that we have learned through Heart Health we are incorporating into the Healthy Baby Club. There [in Top] we do not have prenatal classes. We have informal groups where the people get together and the public health nurse comes in, has a cup of coffee or a drink of juice and discusses what the people want to talk about.

We know that if you want people to come to something, you have snacks and prizes. With the Healthy Baby Club, whenever I do a presentation now I bring some little gifts. I did a session on budgeting, but I did not do a presentation. I took the [supermarket advertising] flyers up and people talked about how they saved money. We came up with a list of how this group saved money as compared to the group at the other table.

During that, I learned that the pregnant women and nursing mothers were all using 2% milk. They are supposed to be using whole milk, because of the calories. I would never have learned that unless I had sat down with them. Then we discussed the pros and cons, why are you buying 2% milk. When you are pregnant, you do need the extra calories. If I had been up teaching, I would never have found that out because they go and pick up their own food supplements. It did not occur to them because we teach everybody to go on 2% milk.

School milk program. In the elementary school in Beard, the milk program

worked with a provincial initiative to subsidize the cost of milk sold in schools.

Unfortunately, the school was closed at the end of the year and the program died with it.

One participant described the rationale behind the school milk program:

In Beard, there was no cafeteria service. The kids were leaving the school, going to the store and buying pop and junk food for their lunch. We introduced a school milk program there. The kids did not know they were involved in the Heart Health Program. They started buying the milk. They started bringing lunches to school. We thought that was a much more healthier diet for their lunch meal then going off to the store and buying pop.

Smoke Free Buildings. Two groups attempted to make buildings in their communities smoke free but neither group was successful during their heart health project. Cove tried to make the buildings run by the town council smoke free. In Top, people spoke about their work to make the community centre smoke free. Because this policy was never implemented, it was not evaluated in terms of whether or not it was gender sensitive.

In this section, I have described the six policies identified by key informants as having been developed by their heart health project. At this point, I examine the policies to see if they fit the definition of a healthy public policy.

A Working Definition of Healthy Public Policy

I have used two sources for the definition of a healthy public policy. The first comes from the sustainability study (Neville, et al. 2000) and the second from Pederson, Edwards, Marshall, Allison, and Kelner (1988). For the purpose of the sustainability

study (Neville, et al. 2000 p. 27), policy change was defined as indicative of healthy public policy when (a) intersectoral collaboration was required for its development, (b) it was a change that promoted the health of the target population, and (c) it was developed through a process of consultation with representatives of the target population. Pederson, et al. (1988) gave a definition of healthy public policy as being “ecological in perspective, multisectoral in scope, and participatory in strategy.” Using these definitions of policy, I examined the policies that the key informants identified. All six policies were aimed at improving the health of the target population. However, a lack of intersectoral collaboration in redesigning the Healthy Baby Club disallow it as healthy public policy. As well, the adoption of the Heart Smart Restaurant program, the introduction of a school milk program, and the setting up of a basketball court could not be characterized as having been developed through participatory processes.

Two interventions fit the definition of a healthy public policy. The walking clubs were designed to improve the health of participants, involved collaboration of the school boards and local government to get permission to use their facilities for the walking clubs in winter and the participants the women were involved in setting them up. The attempts in both Beard and Top to make buildings smoke free would have met the definition of healthy public policy articulated above, had they been successful. The attempts to introduce smoke free spaces was multisectoral as it included both the municipal government and a community-based organization and it targeted the health of people who used the buildings, some of whom were involved in the development of the policy. Unfortunately, these policies were not implemented in either Beard or Top. Accordingly, it was not examined with the gender lens.

When I started this research, I had planned to examine policies that emerged from the Heart Health Programs in the communities investigated. Although the key informants did identify programs they thought were policies, only one policy was implemented in the case studies: the setting up of walking clubs. This policy will be examined with the genders lens along with programs developed in the three case studies.

FINDINGS RELATED TO IDENTIFICATION OF PROGRAMS ADAPTED TO THE DIFFERENCES IN WOMEN'S AND MEN'S LIVES

Interviews with key informants suggested that a wide range of programs were carried out in Top, Beard and Cove. The interviews yielded little evidence that the women delivering programs consciously attempted to target the programs specifically towards women's needs. Some evidence supports the conclusion that those designing or delivering the programs were aware of differences in women and men's lives and that this knowledge was used in program planning to increase men's participation. For example, in Beard the committee members designated a specific time for men to use the exercise equipment in one of the community buildings. The number of men that came was small and the committee did not continue the strategy. Key informants indicated that women were the majority of participants in Heart Health Programs in the three communities investigated. Based on key informants' recollections about program attendance, the programs clearly had greater appeal to women than to men. The fact that little discussion took place in the three communities about women's health and that the programs clearly still had greater appeal for women suggests that having women present in decision-making positions can have an impact on the decisions taken. In all three sites, women were the only decision makers for most of the time the heart health projects operated. Cove had started with two men on the heart health committee, but they left.

One woman said she did not think “men would want to spend time sitting around with a bunch of women.” Another woman thought men did different things than women. Although Top had a male employee for one summer, Beard had no men on the decision-making heart health committee.

Although the key informants in the three case studies said that women came to their programs and that women were the primary participants in those programs, these programs were not chosen to meet women’s needs. When asked if they had undertaken any specific activities in their projects to ensure that women were involved in community Heart Health Programs, in all cases the key informants indicated that no special strategies had been developed with the explicit purpose of encouraging women’s participation. Clearly, no strategies were needed since women did participate. When asked if they had done anything to encourage the participation of women, one key informant said “Not really, but I found more women were involved in the project.” Another key informant gave her explanation for why more women took part in heart health project activities: “The thing with the women is they come out a lot faster than the men do in the community. There were always more women involved than men.”

The National Evaluation Steering Committee and Writing Group produced a process evaluation of the Canadian Heart Health Initiative (2001). In the 40 page report gender is mentioned four times. For example, the report states that women were the target group in seven percent of all projects. The gender of the people who attended the programs in any of the provinces is not given. Therefore, I cannot say if this predominance of women attending the programs is unique in Newfoundland or reflective of the norm.

A woman talking about a Heart Health Program community exercise class commented: "We decided to give the men an hour, but they stopped coming. Mostly we got women. Men did not seem interested. I do not know why. Men might think it is a woman's thing." Another woman commented, "It was not a deliberate thing to try to design the programs to draw the women out. The women came and, in fact, whatever you designed met the needs of the women, because they came. However, it was not deliberate."

Pauline, a health professional said,

I am not really sure, but when I think of heart health for Top, the picture in mind is of women. I did not think of that until you just asked the question. When I think of the memories I have they are generally of women not men. I do not know if it was related to women coming with a sense of community, if the Centre gave them that kind of network or if men were not available during the times that programs were offered. I think some programs really met the needs of women, in particular, the community kitchens, the community garden and the exercise part. It really spoke to what women wanted. I do not know if it just happened that way. From what I understand it wasn't intended to be targeted towards women, but it seemed that was just the direction that it took.

No deliberate plan was devised to develop programs for women. The plan was to produce programs for the entire community. No evidence suggests that the people involved in the heart health projects discussed their success in getting women to attend their events. Several respondents commented that they had not even thought about this

predominance of women before my questioning. When asked why women attended more than men, key informants gave several ideas including that the programs met women's needs. The concept of the women being the workers in the community was also raised. Women are the workers in these communities. They do the organizational work in volunteer organizations. So the organizers of the HHP were not surprised when women came to their events. The organizers did not see any need to discuss the norm. This was unfortunate as they talked very little about women's health needs, their own health needs or their role in designing programs for women.

Based on my experience working in health care in Newfoundland, I believe that the provision of health care in the home and community is seen as women's responsibility. Women are responsible for the health of their parents, their children, and their husbands. This is not a joint responsibility with men. Thus, men have no need to know about this work. Key informants spoke about the fact that men did not do things with a bunch of women, that they had their own activities. This fact that men do their own things needs to be made use of in future programming by getting men to design programs for themselves. It may require that specific organizations dominated by men such as volunteer firefighters be asked to take on heart health programs as part of their training. This would be appropriate as fire fighters need to be in excellent health to do their job. Kanter's model would suggest a group such as volunteer firefighters dominated by men would produce programs supportive of men.

While there were some programs specially adapted to the differences in women's and men's lives, these programs were for men. The HHP committees were so successful in getting women to attend their programs that had no need to develop programs for

women. Unfortunately, there was no discussion of this success and no examination of why it had happened. No one raised the idea of involving men in the planning of programs as a strategy to encourage men's participation. Thus the opportunity to learn from their success with women and to transfer that success to programs designed for men was lost. If this research had happened earlier in the Newfoundland And Labrador Heart Health Project, then this information could have been fed back to the projects for their consideration.

Programs Targeted towards Women

When asked specifically about programs designed for women, the key informants identified two programs. Top organized focus groups about women and smoking, and Cove ran a session about CVD and women.

In Top, a male health professional working for another health project was looking for a site to do a focus group about women and smoking. Since the provincial heart health criteria required that the project do something concerned with smoking cessation, it was an ideal fit. The heart health project organized focus groups about women and smoking with a plan to offer programming on smoking cessation. However, the smoking cessation programs were not actually delivered because the residents in Top did not want them. In neither heart health project was any suggestion made that people who smoked had asked for programming to help them stop smoking; this topic originated with the provincial program. In Top, they organized the focus groups on women and smoking because it was needed for another Atlantic Canada program, not because there was an interest within the community. One of the volunteers from the community spoke about her smoking and about the smoking by other women in the community.

Smoking was one thing that we looked at when Philip was here with *[another program in Atlantic Canada]*. He came over and ran the focus groups with women on women and smoking. That was successful in terms that they had many volunteers. After that, Philip, Annmarie and Lucy at the Centre tried to start a group of women to look at smoking issues-- trying to get them thinking about how to stop smoking. Smoking has been the hardest thing to get going and that kind of fizzled out.

In Cove, key informants spoke about providing information such as the health risks associated with smoking because they thought it would be good for their family members to stop smoking. Members of the HHP provided this information at events where smoking occurred such as bingo games. While none of the key informants in Cove smoked at least one did in Top. Because no programs were developed from these focus groups, there was nothing to examine with the gender lens.

Strategies to involve men

In all three case studies, key informants pointed out that few men attended events. The informants spoke about the work they did to encourage the participation of men and they identified strategies they used to encourage men to attend events, such as developing and administering surveys to ask what programming men wanted, then following up by holding programs specifically for men. None of the heart health projects had men involved in planning their programs. Only Cove ever had men on the heart health committee and the two men did not stay very long. One man was the principal of the elementary school and the other man was the mayor. Although I did not interview either of them and I do not know why they left, I surmise that the reason may be the same reason

why women do not stay in male dominated places: one feels like an outsider and in other places one feels more welcome.

A health professional speaks about the strategies used in Top:

We kept trying to get the men. Maureen tried to get Tae Kwon Do on the go. The men would come to the Health Fairs and things like that and they'd come to some of the activities, but it was mostly the women. But why the men won't come out. Whether it's that they're not comfortable or they don't see it as their role or whether they're home looking after the children, or they're working, or they're doing other things. But Maureen again would always try to get the men in the fitness classes. They've always been invited. And we've always worked to get them to fill out the surveys and that kind of thing. But maybe they see themselves as having a supportive role to the women or whether it's just the women have taken it and whether they are getting that support, I don't know. No, we always said, "Can we get some men?" Maybe this program will draw them in and there's no reason why they couldn't be in the kitchen and in the community gardens. I think there were some men involved, but it has always been the women that have taken the leadership on.

This quote reflects the wide range of ideas that key informants gave as to why men did not come. These include men not seeing health as their role or, in my understanding, as their responsibility, so they are elsewhere such as at work. The idea that men would not feel comfortable doing things with women is raised. The concept of recruiting men to develop programs is not mentioned, but the idea of surveying men to discover what they

want was discussed.

Application of a Gender Lens to Identify Gender Sensitive Policies and Programs

In this section, I outline findings related to the application of a tool called a gender lens, which I have used to determine whether the programs were gender sensitive. When I designed the research and gathered the data, I had anticipated analyzing with the gender lens only policies and programs designed for women. However, as my earlier discussion outlines, at the analysis stage I discovered that the case study communities had developed only one policy and few programs for women and thus I expanded my analysis to include all the programs for which I had sufficient information.

At the conclusion of my data collection, I did have sufficient information to evaluate the Heart and Stroke Foundation restaurant program, the walking clubs and basketball court, the redesign of the Healthy Baby Club, the introduction of a milk program in an elementary school, the session about women and heart disease held in Cove, the community kitchen in Top, and the exercise classes held in all three sites. I describe these classes below. Because I conceptualized the focus groups on women and smoking as a form of need assessment and since no program emerged from these focus groups, there was nothing to examine from the standpoint of gender sensitivity.

Exercise Classes. Women predominately attended the exercise classes in all three sites. Since the programs were designed to reduce common barriers to women's participation, the classes were free in all three projects. In Top, childcare was provided on site to support women who wanted to attend the classes. The video used in the exercise classes featured a larger woman as a leader and the participants were larger women. In Cove, the aerobic instructors were female volunteers who attended training outside of

their communities. In Beard, the classes were held in many places such as the only high school and a community center to make them geographically accessible.

Gender Lens

Next, with the gender lens, I examined the seven programs and one policy for which I had sufficient data. I did this by answering the following five questions for each:

1. Does this program affect women predominantly?
2. Does it create a barrier to women's equality?
3. Does it have no effect on women's equality?
4. Does it promote women's equality?
5. What changes would you have to make to promote women's equality?

Table 3.4, below, presents a matrix of these seven programs and one policy as examined using the gender lens. The first four of the five questions, that comprise the gender lens, are listed on the horizontal axis and the heart health project programs and policy are listed on the vertical axis. This table summarizes the findings concerning the extent to which each of the programs responds to the criteria outlined in the gender lens.

TABLE 3.4: ANALYSIS OF POLICY / PROGRAMS ACCORDING TO GENDER LENS

Policy /Program	QUESTION 1 AFFECT WOMEN PREDOMINANTLY	QUESTION 2 CREATE BARRIER	QUESTION 3 NO EFFECT	QUESTION 4 PROMOTE EQUALITY
Walking Clubs	Yes	No	No	No
Heart Smart Restaurants	Unknown	No	No	No
Basketball	Unlikely	Potential	No	No
Healthy Baby Club	Yes	No	No	Yes
School milk program	No	Unknown	No	No
Women and heart health	Yes	No	No	Yes
Exercise classes	Yes	No	No	Yes
Community kitchen	Yes	No	No	Yes

Heart Smart restaurants. The Canadian Heart and Stroke Heart Smart Restaurant program has never been evaluated in relation to the gender of the user (W. Clarke, personal communication, April 2001) so I do not know if it affects women predominantly. Men may be more likely to consume food in restaurants because they have greater access to discretionary income than women. It is unknown whether the cost of Heart Smart food choices in restaurants pose any direct barriers to women's health.

A challenge that many women face is the lack of time to care for themselves. When women do have the time, they often feel guilty if they spend it caring for themselves (Henderson, Bialeschki, Shaw, & Freysinger, 1989). A program that validates women's need to care for themselves promotes women's equality. If women defined eating out as caring for themselves, then the Heart Smart restaurant program could be defined as promoting women's equality. Thus, the Heart Smart program could support women's equality in that one way to promote equality is to support women in their efforts to care for themselves.

Walking clubs. Women were the main participants in the walking clubs. There were no fees and no special equipment (other than walking shoes or sneakers) were required. The only barrier may be the cost of a pair of shoes. The walking clubs provide an opportunity for women to engage in physical activity, the lack of which has been identified as a risk factor for CVD. According to data released in a special issue of Health Reports (Perez, 2002), men are more likely than women to engage in vigorous activity during their leisure time. Women are also less likely than men to use public recreational facilities (Fenton, Kopelow, & Viviani, 1997). According to the World Health Organization (1998), women's health is linked to their status in society, in that health

benefits from equality and suffers from discrimination. Thus walking clubs are a gender sensitive policy as they promote equality through providing a method of vigorous exercise that is designed to meet women's needs.

Basketball court. Because data were not kept on who used the court, it is not known if this program affected women predominantly, but it is unlikely since women are less likely than men to use public recreational facilities (Fenton, Kopelow, & Viviani, 1997). Similar resources would need to go into developing a program to encourage physical activity among women. Young girls might be denied an opportunity for a physical activity, because women do not play basketball at the same rate as young men. If allocating resources to this activity meant that funds were not available for supporting a program of greater appeal to girls and women, such a program may actually hinder women from achieving equality. The existence of basketball courts does not promote women's equality. One way to ensure that the facility better met the needs of women would be through social programming (such as advertising a women's weekly pick-up game), to encourage women's participation.

Healthy Baby Club. The Healthy Baby Club was designed for mothers of high-risk infants. Any change in how the community health agency delivered the Healthy Baby Club would predominantly affect women. The change in the delivery of the program should not have created a barrier to women's equality--rather, it ought to have facilitated women's equality by increasing women's knowledge. The Healthy Baby Club allowed women to learn skills to aid them in becoming better mothers and increasing women's skills is one way to promote women's equality. The decision to change the way the Healthy Baby Club was delivered increased the chances the program could promote

the equality of women. Good parenting skills and healthy babies should result in the women receiving more positive comments about their skills as mothers, which in turn should result in fewer negative comments about their mothering skills. Basing the Club on information from the women's situation and needs increased the possibility that women would gain access to information that might aid them in increasing the degree to which they felt in control of their lives. A link has been documented between the degree to which one controls her or his life and CVD (Karasek, 1979; Karasek & Theorell, 1990).

School milk program. Approximately 50% of the provincial elementary school age population is male and 50% is female (Newfoundland & Labrador Centre for Health Information, 2000). Thus, boys and girls were equally likely to have been affected by this policy. The school milk program would not be a barrier to equality for girl children. It may be a barrier to equality for whomever delivered the program because this would be an additional piece of work either for parent or for the elementary teacher both of whom are more likely to be female. It may be an example of a woman using her very limited leisure time caring for others. This policy did not last because the school was closed in the next academic year due to declining school enrollments. While in many countries, female children are denied food and education in deference to male children (World Health Organization, 1998), there is no evidence of this in Canada, and therefore the school milk program would not promote equality for girl children in Newfoundland.

Women and heart health. In Cove, the heart health project presented a session using the kit Women and Heart Health: Take Time to Care for Yourself, which was developed by the Newfoundland And Labrador Heart Health Project for women. Only

women were invited to attend this event, where issues affecting women predominantly were discussed. The program does not create a barrier to women, but rather has the potential to influence women's equality by giving women information that they could use to change their behaviour to reduce the risk of heart disease. The Women and Heart Health program gave women information about health problems, along with strategies to address these health problems. Because no follow up was offered to the women who participated in these programs, no way of assessing the use of the information is possible. According to the gender lens perspective however, this program was gender sensitive.

Exercise classes. Women were the main participants in the exercise classes led mostly by women volunteers. The leader of the exercise video was a larger woman so she was a role model for the participants. Increased exercise has the potential to make women feel better about themselves by improving their health. The improvement of women's health is one aspect of improving women's equality. This program does not create a barrier to women's equality because, as discussed above, it was free, childcare was provided and it was held at an accessible location.

Community kitchen. Only women attended the classes in the community kitchen. This was an opportunity for women to expand their knowledge and skills, to enjoy childfree time with other women, and to have cheap and nutritious food to serve their families. All of these would make women feel good about themselves and their work. The fact that the community kitchen was full each time the program was offered suggests that the program was valued by the women, perhaps because it made them feel good about themselves and their work. They would have also appreciated the inexpensive and nutritious meal for their family. However, the community kitchen presents a dilemma: on

the one hand, it meets a real need to provide inexpensive and nourishing food to the women's families, but on the other, it supports the belief that food preparation is women's work. This program promoted women's equality through women learning new skills and by giving women participants childfree time in which they could socialize with peers and have fun.

Of the seven programs examined here, four were found to be gender sensitive: the exercise class, the community kitchen, the Women and CVD session, and the redesign of the Healthy Baby club. The one policy, the introduction of walking clubs, was gender sensitive. Beard had one gender sensitive policy (the walking club) and a one of its eight programs (the exercise classes) was gender sensitive. In Cove, of the nine programs the heart health project delivered, two were gender sensitive programs (the exercise classes, and a session about women and heart health). Cove also had a gender sensitive policy, (the walking club). Top had three gender sensitive programs: the exercise classes, the community kitchen and the Healthy Baby Club. Table 3.5 lists the four gender sensitive programs and one policy by case study.

TABLE 3.5: GENDER SENSITIVE PROGRAMS/POLICY BY CASE STUDY

PROGRAM POLICY	GENDER SENSITIVE	BEARD	COVE	TOP
Exercise class	Yes	Yes	Yes	Yes
Community Kitchen	Yes	No	No	Yes
Women & Heart Health	Yes	No	Yes	No
Healthy Baby club	Yes	No	No	Yes
Walking clubs	Yes	Yes	Yes	No
Total	5	2	3	3

Changing Programs to Promote Equality

The final step in using this gender lens is to identify changes to programs that might facilitate the promotion of women's equality. Once programs have been

implemented, it is important to monitor them to determine whether they promote women's equality. In other words, the work of ensuring that interventions promote women's equality does not stop with design or implementation, but rather continues with monitoring.

In determining whether or not programs promote women's equality, it is not adequate to look only at program outcomes--we must also look at what is often invisible labour required to deliver programs (Balka, 1997). For example, the success of the school milk program rested on women making sure that milk was available, distributing the milk to students, and collecting money to pay for the milk. Once programs are implemented, they must be monitored in order to determine whether the programs had a positive effect on women's equality because women's equality is a pre-cursor to women's health (World Health Organization, 1998). Monitoring must take into account the time women spent implementing programs, since time they spend caring for others is time they cannot spend caring for themselves.

Several of the programs introduced through the Heart Health Project might be altered to better meet the needs of women with the insights that additional data collection undertaken in the context of post-implementation monitoring could yield. For example, as a part of each program, data could be collected about the gender of those who participate in a program. This could be applied to the Heart Smart Restaurants and the basketball court. Researchers need to collect data that allows them both to study the effects of interventions on women and to determine if any gender-based differences exist (Messing, Stellman & Siriann, 1998). Below I describe how the inclusion of data collection that disaggregates male and female data could improve our insights about the

extent to which programs developed in the three communities investigated here met the needs of women and, as a consequence, promoted women's equality.

In the Heart Smart Restaurant program it would be interesting to determine if the restaurants determine serving sizes by the needs of men or women. To promote physical activity of young and older women, one needs information about who uses what types of recreation facilities. Therefore, for example, we might begin by asking who uses the basketball court and whether or not this is a physical activity in which girls engage. If it is determined that girls do not use the basketball court, the next step would be to determine whether social constraints could be removed through programming. For example, if it were determined that young women do not play because men dominate the court, then the introduction of a program (e.g., women get court priority on Tuesdays) could address this constraint. If basketball is not an activity popular amongst girls and women, a next step would be to determine in which physical activity girls and women engage (i.e., aerobics) and to search for ways of supporting programs targeted towards meeting women's needs.

If information about who organized and delivered the school milk program was available, then information about how such programs are delivered (i.e., by whom) could be acknowledged, which is an important feature of maintaining one's self esteem and health. Similar information about how programs were implemented and delivered was lacking in other programs. This information is needed, in that knowledge of who contributed to making programs happen can lead to the acknowledgement of those contributions and can also serve as a basis for examining whether work is equitably shared. The cost of activities might be a barrier to some women and although one cannot eliminate all barriers, one must be aware of the different programming needs.

FINDINGS RELATED TO FACTORS THAT MAY CONTRIBUTE TO THE DEVELOPMENT OF GENDER SENSITIVE PROGRAMS

Here I turn to the final objective of this research: the identification of factors that may have contributed to the development of gender sensitive programs. My findings suggest that women need only be present and not specifically aware of gender-based differences in order to develop programs that meet some of women's needs. I examined four factors to determine what role women might have in producing gender sensitive programming: the reasons people got involved, how they learned about heart health, the influence of professional education on awareness of men and women's experiences of CVD, and the cohesiveness of the group.

To be funded by the provincial heart health project, all community projects had to address three of the four risk factors identified in the Newfoundland Heart Health survey: smoking, lack of exercise, high blood pressure, or high cholesterol levels. The provincial project had as its target population all the citizens of the province. During the research, key informants identified additional criteria that their projects had to meet. For example, in Beard, the heart health projects had to bring in jobs. In Top, one objective was to get an exercise program for larger women while in Cove, the objective was to introduce some healthy activities such as the Heart Smart restaurant program. All three projects met these objectives.

Given that Top had identified the needs of women as a reason to apply for funding, I had expected them to produce programming for women. In Beard, the funding application was pursued by two women both working for economic development groups, one a traditional organization and the other focussed on women in private enterprise. I wondered if the fact that the two people who had completed the grant application were

women, one of whom worked for an agency focused on women's needs, might have led them to focus the heart health project on women. This was not the case. However, it did bring a paying job into the area, a goal of both the women who developed the grant application. In fact, all three heart health project communities investigated here were very clear that their programs were geared towards the entire community and not targeted specifically towards the needs of women. Each site offered programs that were gender sensitive.

The first factor I looked at was how the committee members became involved in these projects. First, committee members became involved with projects through their jobs with the public health system. Second, committee members became involved as volunteers with the project. In Beard and Top there was a third option: committee members became involved through a job with the project. The Cove project had no paid staff.

I found that in all three sites, the staff from the public health agency had chosen to be involved with the project and had enjoyed the opportunity. It was a unique experience for them because this was the first such partnership between community-based volunteers and paid public health staff. In Beard, one key informant had the heart health project included as part of her work as a public health nurse. Public health staff in both Cove and Beard saw this as an opportunity to do something different from the regular health program. A key informant in Top explained this process:

When the notification went out to the Community Health Units that there would be money for Heart Health Projects, one of them came across my desk. I had worked in Public Health since 1981 and this was the first time

that there would actually be new monies to have a project around a certain health concern.

The personal reasons the volunteers provided for getting involved with the heart health project fit into five categories as seen in Table 3.6. These were: a chance to improve their own or their family's health, an opportunity to learn, membership on the board of a sponsoring organization, a chance to do good work, or, they were asked to be involved.

In both Cove and Top, some volunteers said they became involved for their health or the health of their family. This was the only factor mentioned in more than one community. In Top, women were members of the organization sponsoring the heart health project. One goal of the sponsoring organization was to improve the lives of children and their mothers through the provision of childcare. Those women had experience with projects designed to improve the health of women. In Top, women who had a commitment to women's health (through their membership on a sponsoring organization or through a desire to improve their own or their family's health) dominated the volunteer members of the groups.

In Cove the major reason people gave for why they had gotten involved in the heart health project was that they were asked to be involved by a town councilor, who was a major player in this site. The opportunity to learn was mentioned as a reason for involvement by three women in Beard. This site recruited people interested in learning skills, such as how to conduct a needs assessment through a survey, how to run a lifestyle clinic and how to measure someone's blood pressure.

TABLE 3.6: REASONS VOLUNTEERS BECAME INVOLVED

REASONS	BEARD	COVE	TOP
Own or family's health	Nil	2	1
Opportunity to learn	3	Nil	Nil
On board of sponsoring organization	Nil	Nil	2
Good works	Nil	Nil	1
Asked to be involved	Nil	3	Nil
No answer	1	Nil	Nil
Total respondents	4	5	4

Although clearly women followed several different trajectories in becoming involved with the Heart Health Projects, an area warranting further investigation is whether differences in the trajectories had any impact on the programs developed by the projects. Cove and Top were the two heart health projects that had a greater number of gender sensitive programs. Further research might reveal that a woman's desire to improve her or her family's health helps to implement gender sensitive programming.

The next factor looked at was where the key informant learned about heart disease. When asked how they had learned about heart disease, key informants named four sources of information including a family history of CVD, professional education, contact through the Heart Health Project, and contact through the media. Some informants did not respond to this question. Table 3.7 lists key informants' sources of information on heart disease.

With the exception of the public health staff in Top, all key informants had a family history of heart disease. This personal experience with CVD is a major reason people became involved in a heart health project. The public health staff in all sites acknowledged the role that their professional education had played in their learning about heart health but they also named another source such as either family history of CVD or

the heart health project as their main source of information. One public health staff member in Beard said that when her father had a heart attack she had learned the most about CVD.

I learned about it professionally. But I really learned about it last winter when my father took a series of heart attacks. When you have personal experience with an illness, whether it is heart disease or any other, you're a person first. Your professional knowledge goes out the window, somehow. You're a sister or a mother or a daughter or a niece or whatever, first. So that's when I got my in-depth information.

Two volunteers mentioned the media as a source of information about heart disease. One health professional credited the heart health project as her major learning experience.

And [*at Specific University*] we did a course on communicable diseases and we did another one on chronic diseases. I remember learning a little bit about heart health then and doing a couple of small projects. I think my major learning with it came around the project.

TABLE 3.7: SOURCES OF INFORMATION ON HEART DISEASE

SOURCE OF INFORMATION	PUBLIC HEALTH STAFF			VOLUNTEER			PROJECT STAFF		
	Beard	Cove	Top	Beard	Cove	Top	Beard	Cove	Top
Family History of CVD	1	1	Nil	1	4	2	1	N/A	1
Professional education	1	2	1	Nil	1	Nil	2	N/A	Nil
HHP	Nil	1	1	1	3	Nil	Nil	N/A	Nil
Media	Nil	Nil	Nil	1	2	1	Nil	N/A	Nil
No answer/ No Source	Nil	Nil	Nil	1	Nil	1	Nil	N/A	1
Total People	1	2	2	4	5	4	2	N/A	2

Note: Key Informants could give more than one response, HHP=heart health project

Previous family experience with CVD is a factor in why people became involved with the heart health project. I found no pattern relating this variable to gender sensitive programming. If the data on people becoming involved due to family history of heart disease were given to all the heart health committee members then it could be used a basis to provide them, as women, with information on their own risk of heart disease and, thus, they might be open to programs for women such as themselves.

In three cases, evidence suggested that some key informants with health professional education (i.e., registered nurses or nutritionists) had some understanding of the differences in men and women's experience of CVD (see table 3.8). However, no evidence implied that an understanding of differences in occurrence, diagnoses or treatment of CVD in women was used in program development. According to Kantar's (1977) work, this is not surprising because in both Beard and Top the representation in both groups was skewed, meaning people unaware of gender difference in CVD dominated the groups.

In the third case (Cove) which was a tilted group, the dominant number of key informants were unaware of gender differences, but a minority of 28% were aware of them. Cove did host three gender sensitive programs. Having 28% of the group (a tilted group) aware of gender differences allows for the creation of allies and coalitions in which the minority can affect the culture of the group. Unfortunately, I did not go back to the community with this finding. If I had, I might have been able to see if the people who were aware of gender differences created allies and coalitions to facilitate the use of gender sensitive programming. In Cove, one of the two people aware of gender differences was a volunteer and the other was a paid staff person with the health care agency.

TABLE 3.8: AWARENESS OF DIFFERENCES IN WOMEN AND MEN'S EXPERIENCE OF CVD

KEY INFORMANTS (KI)	NUMBER OF KI	KI AWARE OF DIFFERENCES		
		Beard	Cove	Top
KI without health education	4 Beard 4 Cove 6 Top	Nil	Nil	Nil
KI with health education	3 Beard 3 Cove 2 Top	1 of 3	2 of 3	1 of 2
Total interviewed at site	22	7	7	8
% of KI not aware of difference		85.7	72	87.5
Type of group		Skewed	Tilted	Skewed

The committee members of the Cove HHP were a tilted group based on awareness among women educated as health professionals of the differences in men's and women's experience of CVD. Cove had three gender sensitive programs, walking clubs, exercise classes, and the women and heart health session. But this community had the most secure financial basis (being next to a national park) and level of income is related to health status (Federal, Provincial, and Territorial Advisory Committee on

Population Health, 1996). Top also had three gender sensitive programs but had a skewed group and had the lowest level of income of the three projects. A person had to be eligible for subsidized public housing to be living in the area of the Top HHP. It may be the outcome of gender sensitive programs can be reached by several approaches, such as having a tilted group. While the TOP HHP did not have this knowledge they did have the experience of working together for women's health.

What role did cohesiveness of the group have in facilitating gender sensitive programs? In Top, members of the sponsoring organizations had a history of working to improve their own lives through their Tenants Association and their childcare initiatives. In Cove, community members created a group and maintained it for the entire heart health project. These groups appear to be places where the women felt comfortable to raise ideas based on their own experience.

In the Cove case study, the women talked about how they kept people involved in their heart health committee. In this case, people had been invited to join the heart health project and stayed the entire five years. The heart health meetings were seen as a place where they could contribute their ideas, where they could learn, where they could see friends, and where it was important to be. Each of these is discussed briefly below.

A place to contribute one's ideas. Several of the key informants spoke about how the heart health meetings were a place one could speak, be heard, and have one's ideas implemented. The chair of the committee said,

I think it was, I just let the meeting flow and let everybody do their thing.

If we were having some kind of an activity for the community, I would let the committee come up with the ideas and let everybody express their

opinions. No matter how outrageous it was, go ahead and do it. Let everybody feel that they were involved, instead of sitting there and saying, no, this is how we do it or that is how we do it. Let everybody do their own thing.

Another committee member described the meetings thus:

Well, we all agreed. We probably asked each other and discussed it in a meeting. It was just yes or no (if we were going to have it or not). There was never any arguing. Everybody got along. We had great meetings, I must say. If we did not like something, we spoke up, said our piece.

Another key informant's comments on the meetings were: "We just decided among ourselves. We did not vote on anything. Someone came up with an idea and we discussed it and then and probably added a little bit more to it."

A place to learn. The meetings were seen as a place to learn and the women enjoyed learning.

There was a girl that used to come in from New York Community Health. She attended many of our meetings and she brought in many ideas. And you felt, if you missed the meeting well, you missed some points that she was bringing us.

A social place. The heart health committee meetings were places where friendships started and then were nurtured. When committee members travelled to events outside their town, it gave them another opportunity to cultivate their relationships as well as learn new things. One woman emphasized the social aspect of the meetings.

It was a social afternoon. Catch up on gossip; eat low fat muffins in a

relaxed atmosphere. We did our business so everyone could speak. Very informal. We became friends. We did a lot of activities outside the community as a group and we took turns going to them.

An important place to be. These meetings were seen as important and it was important to get as many as possible to them. Before each meeting, the secretary phoned each person on a list to remind them of the next meeting. The time for the meetings had been changed to meet the needs of the committee members.

We made sure they knew about the meeting. Phoned them at home on a personal level. Women made them feel important. If you were invited to be a part of this group, it was important.

Yes, they changed then and had it 7:00 in the evening, which was better for the working women. I was working and I could not get to any of the lunch ones. I used to feel left out when they had them at lunchtime.

The key informants in Cove raised the topic of the importance of the group in their lives. Because I was unable to analyze any of my data from Cove before doing the interviews in other places, I did not follow up this thread in the other two case studies.

So far, I have presented my findings on several factors I thought might influence the development of gender sensitive programming. The first factor was how committee members became involved in the heart health project. From the volunteers in Cove and Top, some data suggest that the desire to improve one's health or one's family health might contribute to gender sensitive programming.

Looking at the data on awareness of the differences in men and women's

experience of heart disease according to Kanter's model, I found two skewed groups (Beard and Top) as defined by lack of awareness in difference in men's and women's experience in heart disease, and one group (Cove) that was tilted (see Table 3.11). In the skewed cases, people unaware of the differences dominated the groups. In the tilted case study, the potential existed for the development of allies and coalitions but I did not find any evidence that this occurred.

Both the Cove and the Top case studies suggest that a cohesive group existed in these locations. In Cove, this data came from the key informants who raised the topic of how much they enjoyed the meetings and wanted to attend. In Top, the group had a long history of working together on several issues including lack of childcare and tenants' issues. The existence of a group that met women's needs may have been one of the factors that allowed for the development of gender sensitive programming.

Other factors that might contribute to gender sensitive programs

So far I have analyzed four factors to determine what role they might have had in producing gender sensitive programming: the reasons for which people became involved, how they learned about heart health, the influence of professional education on awareness of men and women's experiences of CVD, and the cohesiveness of the group. In addition, my research documented three strategies that the three projects used to get the people to participate in programs including: (a) a needs assessment; (b) the use of personal contacts to encourage participation; and (c) scheduling events to avoid timing conflicts. Each of these strategies is discussed briefly below. These strategies might be factors that contribute to gender sensitive programming.

Needs assessment. All three sites conducted a needs assessment. In Beard, five

female members of the heart health project were trained to do a survey. Then they were responsible for administrating the survey in the five communities where the project took place. In Cove, the survey was delivered to people's mailboxes and then students went door to door to pick them up. In Top, the Tenant's Association had completed a needs assessment before the project. The Top assessment identified the need for an exercise program for larger women. All the sites used the information from these needs assessment surveys to design their programs. One woman in Beard gave a clear example of a program's feature designed to fit the people's needs.

We looked at the area that we were in geographically and the age groups that we were dealing with. A lot of the people in our communities were older, so we did not pick activities that were too vigorous. Financial status was not great. So, we had to pick activities that people could afford to participate in and activities that we felt that people would be able to carry on after the project ended, such as walking.

A review of the needs assessments to see if people asked for information on tobacco or for programs to help them stop smoking would be useful. The data I have indicates that smokers did not ask for this programming; rather, non-smokers thought it would be a good idea.

Personal contacts. Each site used personal contact to involve people in programs. In one community, the paid coordinator made contacts by phone and through home visits. One coordinator described her process this way:

Oh yes, I was always calling Annmarie. What can I do to get those ladies here? Whether it is the time of day, childcare, make sure they are

informed. I would be calling people up and reminding them, do not forget.

Maybe that was too much, but again, I wanted to get them over here. And

I was doing whatever I could think of to get them over here.

Scheduling programs to avoid timing conflicts. In each community, the heart health committee scheduled programs to avoid conflicts with other organizations' events. This was seen as an important strategy to encourage attendance at Heart Health Programs. Eva said, "We had several projects on the go at that time. It was a matter of scheduling. Scheduling the times that would fit into when people would be available."

In summary, the three projects used three strategies to get people to attend programs that I think may have had a role in producing gender sensitive programming for women. I expect that women mostly completed the needs assessment survey and therefore programs were designed based on women's expressed needs. Because women made the personal contacts to encourage participation by phoning other women, they had added encouragement to attend that the men would not have had. The final strategy was to schedule programs to avoid timing conflicts. Because the women were the ones providing the information on other scheduled events, would they have had information on activities that men mainly attended?

SUMMARY

Here I have summarized findings by case study. The sample of key informants in two of the three case studies was uniform for gender, according to Kanter's (1977) typology. Only Top had a male as a key informant. In fact, the decision-making bodies in all three case studies were uniform in that for most of the life of the heart health projects the decision makers were all women. The demographic information was similar in the

three cases since all the volunteers were married women and the only lone people came to the project as part of their paid employment. One gender sensitive policy was identified.

The three heart health case studies were very successful in getting women to attend their many programs. However, key informants in all three projects were very clear that women were not a target audience. Men did not attend in large numbers and each heart health project developed strategies to encourage male participation. Even though programs were not targeted to women, they did deliver programs that were found to be gender sensitive. Of the seven programs that I had sufficient information to evaluate with the gender lens, four were found to be gender sensitive. Suggestions were made to make the other three programs gender sensitive. The last section of this chapter explored four factors that may contribute to the development of gender sensitive programs. These factors are a family history of CVD, a desire to improve health either one's own or one's families and the experience of a cohesive group. A tilted group where some people had a professional health education background may also be a factor.

It remains to discuss the strengths and limitations of my research design and my findings as compared to the research literature. As well, I will identify issues for the Newfoundland and Labrador Heart Health Program and potential future research. Finally, I will discuss implications for community health practice.

CHAPTER 4 DISCUSSION

This chapter discusses my research findings. In the first section, the strengths and limitations of the research methodology used in this study, which included the application of a gender-based analysis, are discussed. Subsequently, research findings are discussed in relation to the research literature. Implications for healthy public policies in the Newfoundland And Labrador Heart Health Project are presented along with suggestions for future research, and implications for community health practice. The chapter ends with a summary of the thesis.

STRENGTHS AND LIMITATIONS OF THE RESEARCH

Research Strengths

The main strength of this research is that it documented a common experience of women in community health organizations, and sheds light on both how their presence influenced programming for women and why women get involved in community health initiatives.

Women as Decision Makers in Community Health Initiatives

I decided to investigate community heart health projects because I believed that having women as the majority of decision makers in a community health project was atypical. However, I subsequently discovered that this was not true. Both men and women volunteer, but they volunteer in different sectors. This results in gendered voluntary organizations (McPherson & Smith-Lovin, 1986). Women are the main providers of health care in the home, in the formal health care system (Federal /Provincial /Territorial Working Group on Women's Health, 1990), and in community volunteer

health organizations. Women are the decision makers in voluntary health organizations. Men volunteer in different agencies, such as community firefighter and service organizations such as the Rotary Club. The heart health project was reflective of the norm (where women comprise the majority of volunteers in a health organization) rather than the exception. As one key informant in Beard said “My perception here and that's typical in almost anything related to health, women tend to be the caregivers and the nurturers and tend to be aware of those things and want to be involved.”

In the research literature about women’s empowerment, I found nothing about the impact of women in senior decision-making positions in traditional health organizations. Researchers have focussed their work on documenting the absence of women in senior positions such as world leaders, corporate executives, and university professors (Wenneras & Wold, 1997). I was unable to locate any Canadian studies that looked at the impact of having women in decision-making positions in either voluntary or paid positions, inside a health care organization.

A strength of this study is that it looked at a common experience of women volunteering in a community-based health care organization which had not been done before. I found that the presence of women in decision making positions in community health programs does lead to some programming that is sensitive to the needs of women.

Women’s Engagement with Community Health Initiatives

The use of a qualitative research methodology to investigate the role of women in community heart health projects contributed to our understanding of why women get involved with community health initiatives, because they were able to tell in their own words why they got involved and what they enjoyed. The key informants were able to

suggest to me who to interview and to tell me things I did not know to ask about. When I started this work, I had assumed that women would be involved as volunteers in community health initiatives for their own health. This assumption was based on my experience working with activists in the women's health movement, and my belief that things had changed since the early 80s when women were involved in the Women's Health Education Project (WHEP). With WHEP, women clearly enjoyed sharing information about their own situation with other women and I assumed that in the twenty years that had passed since WHEP that women were now able to invest energy in their own health. Thus, at the onset of this project I expected that women had gotten involved with the community heart health initiative out of concern for their own health. However, through this research it became evident that women's knowledge of heart disease came through a family history of heart disease, and women's involvement in community heart health programs often grew out of concern about family members' heart health status, rather than out of concern for their own health status. Thus if community-based health initiatives are to improve women's health they will have to educate women about why they are at risk for CVD and provide more programming that addresses their health. Having woman as the majority of decision makers does not mean they have the desire to develop programs to meet women's health needs.

Women Decision Makers and Gender Sensitive Programming

I started this research thinking that having women as the majority of decision makers in a community health project would produce a positive outcome for women. According to Kanter's (1977) work, having a majority of like-minded people in decision-making positions would allow the development of policies that the decision makers

wished to make. I had assumed that women had gotten involved in the Heart Health projects to improve their own health or to address the health needs of other women and thus would develop policies and programs for women. However, this was not the case. Two people said they had gotten involved with the heart health projects to improve their personal health. No one said she had gotten involved to work for women's health in general. Even in Top, where key informants said they applied to the provincial heart health project to get funds to provide an exercise program for larger women, the women did not say women's health was the reason for their involvement.

Two women working in different economic development associations had developed the original grant application in Beard. One woman worked for a development association and the second woman worked for a group that was developing the economy by focusing on women. Those two women saw the heart health project as a way to bring a paid job into the community. The project was successful in doing that, and two female nurses obtained the paid position. Having an income is certainly one road to better health. However, in both the planning that went into securing funds for the paid position, and the hiring for that position, I uncovered no evidence that the decision makers defined that they were doing something for women. Fortunately they produced programming that benefited women without this awareness.

Polls and surveys over the last 10 years have found that women do not define heart disease as a health problem for women (Collins, Hollander, Koffman, Reeve, & Seidler, 1997; Coutts, 1995; Fayerman, 1999). If women do not define heart disease as one of their own health issues, then few women will become involved in the heart health project out of concern for their own health. Thus, projects that have as their objective to

improve women's health will have to design and develop programs to move women from caring for others to caring for themselves. This was done in the Newfoundland Heart Health project, when the women produced the Women and Heart Health resource kit. The writer said that women are often so busy taking care of other people, such as their spouse, their children, and older relatives that they have little time or energy to care for their own health. Facilitators were advised that they must consider the pattern of a woman's life and the role that a woman's responsibilities play in the decisions that she makes.

Responsibility for childcare or care of other relatives often means a shortage of time.

This, combined with lack of social support may hinder a woman's ability to participate in programs. The manual further suggests that facilitators schedule information sessions at times that are convenient for most women. The resource kit was used only once, thus the information was not available to the women who attended the three Heart Health Projects. Additional strategies will have to be employed to promote this resource kit such as giving workshops at educational meetings for public health staff and training workshops for community volunteers if it is to be used.

If community-based programs are going to be successful, then more programs will have to be targeted to gender. Men and women will have to produce programming independently. One way to do this may be to work with organizations that have a membership that is predominately one gender or the other. In Beard and Cove the volunteer firefighters were all men. Volunteer fire fighters exist in most communities as home owners cannot get fire insurance without their existence. For women, there are several possibilities including church auxiliaries and the Women's Institutes

Research Limitations

Although the research design pursued here yielded valuable insights about the impact of women in decision making capacities in community health initiatives, the research design also had some shortcomings. In particular, there are limitations related to data saturation, member checks, and the timing of the data collection.

Data Saturation

Resource limitations related to the costs of travel to remote communities necessitated that all interviews were conducted before any data were analyzed. Consequently, there was no opportunity to refine the interview instrument to collect additional data, based on the analysis, that might have enriched the findings. This resulted in a lack of data saturation, which is a key feature in qualitative work. Schreiber (2001, p. 66-67) defines data saturation thus: "Saturation, often called "theoretical redundancy," occurs when the categories and theory are fully explicated and no new information about the core processes is forthcoming from ongoing data collection. This may not happen until late in the final write-up because it is in committing the theory to the page that the researcher may discover gaps in the data. When this happens, the researcher must identify the best sources of data to answer the questions that will fill these gaps. Sometimes graduate committees, especially at the masters level, limit the scope of a study for purposes of completing a program. One example that illustrates the benefit that might have resulted from additional data has to do with the limited information about the three strategies (the needs assessment, the personal contacts, and the timing of programs) that all three projects used. Because the significance of these strategies was unknown at the

time of the interviews and this information was not probed for, the research undertaken here cannot add to our understanding of the role played by those strategies in getting women to participate in programs.

Member Checks

Some (Morse, et al. 2001) suggest that after data are analyzed, findings should be shared with the key informants to see if the analysis matches their experiences. I did not do such member checks. My finding that women who were educated as health professionals were more likely to be aware of the differences in women's and men's experience of heart disease would have been an excellent thing to check out with the key informants. In Cove, two women with professional health education (a volunteer and an employee with the public health agency) knew about differences in women and men's experience of heart disease. Two other women brought in the program about women and heart health. Had member checks been undertaken, I could have asked those women if they could remember how the decision was made to present the program about women and heart health, and if any objection had been made to their having the session. Further probing about whether or not the two women who had health education created an alliance with the women who suggested the program, might have given me more insight into the usefulness of Kanter's (1977) model, which suggests like minded people create alliances in decision-making processes.

My research instrument included questions about how decisions were made about programs, but I got very little information in response to questions on this topic. When I asked people to respond to these questions, they often said it was too long ago to remember that level of detail. Member checks might have allowed me to jog memories

with my interim analysis. This speaks to another limitation of the research reported here: the timing of the data collection.

Timing of the Data Collection

Another limitation of the design was the timing of the data collection. I did my interviews in the fall of 1997 and the winter of 1998, after the demonstration phase of the Newfoundland and Labrador Heart Health Project that ran from 1991 to 1996. In all cases, I was asking key informants to remember what had occurred more than five years earlier. When asked about the decision-making for individual programs, the key informants found it very difficult to remember that level of detail from that long ago. This form of data collection would have been more fruitful if done closer to the time the decisions were made because people are more likely to recall recent information. If this research had been done during the demonstration phase, then the research findings would have been available to the heart health projects. These findings might have been useful to the projects, as they might have used to acknowledge their success in getting women to attend, to refine their programs to better meet women's needs and to work with men's groups to better plan programs to meet men's needs.

Additional data about the needs assessments might have enriched the findings reported here. For example, if I had known the gender of the people completing the needs assessments then I would have been able to check if the current programs meet the identified needs. I would have also been able to comment on whether men's needs were not met because the program planners did not have input from men. However, because the needs assessments that were undertaken in the planning phases of the community heart health programs occurred up to a decade ago, none of that information could be

located by the communities at the time the research reported here was undertaken.

DISCUSSION OF FINDINGS RELATED TO STUDY OBJECTIVES

Women were the primary group who attended the heart health programs explored in the case studies reported here. This was an unexpected result since there was little program planning specifically for women. The only planning that took gender in account was done to encourage men to attend heart health program activities. For the most part, heart health program planning was not based on discussions about women's health or knowledge of the differences in women and men's experiences of heart disease.

Using a gender analysis tool (Muzychka 1995), five programs were determined to be gender sensitive: the exercise classes, the walking clubs, the community kitchen, the women and heart health session, and the healthy baby club. Because this was an exploratory case study, potential factors that might lead to the development of gender sensitive heart health programs were identified.

Differences in Women's and Men's Experience of CVD

This research showed there was little awareness of the differences in women and men's experience of heart disease in three community projects of the Newfoundland And Labrador Heart Health Project. The only people who were aware of these differences were women educated as health professionals. This is consistent with the research literature that women are not aware of their risk for cardiovascular disease. There has been concern raised that the gender of the patient affects the access to and use of medical care (American Medical Association Council on Ethical and Judicial Affairs 1991). The lack of awareness among some physicians of women's risk for CVD has been discussed

in the literature (Heart and Stroke Foundation of Canada 1997). The fact that physician refer fewer women than men with CVD for exercise rehabilitation (Wenger, et al. 1993) has been documented. This decreased awareness must be acknowledged and then addressed. Providing women and health care providers with information about women's risk of CVD must be done if we are to reduce the morbidity and mortality rates of CVD. Some writers (Gijsbers Van Wijk, et al. 1996) have been more specific and said gender sensitive courses on women's health should be provided to health care providers.

Gender Sensitive Healthy Public Policies

I planned my research to look at healthy public policies for two reasons. First, the Newfoundland and Labrador Heart Health provincial project had a committee concerned with the development and implementation of healthy public policies. This committee facilitated a booklet Making public policy healthy (Hanrahan, 1994) and developed a workshop to use it. Second, the sustainability study (Neville et al.) looked at the existence of healthy public policy as an indicator of sustainability. Given that none of the Newfoundland community projects had initially intended to produce policies it was amazing even one was implemented. Thus, although an objective of this research was to determine the impact that having women as the majority of decision makers had on gender sensitive policy development or implementation, a dearth of policies necessitated that the focus of this research be expanded to programs.

Gender Sensitive Programs

Another objective of this research was to identify any programming that took place that reflected efforts to adapt to the difference in men's and women's lives, or, to

phrase it another way, to determine if there were any gender sensitive programs. I used a gender lens (Muzychka, 1995) to assess gender sensitivity. However, in many instances, I had not gathered enough data to apply the gender lens. This occurred because I initially thought that there would be policies and programs that were explicitly focused on women. However, only one policy was developed within the case study communities, and few programs were developed that focused explicitly on women. Thus, during analysis, I considered whether all of the programs developed in the case study communities were gender sensitive, according to the criteria laid out in the gender lens.

Williams (2000) discusses gender-based analysis in Canada. Gender-based analysis is a set of tools developed by governments as a mechanism for them to document how they are improving the situation for women in their countries. Williams interviewed women from across Canada in search of examples of policies or programs that had been developed using gender-based analysis. She discovered that while gender-based analysis is discussed in various provincial and federal government documents and that training sessions concerned with gender sensitive policy development have been conducted, the development of policies that have used a gender-based analysis has been almost non-existent.

Williams (2000) cites several women who mentioned the same example, the changes in the Employment Insurance Act introduced by the federal government in the late 90s. They asked whether the new legislation had been subject to any gender-based analysis. It is a matter of record that a Member of Parliament said that a gender-based analysis had been done showing the legislation more "favourable" to women than men, because men's benefits would be reduced more than women's benefits, and because the

new hours-based system would allow more part-time workers, most of whom are women, access to benefits. A later review of the impact of the legislation, however, found that fewer women and young people qualified under the scheme than the government had claimed had been subjected to a gender-based analysis. In this example gender-based analysis was not used during the development of the policy rather it was applied after legislation had been introduced in the House of Commons. The application of the gender lens subsequent to policy or program development can be problematic, and is certainly less desirable than applying the gender lens during policy or program formation.

Other programs might have been gender sensitive for women, but limitations inherent to the data made it difficult to make such a determination. An example of this is the Heart Smart Restaurant program. According to W. Clarke (personal communication, April 2001) of the Canadian Heart and Stroke Foundation, the Heart Smart restaurant program has not been evaluated by gender of user. The gender of the people using the basketball court was another example where data about the gender of program users was not collected. The school milk program did not affect women predominantly in that both boys and girls benefited from the existence of the program. However, it is unknown who administered the program. This was most likely a woman's job and thus took time that the woman could have spent caring for her own health. Nonetheless, application of the gender lens to the programs developed in the case study communities did allow us to identify four programs and one policy that were gender sensitive to women: the exercise classes, the community kitchen, the women and heart health sessions, the healthy baby club and the walking clubs. It is of note that the community of Top was the most financially disadvantaged of the three communities (in that one had to be eligible for

government assisted housing to live there), and the community of Port was the most advantaged (as there were employment opportunities there). Both of these communities had the same number of gender sensitive programming.

Programs That Did Not Work

In the case studies, the programming concerned with smoking cessation did not work. The authors of the Newfoundland and Labrador heart health survey identified smoking as a risk factor for heart disease. When the funders developed the criteria for the community-based programs applicants were required to address three of the four risk factors identified in the heart health survey: lack of exercise, high blood pressure, use of tobacco, and cholesterol levels. The three projects each had programming aimed at smoking cessation. Because I did not have the data from the needs assessments, I do not know if smoking cessation was raised in any of the needs assessments. I did not ask key informants if they smoked and only one person volunteered that she smoked. My understanding is that few of the decision makers in the three case studies smoked and that they were working to change other people's behaviour. This is probably an example of a program designed by people who were not the market for the program. An analysis was offered by a person from Top when asked why the smoking cessation program did not work:

We tried to push it as much as we could, looking at women and smoking.

Lucy had the different resource kits to help women to quit smoking and all the kind of thing. They were not ready. A lot of the community leaders who are women smoke and they wanted to quit. Some of them quit and started again. For whatever reason they were not ready to take that on.

Smoking was not something people in the case study communities wanted to change. Although chosen by all of the case study communities as one of the risk factors that would be targeted as an intervention with the heart health program funding, this risk factor was not of sufficient concern to program participants to engender their participation in large numbers. Program planners hoped the intervention would lead to smoking cessation among people in their lives (such as daughters or husbands). However, the program participants themselves did not share the desire to quit smoking, and thus in all of the case study communities, smoking cessation programs were poorly attended. As such, the smoking cessation programs were not successful. For programs on smoking cessation to be successful specific research on what works, with whom and how and to deliver them must guide program planning, monitoring, and evaluation.

FACTORS THAT MAY CONTRIBUTE TO THE DEVELOPMENT OF GENDER SENSITIVE PROGRAMS

This qualitative research set out to identify factors that might contribute to the development of gender sensitive programs. One of the findings of this research is that programs may meet women's needs, in spite of having neither been planned as women's programs nor having been thought of by program planners as programs developed specifically for women. Put another way, programs that meet women's needs can result from processes that do not set out to develop programs that explicitly meet women's needs.

This research has suggested several factors that may have contributed to the development of gender sensitive programming. These include the dominance of women in the heart health committees, how they learned about heart health, the cohesiveness of a

group, and knowledge of the differences in women and men's experience of CVD. Each of these is discussed briefly below.

Dominance of Women on the Heart Health Committees

Women dominated the heart health committees. According to Kanter's (1977) model, the heart health committees would have been uniform if all members had been women, or skewed if committees had been numerically dominated by women. According to Kanter, in both uniform and skewed groups, women can control the decision-making process and produce outcomes based on their ideas. Was the greater prevalence of women on the heart health committees a reflection of Newfoundland culture where women and men live in gendered worlds with the responsibility for the family's health falling within women's domain? Heller (1986) documented the extent to which Canadian women perform the role of home guardian. She found that women assume the responsibility of monitoring men's health and emotional balance and, in most cases, of nursing them when they are sick. In contrast, she found most women reported that no one looked after them when they were sick.

The demographics of the members of the three case studies were similar. The volunteers were all married women. The few lone people came to the heart health committees through paid employment with either the project or the public health agency. Although demographic information was not kept about the people who attended the programs, key informants consistently indicated that the majority of program participants were women. The vast majority of women in these communities are married, so it would not be an unreasonable deduction that the people attending the programs were similar to program designers in gender and marital status.

In an effort to discern whether women outnumbered men as heart health program participants because the programs better met their needs, several computerized literature searches were conducted to see if there were any data about the participation rates of men and women in community-based health programs. In the mainstream health literature, the gender of people involved in community-based health programs generally is not mentioned. There is still a problem in identifying gender as a factor worthy of documentation in health research. In 1996, the Pan American Health Organization produced Health Promotion: An anthology. In their chapter titled Community-based approaches to health promotion: Guidelines for community mobilization, Pancer and Nelson (Pan American Health Organization, 1996) said they chose to write about CVD because it was the leading cause of death in Canada. In the fifteen-page article, the authors summarize five community-based heart health promotion programs (the North Karelia Project, the Stanford Heart Disease Prevention Program, the Pawtucket Heart Health Project, the Minnesota Heart Health Program, and the Pennsylvania County Health Improvement Program). Gender is mentioned once if you count the listing of the Housewives Club as a community-based organization in the North Karelia Project.

In contrast, The Canadian Heart Health Initiative Process Evaluation of the Demonstration Phase (2001) mentions gender. In this report, women are identified as the target group in 7% of all projects. Women are identified as a sub population (along with school-aged children, farm communities, and rural populations) that were the focus of educational resources. Finally, the authors indicated that young females from low-income neighbourhoods were the target population for some physical activity initiatives. Because the gender of the people who attended the programs in any of the provinces is not

identified, it is impossible to know whether the predominance of women program participants is unique in Newfoundland or reflective of the norm in other Canadian projects.

Literature that would shed light on questions such as “do more women than men participate in health promotion programs?” appeared in publications dedicated to women’s health, such as Healthcare Women International, or Journal of Women’s Health, but were noticeably absent from more mainstream health publications such as Lancet. Articles that discussed heart health program participation failed to mention gender, and articles that addressed the participation rates of women in programs were rare.

In studies that appeared in publications dedicated to women’s health issues, women’s participation rates are reported and discussed. For example, in her study of older men and women with osteoarthritis belonging to a health maintenance organization in the USA, Gallagher (1997) found that men and women volunteered in proportion to their representation in the osteoarthritis population. In the same publication Women & Health, Collins, Hollander, Koffman, Reeve and Seidler (1997) report that women generally participate in worksite health promotion programs and use health education services more than men do.

There were a few articles such as Pratt, Hurst, Williams and Martin (1999) published in journals that were not focused solely on women’s health. Although the article by Pratt and colleagues appeared in a journal that was not dedicated to women’s issues, it should be noted that all of that article’s authors were women and their main focus was race. Pratt et al. reported that 46% of the participants in the cardiovascular

programs they discussed were men and 54% were women, and in the evaluation focus groups, 64% of participants were men and 36% were women. Although women participated in the programs discussed by Pratt et.al. (1999) to a greater degree than men, feedback about programs (through evaluation focus groups) came predominantly from men.

During the three-year WHEP, I came to understand the extent to which women and men in Newfoundland and Labrador lived in different worlds (Women's Health Education Project, 1984a, 1984b). When I began work on this thesis, I believed that the gendered nature of men and women's lives on the island of Newfoundland had changed in the twenty years since the WHEP, and that women's and men's lives would not be as separate in the late 1990s as they had been in the early 1980s. In conducting the three case studies reported here it became apparent that men and women still had very gendered lives in Newfoundland in the late 1990s. Men had their worlds, for example, as volunteer firefighters and players in dart leagues, and women had their worlds that revolved around the community center, for example. In Cove, one key informant said "I think a lot of times with men; they're off on their own. They are busy at something else. Some men don't need to know."

Another person in Cove said,

Well, a lot of the men had their meetings every Thursday for the fire department. They were all fire fighters, the type that would be involved.

Then another night they had a meeting for training. Then there were cards that they used to attend.

A person in Beard made a similar comment:

Well, if you look back through our group, it was mainly women who were on the Beard Heart Health Project. Not that it was limited to women, it is just women who applied. When we look at many groups in the community it is often you find men are on the volunteer fire groups and stuff like that. Some are on the town council. Overall, in many of the groups there are women.

One key informant in Beard spoke about men's lack of involvement in the programs.

The Center was open all day, from 9:00 a.m. to 8:30 p.m. People could go at their convenience. Decided to give the men an hour, but they stopped coming. Mostly we got women. Men did not seem interested. I do not know why. Men might think it is a women's thing.

A comment from a person in Top is consistent with the comments of the participants cited above from both Beard and Cove:

But it was mostly women. I think it was mostly women that used the Community Centre up there. I think it is the way this culture is here. That the men want to stay home in the evening whatever they are doing or go to play darts.

These quotes from key informants suggest that in the case study communities where this research was undertaken, that men and women still inhabit largely separate worlds. Women designed the programs, which thus suited the needs of women. Unfortunately, this research has not indicated whether the programs delivered stretched women's worlds enough to encourage women to care for themselves. The programs attracted women and those participants were most likely to be similar to the members of

the heart health committees. Because there is no data about the gender of the people involved in other provinces in the Canadian Heart Health Initiative, I am unable to say whether the greater participation rates of women in the heart health programs in Newfoundland are reflective of the norm. Findings do suggest that men and women in Newfoundland live in very different worlds, and that the activities related to the heart health programs were located in a woman's world. Although women participated in the programs and one could argue that the program produced some gender sensitive programming for women and very little for men, women's participation in the programs may well have reflected the contemporary Newfoundland culture that links men to some activities and women to others.

In two case studies, Top and Cove, women spoke of their participation in heart health program activities in relation to being in a group. Key informants in Cove were able to identify several reasons they had for wanting to attend meetings. They were a space where they could contribute their ideas, a place to learn, a social place, and an important place to be. The informants suggest that one of the benefits that accrued to women through their participation in program planning revolved around knowing that their ideas could be heard. Many women have the experience of their voices not being heard or their ideas listened to. To be in a group where you are heard is very rewarding as it was for these women. Kanter's model did not examine the importance of voice as a factor in decision-making.

The ability to learn new things was also raised by women in Beard as a reason they became involved in the heart health project. However, women had not learned in the heart health project about the differences in men and women's experience of heart

disease. Women sought the heart health project as a place to learn, and ironically, although they undoubtedly learned, they learned little about women's CVD.

The role of the needs assessment, of personal contacts, and of the scheduling of events in gender sensitive programming remains unknown. Future research should attempt to explore the relationship each of these factors played in the design and delivery of gender sensitive programming.

Informants had learned about cardiovascular disease largely through a family history. Building on this knowledge, the heart health project could encourage both men and women to assess their personal risk for CVD, as a means of encouraging further participation in heart health program activities. Some programming could then be designed to target the personal risk factors for men and women and emphasis could be placed on risk factors experienced to a greater degree by women, such as diabetes. Interestingly, the fact that diabetes is a risk factor for CVD experienced primarily by women was not mentioned by any of the key informants.

This research showed that when women were dominant on the heart health committees they did produce gender sensitive program. This finding is consistent with Kanter's (1977) model that suggests that a proportion of a group must be one third like-minded people to result in outcomes that reflect the beliefs and experiences shared by the like-minded people. However, the progression of the research (e.g., where all interviews were conducted prior to the start of analysis) was such that it was not possible to learn about the dynamics of other factors that may have contributed to gender sensitive programs.

IMPLICATIONS FOR THE NEWFOUNDLAND AND LABRADOR HEART HEALTH PROJECT

The findings of this research suggest that, if the Newfoundland and Labrador Department of Health and Community Services plans to continue programming to reduce the incidence of cardiovascular disease, then education about the gendered nature of men and women's lives must be provided to all involved. The distribution of a flyer to promote the Kit Women and Heart Health: Take Care of Yourself was not enough to encourage the female members of the community-based projects to use the kit. Further education about differences in men's and women's experiences of CVD would allow women to gain information that might allow them to (a) identify heart disease as something that affects them, (b) learn how to reduce their risk, (c) identify symptoms of heart disease, (d) educate their physicians, and (e) get treatment earlier (Stacey, 1997; American Medical Association Council on Ethical and Judicial Affairs, 1991). The heart health project has to be clear in its support for women to care for their own health. An understanding of the need for programs to be geared toward different citizens will have to be a part of the plan.

A gender lens is designed to be used with the people who will be affected by a program, that is, the people delivering and maintaining it, the people using the program, and the people funding it. It is of limited use after a program is in place. Without a mechanism for discussion about whether or not programs might meet the needs of women, and without opportunities to give information back to the stakeholders, the gender lens has limited value. If training on gender and using gender analysis tools were provided to project committee members, then the three projects might have seen the positive aspects of attracting women and the need to tailor the contents of programs to

women. Using a gender analysis tool might have allowed the members of these projects to reflect on who came to their programs and to acknowledge women's work in monitoring programs.

Even when they were not aware of it, the women's experiences allowed them to develop programs that met other women's needs. The research shows that women used their own experiences when choosing programs to organize and this experience was similar to the women in their community. As a result, they chose programs that suited women's needs. The lack of men in the decision-making process resulted in programs that did not meet men's needs, and thus few men participated. Men need to be involved in significant numbers to influence the development of programs and policies that will affect them.

This lack of awareness of gender issues --which affect women as well as men-- needs to be addressed in future programs that are being developed. This is called gender sensitivity training. People need to be made aware of how their experience influences their perspective of the world and thus how this influences the program they design. The use of a gender lens would allow the Newfoundland and Labrador heart health program to design more programs to meet men's needs. Although all three Heart Health Projects had strategies to bring in adult men, they were not very successful. One strategy to increase male participation would be to approach organizations that are predominantly men such as volunteer fire fighters. Such organizations might be interested in programming for their members as they need healthy members to deliver their fire fighting services.

The key informants in both Top and Cove were able to identify programs they developed for women, while the key informants in Beard could not name any such

programming. This finding suggests that this programming was not based on an awareness of the differences in men and women's experience of heart disease, nor was it based on any awareness of the differences in women and men's lives.

IMPLICATIONS FOR FUTURE RESEARCH

This research yielded a number of recommendations for future research. Further research might help understand why the women interviewed saw programming specifically for women as negative while they saw identifying strategies for men as positive. When I asked the questions about any programming that was produced for women, some key informants in all three communities told me that their programs were open to all the community. Having a program that was focussed on women was seen as exclusive and this was a negative feature. Yet all three HHPs had developed strategies to encourage men and none saw this has a negative feature. More research about the gendered nature of men and women's worlds would allow program designers to develop programs for each world. For example, if the maintenance of men's health is seen as their wives' responsibility then an understanding of what allows men to care for their own health would reduce or relieve women of the burden of this role, and free up time to care for themselves. This information would allow future programs to meet the needs of men in Newfoundland and Labrador, as well as the needs of women. Given that (a) one of the health determinants (Hamilton & Bhatti, 1996) is income and (b) gender sensitive programming was developed where there were low levels of income, then research on the ability of gender-based programming to improve health despite low levels of income might provide valuable strategy to improve women's health.

IMPLICATIONS FOR COMMUNITY HEALTH PRACTICE

The provincial heart health project was a federal/provincial funded project that used a community mobilization/development model. All the community professionals interviewed found it to be a positive experience, thus when considering future strategies to provide programming this model should be considered. A gender lens could be applied to all phases of programming from needs assessment, to the development of programs, to their implementation and evaluation. This would be one strategy to allow men and women to benefit from health promotion programs.

Sharing of research findings from this project could be provided to the public health agency staff. Education for health professionals on the differences in men and women's experience of CVD must be provided. This education is part of gender sensitivity training. The provision of gender sensitivity training would allow health professionals to examine their own practice to see if there is gender bias and to offer suggestions for change. This education might result in changes to the health professionals' practices thus assisting more women to get care earlier.

Community health practice must be based on research, thus only programs that work should be used. If new programs are developed, they must be evaluated to see if they produce the desired outcomes. This was a weakness in the area of smoking cessation in the NLHHP as successful smoking cessation programs were not implemented.

SUMMARY

In this research, I examined three community heart health projects in which the majority of decision makers were women. A gender analysis tool called a gender lens was used to determine whether the programs were gender sensitive. Overall, there has

been a general lack of success of gender-based analysis to improve women's situation in Canada. The research documented that the majority of people in three community projects of the Newfoundland and Labrador Heart Health Project were not aware of the differences in women's and men's experience of heart disease. Programs were implemented that allowed women to attend. Nevertheless, decision makers had little understanding of why women but not men participated in their programs.

This research determined that having women as a majority of decision makers in community heart health initiatives allowed for the development of some gender sensitive programs for women. Having women as the majority of decision makers in a community heart health initiative, however, did not allow for programs that were gender sensitive for men. Given the high numbers of men with CVD, the loss of productive work years, and the cost of providing treatment, the provincial governments will want to deliver heart health programs that will be meet men's needs. Thus the provincial HHP will need to work with target men's organization to get men to work on future HHP. Changes in the research design would have allowed me to gather more data and make the analysis more helpful in identifying the factors that might have contributed to the development of gender sensitive programs and in providing direction for future work.

Gender sensitive heart health programs were more likely to be developed when (a) people became involved through a desire to improve their family's or their own health (b) they learned about heart health through a family history of CVD, (c) they learned about the differences in men's and women's experiences of CVD through professional education, and (d) the heart health committee in the community was very cohesive. Researchers are looking for and finding differences in women and men's experience of

illnesses and health. This information has to be shared with community partners and health professionals if we are to have community-based programs that meet the different needs of men and women.

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APPENDIX A: LETTER OF INTRODUCTION

Letters were on MUN letterhead

Date

Address

Dear Ms:

You have been identified as someone who has been involved in the Newfoundland/Labrador Heart Health Program. We are a team of researchers who, in addition to working with our provincial heart health projects are combining our efforts to study an issue which cannot be easily answered using one province's information alone. The research question we are addressing concerns the means by which health promotion programs lead to environmental change supportive of health promotion at the community level.

We would very much appreciate your cooperation with our project. If you are willing to assist us, your participation would include the following. Wendy Williams, the research assistant, will call you within the next two weeks to set up a time for an in-person interview. She will send you a copy of the interview questions in advance so that you have a chance to see what questions will be asked. Wendy will also send you a copy of the interview notes so that you are comfortable that the information has been recorded accurately.

All information from the interviews will be kept confidential. We would prefer to tape record the interview and transcribe it later for data coding purposes, but if you are not comfortable with this, the interviewer can take notes. Tapes/notes will be kept

separate from identifying information of a personal nature. Your name will not be revealed in any publications or reports and information collected from nine communities will be summarized so that individual communities are not identified. If you are willing to be contacted by our research assistant, there is nothing you need to do now -- she will call you shortly to set up an interview time. Once you have been contacted, you still are free at any time to refuse to participate in part or all of the interviews and can terminate your involvement in the study by starting your wish to do so.

If you are not willing to be contacted, please complete the attached refusal to participate form and fax or mail it to us. If we do not receive this form, we will assume it is okay for us to contact you.

Thank you very much for your consideration of our request. We hope you are willing to assist us. We will be happy to make a copy of the findings of this study available to all participants upon completion of the study.

Sincerely,

Doreen Neville

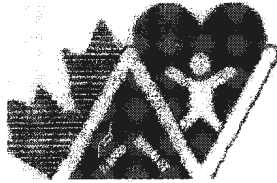
Principal Investigator

Fax: (709) 737-7382 Phone: (709) 737-6215

APPENDIX B: HEART HEALTH LETTER OF INTRODUCTION

Newfoundland and Labrador Heart Health

Government of Newfoundland and Labrador



Dear

On behalf of the Newfoundland and Labrador Heart Health Project, I would like to introduce Wendy Williams. She is part of a research team lead by Dr. Doreen Neville, studying the heart health projects here and in Quebec and British Columbia. The research is designed to determine what are the key factors and processes associated with sustained environmental change supportive of health promotion. Wendy plans to interview people involved in the provincial initiative as well as some of the community projects. Enclosed is a detailed letter about the interview process. The Newfoundland and Labrador Heart Health Project supports this research project and we hope you support it by agreeing to be interviewed. Thank-you for your cooperation with the research team.

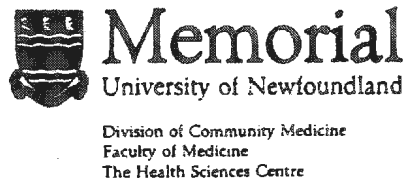
Yours

Catherine Donovan MD

Principal Investigator P. O. Box 8700, West Block, Confederation Building, St. John's, Newfoundland. A1B 4J6

Telephone: (709) 729-3939, Facsimile: (709) 729-5824

APPENDIX C: REFUSAL FORM



REFUSAL TO PARTICIPATE FORM

NHRDP GRANT

Doreen Neville, ScD, Principal Investigator

Dear Dr. Neville:

I have received an invitation to participate in your study concerning the means by which health promotion programs lead to environmental change supportive of health promotion at the community level. However, I am not willing to participate and do not wish to be contacted by research personnel from your study.

Yours,

Signature

Name (please print)

Province (please print)

St. John's, Newfoundland, Canada A1B 3V6 • Tel.: (709) 737-6693/6652 • Fax:

(709) 737-7382 • Telex: 016-4101

APPENDIX D: CONSENT FORM

RESEARCH ON SUSTAINABILITY IN HEALTH PROMOTION

INTERVIEW CONSENT

I the undersigned agree to participate in an interview for researching the question of sustainability in health promotion. In addition Wendy Williams will be collecting data for her master's thesis on the topic of gender sensitivity in Newfoundland Labrador Heart Health project. I understand that the interview will be taped recorded for transcription and analysis and that the tapes will be erased when the analysis is complete. I understand that only the research team will have access to the tapes and transcripts, that no participants will be named individually and that all information will remain strictly confidential.

I am aware that participation is voluntary and I have the right to refuse to participate or to terminate the interview at any time. I acknowledge receipt of a copy of the letter and consent form for my own records

Please sign below

Name

Date

APPENDIX E: INTERVIEW INSTRUMENT SUSTAINABILITY STUDY

Factors for Sustainability in Health Promotion

Newfoundland only

Community Person

Program Involved

ID Number

Introduction

1. What do you believe influences your personal health?
2. What control do you believe you have over your own health?
3. What do you believe influences the health of your community?
4. What control does your community have over its own health?
5. How did you get involved in the heart health project?
6. Describe your community's previous experience with health promotion or community development?
7. What is it about your community that helped or hindered the heart health project get started?
8. Did these community characteristics change over the life of the project?
9. One of the things I'm interested in is, who took the lead in getting the heart health project started. That person is sometimes called a program champion: - did you have such a person in your project?
10. Were there other people whose participation was important for the program?
Now I would like to ask you some specific questions about the project.
11. What information did you use to initially plan your program?
- How did you use X (X = for each information)?
12. What information did you use to actually carry out the heart health project?
- How did you use X (X = for each information)?
13. When you were planning the project, what did you think would come out of it?
14. Why did you think that?
15. Did your expectations about the heart health project change during the life of the project? How did they change?
16. Can you tell me about all the organizations that the planning group was in contact with when planning the heart health project?
17. During the project was the heart health committee in contact with the same organizations or different ones?
18. Were there other projects and issues in your community that competed with the heart health project for people's time and energy?
19. What happened early in the life of the project that either encouraged or discouraged you from being involved with the project?
20. Can you describe the coverage the heart health project had in the local media?
21. What kind of attention did the heart health project get from other groups in your community?
22. How did the heart health project provide recognition to the volunteers, paid staff and other supporters?

23. What feedback did you receive about how the heart health project was going?
24. How was this information used?
25. Can you describe how the citizens of your community participated in programs sponsored by the heart health project?
26. Now the funding is over, what has become of the original heart health committee or coalition?
27. Is there a new or different coalition that has been established that is concerned with heart health?
28. Are you aware of any organization in your community that has adopted an agenda promoting heart health, can you tell me about that?
29. This question deals with decisions or actions that are intended to have a positive effect on the heart health of people, for example building recreational facilities or anti-smoking regulations: are there any policies like that which were implemented in your community since the heart health project began?
30. Thank you for answering the previous questions. Now I would like to change the focus and ask some questions about the heart health project as it affected women and men.
31. Why did you get involved in the heart health project?
32. How did you learn about heart disease?
33. Can you recall any discussions about women's heart health?
34. While both women and men get heart disease, differences in their experience of heart disease have recently been noted. Can you tell me anything about those differences?
35. I would like to find out something about how you got people involved in your project. What sorts of activities did you do in your community?
36. For each activity
 - Were you involved in the coalition when you decided to do (name activity)?
 - Where did this idea come from?
 - Did you talk about it at a meeting?
 - Why did you decide to do this?
 - Who was involved in deciding to do this?
 - How was decision made a vote, discussion, consensus?
 - Why do you think this activity worked?
37. Can you tell me about any projects that you tried that did not work i.e. did not get people involved? What are your ideas about why this did not work?
38. Some health projects have undertaken specific activities to make sure women could get involved in their programs. Did you ever undertake any strategies especially for women?
39. Have you seen the NLHHP kit *Women and Heart Health: Women take time to care for yourselves*? If no. Would you like information on this kit? If yes, get mailing address.

Thank you for your time and interest.

APPENDIX F: INTERVIEW INSTRUMENT THIS STUDY

1. Why did you get involved in the heart health project?
2. How did you learn about heart disease?
3. Can you recall any discussions about women's heart health?
4. While both women and men get heart disease, differences in their experience of heart disease have recently been noted. Can you tell me anything about those differences?
5. I would like to find out something about how you got people involved in your project. What sorts of activities did you do in your community?

Then for each activity, ask the following details.

1. Were you involved in the coalition when you decided to do (name activity)?
2. Where did this idea come from?
3. Did you talk about it at a meeting?
4. Why did you decide to do this?
5. Who was involved in deciding to do this?
6. How was decision made a vote, discussion or consensus?
7. Why do you think this activity worked?
8. Can you tell me about any projects which you tried which did not work i.e. did not get people involved? What are your ideas about why this did not work?
9. Some health projects have undertaken specific activities to make sure women could get involved in their programs. Did you ever undertake any strategies especially for women?



Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

1997 09 30

Reference #97.131

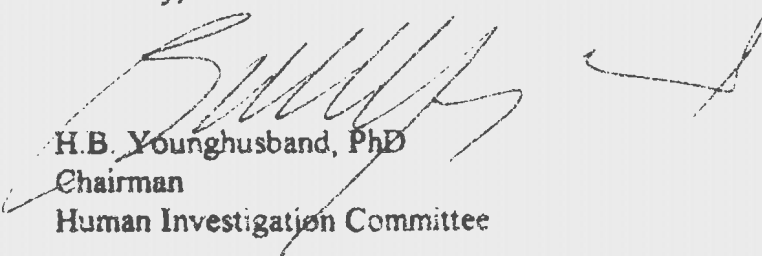
Ms. Wendy Williams
c/o Community Health
Faculty of Medicine
Health Science Centre

Dear Ms. Williams:

This will acknowledge receipt of your correspondence dated September 10, 1997, regarding the research application entitled "Gender Sensitivity in the Newfoundland Heart Health Project".

The Committee granted full approval of the application and wish you every success with your research study.

Sincerely,


H.B. Younghusband, PhD
Chairman
Human Investigation Committee

HBV/jglo

c Dr. K.M.W. Keough, Vice-President (Research)
Dr. E. Parsons, Vice-President, Medical Services, HCC

SUPPORT





