

**SELLING THE MENOPAUSAL BODY:
A CRITICAL ANALYSIS OF PHYSICIAN TARGETED
HRT ADVERTISING
– AND –
COMMUNITY-UNIVERSITY CO-OPERATIVE MODEL
CASE STUDY:
A REFLEXIVE AND EXPLORATORY LOOK AT ONE CBR
EXPERIENCE**

by

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ABSTRACT

Selling the Menopausal Body: Over time, what role has physician targeted, North America, hormone replacement therapy (HRT) advertising played in the medicalization of menopause? How have these ads constructed HRT knowledge for physicians and women? Employing close textual analysis, I examine several decades of medical journal HRT advertising and place this analysis within existing critical feminist critiques of HRT. I show how these ads systematically and negatively portray women, their bodies and menopause.

Key Words: Menopause, Hormone Replacement Therapy, Medicalization, Advertising

Community-University Co-operative Model Case Study: Can university involved community-based research (CBR) be useful to communities? To what degree can individuals from universities participate in CBR? From a critical perspective, challenging existing models and the current state of university-centred CBR, I present a detailed case study of a community-university collaborative CBR project, Three Days in the Fire Pit, arguing a strong case for a model that successfully navigates CBR and avoids university control.

Key Words: Community-Based Research, Community-University Collaboration

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**1:
SELLING THE MENOPAUSAL BODY: A CRITICAL
ANALYSIS OF PHYSICIAN TARGETED HRT
ADVERTISING**

Introduction

Although Hormone Replacement Therapy (HRT) has been widely prescribed in North America for 70 years and has faced much criticism and debate, it was not until the startling findings of the U.S. National Institutes of Health (NIH), Women's Health Initiative (WHI) trial in July of 2002 that HRT came under heavy fire. After the NIH study revealed increased incidences of breast cancer, heart disease, and stroke for women who were taking some combination drugs, decades of use and millions of prescriptions that had been written were thrown into question. HRT is an important woman's health issue not only because these drugs are targeted specifically at a perceived biological "need" of women, but also because the entire construction of HRT has reinforced heterosexual female stereotypes and can be viewed as a model by which the pharmaceutical industry manipulates information about a wide range of health issues and drugs.

For decades, HRT has played a role in shaping the manner in which menopause is conceptualized through the medical industry. Houck (2005) notes, "In the last hundred years or so, physicians have increasingly courted menopausal women as patients. Menopausal women in turn, have sought medical care. As a result, during the twentieth century menopause became medicalized" (198). HRT has conceptualized and reaffirmed women within a very essentialized and patriarchal context, and has cemented the idea that menopause is an inevitable but unnatural and undesirable process. Bell (1987) argues that with the rise of HRT in the 1930s and 1940s, the medical field "promoted a new view of menopause as pathological and abnormal, and reinforced the stereotypical picture of

women already in existence” (540). Although complex, the North American social construction of women in this era largely saw women’s roles as both to fulfill maternal and wife oriented duties, including hetero-normative sexual roles. At the same time, women were seen as emotionally inferior, controlled by feelings and hormones.

While critical research, much of it feminist, has increasingly examined the medicalization of menopause and 70 years of HRT phenomenon, there remain many facets of critical argument and scrutinizing investigation to be undertaken. I build upon feminist literature that examines and questions the medical industry’s portrayal of menopause and through this examination, ideas of women, their bodies, and ways the menopausal body is devalued and marginalized. My critical approach, led by Hunt (1994), Coney (1994), and Wiley, Taguchi & Formby (2003), views the medical industry as a primary source of social control and power that has shaped how society views and interprets menopause. I ask; how has physician targeted HRT advertising functioned? As HRT developed over the decades, how and what information (pseudo or real) and knowledge has been transmitted to medical professionals and women as consumers through medical journals? Through my analysis, I will describe advertisements that speak more to maintaining a prescription consumption base than constructing socially productive dialogue about menopause.

Boundary of Study

I focus my analysis specifically on print advertisements from the pre-WHI trial announcement period of the 1950s to the 1990s. I examine the prevalence of, and messages conveyed through print advertisements in medical journals. Specifically, I examine four dozen advertisements for HRT taken from the New England Journal of

Medicine, British Medical Journal, Journal of the American Medical Association, and Canadian Medical Association Journal, sources, which physicians in North America heavily utilize. Such advertising became prevalent within the medical community in the 1950s.

A textual analysis of advertisements from medical journals allows me to create a cohesive picture of the use of medical advertising by pharmaceutical companies over the last five decades, and allows my analysis to explore minor and major changes in the representation of women's bodies and the menopausal process. While I do not attempt to draw conclusions that advertising led to shifts in HRT policy, I do discuss how shifts in HRT advertising do or do not follow, chronologically, the shifts in HRT policy as laid out in the historical timeline I describe below.

While my research touches upon policies linked to HRT, these discussions of policy remain in reference to historical developments of HRT and policies involving prescription drug production and advertising. I avoid engaging policy debates more substantively. Although this essay may be of interest to those involved in HRT and prescription drug policy research, my focus is to better understand how HRT has been conveyed through medical advertisements. Despite the fact that discussions of policies involving HRT would prove interesting, needed and warranted, these could be best accomplished in future research projects.

Utilizing a collection of print advertisements, I carry out a textual analysis in a multi-faceted manner. I analyze both overt as well as the underlying messages in an attempt to uncover the complete messages these advertisements are attempting to convey. I analyze pictures, text, wording, layout and all other relevant pieces of information.

Through this analysis, I show the collective ideas that these advertisements have sold over the years. As with many industries (HRT drug sales within the menopause industry), advertising is simply one piece of a larger economic system. I treat these advertisements as representations of the goals of pharmaceutical companies in their attempt to cement HRT as a staple in women's lives.

Lastly, I must note that this inquiry supposes that the type of HRT print advertising that I analyze does have some realistic impact on the rate at which women have been prescribed and taken prescription hormone replacement therapy drugs. While I do not engage in a critical analysis of this presumption or investigate any measurable rate at how this type of advertising impacts decision making, I do recognize that these advertisements are one piece of a complex network of information that informs physicians and women and impacts treatment choices and decisions.

Feminist Approaches and Framework

Medicalized menopause is a complex issue requiring multiple approaches and levels of analysis. Table 1

shows the two main divisions in work I believe are required to address current public medical menopause discourse. The analysis I undertake in this essay clearly falls under the deconstruction

Table 1.1: Breaking Down Medical Menopause

Deconstruct Medical and Social Dialogue/Knowledge of Menopause	Reconstruct Public Menopausal Discourse
<ul style="list-style-type: none"> • How is Menopause Knowledge Constructed? • Who Controls the Flow of Information? • What Information is being Created and Normalized? • How has Medicalized Menopause Impacted Different Women? 	<ul style="list-style-type: none"> • Focus on Women's Experiences <ul style="list-style-type: none"> • <i>Dialogue Outside White Hetero Norm</i> • Reinterpret and Create New Medical Knowledge Base • Increase Public Discourse

side of this process. Neither the deconstruction nor reconstruction process are more important, but both essential in correcting misinformation and confusion regarding menopause and HRT. Across all these processes, both existing mechanisms for information creation and dissemination, and women's experiences play an integral role in understanding the menopausal experience and creating socially productive and beneficial public knowledge.

Feminists have long responded to the social construction of menopause through a wide range of perspectives and arguments, some in agreement, others not. Although several approaches focus on the medical industry and HRT, there exist many other focal points of analysis. These aspects include discussions of women's right to choice, body image issues, the psychology of menopause, and menopause as sociological phenomenon. While many of these approaches are important and useful, I ground my analysis in the critical works of Hunt (1994), Coney (1994), and Wiley et al. (2003), all of whom recognize the multiplicity of feminist and mainstream medical research and call into question the common ideas that the medical industry promotes. What sets these works apart from other feminist critiques is fundamental to understanding my analysis.

Other critiques directly attempt to address menopause and problems tied to the medical industry, such as Goodman (1990) who argues that menopause is clearly a biological phenomenon and more scientific research is needed to understand it in an unbiased way.

Whether menopause itself is the primary subject of investigation or a concomitant factor in the study of social roles, aging, or health, it is necessary to support such research with careful definition of terms, appropriate selection and precise measurement of variables, choice of an appropriate study population, and the design and application of adequate analytical tools. Only then will an unbiased depiction of menopause emerge. (152)

Clearly an effort to address biased medical perception of menopause, Goodman calls upon refocused scientific examination as a means to accomplish this. On the other hand, Bowles (1990) dismisses negative medical and social views of menopause and calls for a better understanding of sociocultural influences on middle aged to older women and the construction of theoretical models of change. The critical approach that I utilize neither marginalizes medical approaches to menopause nor fundamentally calls for strict scientific methods to correct medical missteps. Instead a critical and sceptical recognition and challenge of medical and scientific approaches forms the foundation of my critical approach.

Other debates investigate menopause as a phenomenon, which extends far beyond the medical industry. Ussher (2006) takes on popular culture, including movies, fairy tales and social norms and points out, “older women are all but invisible within both high and popular culture – with the post-menopausal woman represented primarily as the crone, the hag, or the dried-up grandmother figure, her body covered, and her sexuality left behind” (126). Alternative work questions perceptions of body experience as a way to alter approaches to menopause, where “women would have to be open to more active, positive self-images at the same time as medical practitioners would have to be willing to help women construct them” (Martin 1997, 251). My critical approach, led by Hunt, Coney, and Wiley et al., does not directly challenge or support many of these non-medical approaches, but instead views the medical industry as a central force in the creation and maintenance of public menopausal discourse, including the construction of HRT.

Coney (1994) views menopause as about women, and rationalizes her analysis of medical menopause as “simply a matter of giving back to women what is rightfully theirs” (12). This feminist approach calls into question the narrowing of the HRT debate by many in the medical community and among neo-liberal feminists. In this respect, my approach is opposed to arguments that frame HRT and menopause as simply a debate involving women’s choice and free agency, nothing more. This narrowing of debates creates a situation where issues are being discussed on a basis of right of choice with respect to menopausal medical care. These debates fail to recognize the power and degree to which the medical and pharmaceutical industries have created the dialogues, information and perceptions of choice that exist. My approach assumes a certain degree of choice exists for women in North America, but questions the information that is being made available—information that may influence women’s choices and decisions.

Building upon the critical feminist framework I utilize, my analysis is aided by the integration of critical advertising theory. I am informed by literature that questions the practices of pharmaceutical companies, focusing on ethics in approaches to advertising. Prescription drugs, when compared to everyday consumer products, have a different impact on individuals and society as a whole. A more critical approach is needed when assessing the messages in prescription drug ads and the conduct of pharmaceutical companies.

An ethics-based approach to marketing (prescription drugs) recognizes that “good marketing” is about more than selling products and increasing market share. It is about more than complying with applicable laws and regulations. Ethical marketing is about fulfilling responsibilities to stakeholders. Marketing prescription medications is not the same as marketing most other products because the risks to the stakeholders are different. (Weber 2006, 182)

While I largely sympathize with many of the anti-capitalist aspects of these critiques, through this research, I do not challenge the medical or pharmaceutical industry's right to advertise, but do apply a rigid ethical stance when analyzing their behaviours and activities. This stance on pharmaceutical advertising is meant to complement my feminist approach to critiquing the medical industry as it helps place pharmaceutical companies under the same critical lens.

While this existing critical framework guides my analysis, the framework also possesses a detailed notion of the history of HRT and medical menopause. I utilize this historical framework as a comparative reference for the messages and changes in HRT advertisements in my study.

A Brief HRT Framework History

The history of Hormone Replacement Therapy in North America is not a simple one. The term Hormone Replacement Therapy is itself a construction of pharmaceutical companies' efforts to promote the idea that taking these synthesized drugs (not actually biological replacements) is a logical step in stopping the unnatural and unwanted experience of menopause. Because pharmaceutical companies can only create enormous profits from products that can be protected by patents, for 70 years, HRT drugs have been comprised of synthesized estrogen, for example, the highly popular Premarin, manufactured by Wyeth-Ayerst, which is derived from Pregnant Mare Urine. These estrogens do not actually replicate the bodies' "natural" rhythmic, cyclical production of Hormones (Wiley et al., 2003), and can be viewed as similar synthetic supplements but not identical replacements.

Although the concept of delaying menstruation can be found in various cultures and times, Western medicine became fixated on this process with the rise of the modern medical era. Traditional forms of coping with women's "old-age" involved remedies created from substances such as the urine of pregnant women or plant sources, the later which is now again considered an alternative to medicalized HRT, but in the 1930s, menopause became fully realized as a medicalized phenomenon. Menopause, by then viewed as a "stage" in life, became directly linked with medical symptoms, such as hot flashes, fatigue, headaches, vaginal dryness, and sexual "problems"; symptoms which the pharmaceutical industry promised it could alleviate. Most of the early "menopause" drugs were designed solely with the goal of replacing estrogen, a theoretical and practical solution that continued to be the primary focus of this line of research and manufacturing until the 1960s.

The arrival of the 1960s marked a new focus of experimentation for researchers in hormone replacement design beyond estrogen supplementation. Progesterones and progestins became common agents to combine or alternate with estrogen. This was largely a result of the pharmaceutical companies no longer being able to suppress fears associated with the suspected side effect of endometrial cancer, which had been a known issue since the 1940s (Coney, 1994). Even testosterone, which is usually viewed as a "male" hormone, was included in some HRT drug combinations. One liquid HRT drug produced in the 1970s by Ayerst, Mediatric, contained estrogen, along with testosterone, vitamins, methamphetamine hydrochloride and 15% alcohol (Seaman & Seaman, 1977). In an effort to gain increased access to the market, the pharmaceutical industry also invested significant resources in developing different avenues of delivering hormones,

and by the 1990s, HRT could be prescribed in numerous forms, including oral pills, liquids, patches, and transdermal creams.

Because the first medical-model HRT drugs were developed in the early 20th century, they superseded contemporary guidelines for testing pharmacological agents. Although regulations and agencies, like the American Food and Drug Agency (which has existed since 1906), predate HRT, they have changed dramatically over the years and did not function in the same regulatory manner in the early 20th century as they do today (Swann, 1999). Even today, there are ongoing debates over what is labelled a drug and what is labelled a supplement. It is no surprise that in the 1930s, there was little concern over the production of a “natural” hormone replacement, which was constructed as a simple means of supplementing women’s failing bodies.

As noted above, as early as the 1940s, clinicians noticed that endometrial cancer might be a potential side effect for women who were taking estrogen only HRT drugs, an observation that did not prompt actual research until the 1970s. Research concluded that it was in fact the case that estrogen supplementation was causing many women to experience overstimulation of the endometrium (Coney, 1994). The pharmaceutical companies pre-emptively moved beyond this perceived small setback by adding progestogen to estrogen, causing a menstrual bleed, which helps prevent the development of endometrial hyperplasia (Coney, 1994). This was the first of a series of major, widely reported problems with HRT, the first time that the growing industry had to actively suppress women’s fears that a “cure” for menopause might be worse than the actual “condition.”

These fears would have posed a problem for drug companies if HRT had remained simply a short-term prescription drug for treating unpleasant menopausal symptoms, such as hot flashes, anxiety, and other conditions associated with this phase of aging. However, HRT manufacturers and physicians who liked the drugs, largely due to high profit margins and some success in menopausal symptom alleviation, expanded the claims of HRT's role in women's health. From the mid 1960s until the mid 1970s, HRT began to be prescribed for much longer periods of time in an attempt to guarantee women lifelong beauty and the ability to maintain their femininity, which has been long intertwined with perceived value and worth for women. From the mid 1970s until the beginning of the 1980s HRT was touted as a way to experience symptom-free menopause; enabling women to stay in the workplace and enjoy their older years. Finally, by the early 1980s, drug companies began to promote HRT as a means for escaping chronic disease (MacPherson, 1993).

Over the past 20 years, it has been under the guise of disease prevention that the number of women to whom HRT was prescribed skyrocketed. This is because at the very hint of menopause, it has been asserted that all women should start HRT to prevent osteoporosis, breast cancer, and heart disease. Following the cancellation of part of the WHI trials in July 2002, it is now widely accepted that only the claims about osteoporosis hold any truth, but even with this, there lies many unanswered questions with respect to the acceptable use of HRT for large numbers of women for this one potentially small benefit. It is important to note that prior to the 1960s, osteoporosis was medically catalogued and viewed as type of general bone disease (Van Keep, 1990). Most women were advised to drink plenty of milk and engage in weight-bearing exercise. It is clear

that both men and women lose some bone density with age, and that after menopause, many women lose it at a measurably faster rate. However, claiming that most women experience some loss in bone density is a far cry from the suggestion that all women run the risk of major bone breakage once they have entered menopause.

Nevertheless, in the wake of criticism about HRT's association with some forms of cancer, the pharmaceutical companies began to market HRT as not simply a way to fend off bone loss, but as the best way to do so. In 1986, manufacturers fought for and obtained U.S. FDA permission to include bone loss prevention on HRT usage labels (Wiley et al., 2003). For women, it is very common that at the mention of menopause, their physician has taken it upon her or himself to mention the potential of HRT to prevent future bone loss, without regard for family history or lifestyle. By 1990, U.S. sales of the major 20 estrogen drugs equalled nearly ½ billion dollars ("Risks vs. benefits", 1992). Advertising may well have had a role in achieving this substantial pharmaceutical success.

Although it is not accurate to claim there has never been research on HRT drugs, until recent years, this research had been carried out and reviewed solely by drug companies. Moreover, prior to the WHI studies, HRTs had never undergone controlled clinical trials. This means drug tests were conducted using the experiences of women with the drug in real-life diagnostic settings. These types of studies do not allow for controls, and a variation in the reasons a doctor prescribes HRT and the reasons an individual takes HRT can often occur. Issues of "labelled" versus "unlabelled" use of HRT arise in these studies. At least under current drug legislation and advertising, the "label" informs the doctor and consumer what a drug has been tested and should be used

for, although this has not always been the case. Doctors often—and are legally able to—prescribe a drug for uses other than that which is labelled, and it is also possible for consumer to use prescriptions for “unlabelled” usage. For example, although HRT drug prescription labels did not mention the reduction of the risk of heart disease, this was a major rationale for long-term use among women in the 1990s (“Off-Label drug use”, 1997).

Several other studies that have examined medical compliance have suggested over the years that women do not stick to the prescribed dosage of HRT. A wide number of reasons for non-compliance have been pointed to. Women who have not had their uteruses removed are usually prescribed some amount of progestogen, as opposed to estrogen only, to reduce the chance of endometrial cancer, but this often leads to unwanted bleeding. Women often custom tailor their use of HRT to avoid certain unpleasant side effects. Some women don't take their HRT all together; a Massachusetts Women's Health Survey in the mid 1980s reported that 20% of women prescribed HRT stopped taking the drug after 9 months, and that 20 to 30% of the women surveyed never had their prescriptions filled because they were not convinced of the benefits or certain of the risks (Ravnikar, 1987). As Richter and Patton (2007) point out, many feminist critics of health care have argued that women seem passive in relation to their doctors, but at the same time are willing to define their own treatment. When doctors prescribe HRT for reasons that may or may not coincide with labelled usage, and women make their own decisions about whether to adhere or not adhere to HRT prescriptions, based on the label or their doctors' recommendations, a complicated scenario is created. HRT advertising may influence some of the complex decision making that occurs in this relationship.

Pharmaceutical companies achieved widespread HRT use, in part because, as mentioned prior, drug development predated testing and regulation laws. Because of this, numerous claims and questionable truths were successfully created through the pharmaceutical industry's will. Only the sudden news of the WHI trial cancellations in 2002 slowed down the progress of the pharmaceutical companies. Since the findings of the WHI study were reported, there has been a dramatic decrease in the number of prescriptions for two of the most popular HRT drugs, Prempro (combined estrogen and progestins) and Premarin (estrogen) in Canada and the US, having dropped 66% and 33% respectively (Vanderhaeghe, 2004). There are several other major studies underway to analyze combinations not tested in the portions of the WHI study cancelled in 2002 (although one of these trials was also halted in 2003, and another in 2004)¹, and doctors continue to debate conditions under which they will prescribe HRT, while women across North America re-evaluate whether they should use it or not. Building on this history, I ask the question: How prevalent have medical HRT advertisements been over the decades and what messages have they collectively conveyed?

HRT Advertising and the Medical Community

Prescription drug advertising is not a new phenomenon within the medical community. The access and influence that pharmaceutical companies have in relation to doctors is neither minor nor hidden. Even if the average North American does not read

¹ As reported by many news sources, The WHI shut down the memory arm branch of the HRT study in May of 2003 because they found an increased risk of dementia in women 65 and older who took combination therapy. Additionally, in early February 2004, the WHI shut down an estrogen-only portion of the trial, involving 11,000 women with hysterectomies because while there was found to be no apparent positive or negative affect on the heart, the data shows that estrogen alone increases the risk of stroke, enough so that the agency deemed these otherwise healthy women were at too great a risk to continue their HRT therapy (HealthDayNews, 2004).

medical journals, a single trip to the doctor's office will provide any patient with an inescapable view of notepads, prescription pads, pens, gadgets or other items that are plastered with the name of pharmaceutical companies or specific prescription drug names. While such exposure at the doctor's office via an occasional visit may not directly drive patients to consume certain prescription drugs, it is hard to imagine that physicians are not impacted to some degree by the daily interaction with such product placements, daily interactions that have been occurring for decades. Weber (2006) argues that "relationships that have come to exist between prescribing physicians and the companies that manufacture and market medications inevitably affect the nature and quality of the healthcare provided" (38). Whenever a physician opens a medical journal, the relationship between doctor and pharmaceutical company is reinforced.

HRT advertisements in primary medical journals were consistent through the mid 1980s. Although my analysis covers four dozen advertisements, repetition of ads was a common sight over the decades. Pharmaceutical companies appear, on average, to have run ads for a year and I generally found reuse of the same ads up to a dozen times. The specific ads I discuss are utilized specifically to represent the general themes and messages that run throughout medical HRT advertising, as well as changes over time. Through the analysis of these advertisements, several distinct lines of rhetoric appear. Although the messages in these advertisements are not specifically congruent, there are certain concepts and ideas that are prevalent across the history of medical journal ads. These underlying messages are a reinforcement of the authority and patriarchal role of physicians, the portrayal of menopause as an illness and the perpetuation of generally negative set of essentialized female stereotypes.

I also find that medical ads follow a similar trajectory to the critical feminist history described above. While not exactly mirroring shifts in drugs policies, advertisements have generally gone through phases where they change rationalizations for HRT, such as shifts in advertising drugs for feminine youth and beauty and eventually disease prevention. Ads in the 1950s and 1960s are proportionally divided between messages conveying the woman as homemaker, the woman as depressed, the woman as irrational, and the doctor as caretaker, whereas ads in the 1980s almost exclusively portray a more modernized, independent and happy woman.

Prior to discussing specific advertisements and changes over time, it is important to note that another major current runs across all medical HRT advertising. Like many aspects of medical rhetoric, North American HRT advertisements exclude an enormous amount of women. Across all the advertisements I examined, I found only one non-white image that recurred in two ads. If one were to base their menopausal knowledge purely on medical HRT advertisements, they might quickly come to the conclusion that only middle-class white North American women “suffer” from menopause. While this perception obviously evades reality, it does add weight to suspicions that pharmaceutical companies and the HRT industry may have been and still are more concerned about creating rhetoric that support profitability than creating beneficial information for all menopausal women.

Maintaining Consumption

If the drug companies had maintained one rationale of drug use through HRT advertising over the last 50 years, the impact and investigation of ads may not have proven nearly as interesting or important. Maintaining the consumption base, not their

messages, has been the priority. The pharmaceutical industry has been very successful at creating major shifts in the rationale for consuming HRT over time and advertising has evolved to help re-justify and re-inform physicians with respect to these changing rationales. This shifting selling point has, over time, given doctors an expanded set of reasons to diagnose women as “ill” and in need of HRT. Why it might be hoped that changes in advertising occurred through legitimate scientific investigation and understanding, this is not reflected in the way advertisements have been carried out. Talking about pharmaceutical practices, Weber (2006) makes the simple yet important observations that “ethics and the law are clearly not the same” and “the fact that the law does not prohibit a particular industry practice is not reasonable basis either for engaging in it or for defending it” (5).

Although certain messages and values are maintained across HRT advertisements, they also vary to a great degree. Some of these variances occur during the same decades and across all ads, creating a negative, but complex image of women, whereas other variations in ads are chronological and change systematically over the decades. These chronological changes are most directly tied to how medicalized the ads appear, partially in how much technical information they attempt to convey. Ads in the 1950s display little or no technical medical information, while ads in the 1970s begin to have prescribing guidelines, warnings and drug company supportive research information. Additionally, the ads do show a chronological change in specific lines of rhetoric can be seen to develop over time. There exist distinct differences between HRT ads created in the 1950s versus ads created in the 1980s. These differences very closely reflect the critical history

outlined above, whereby menopause symptom rationalizations for use give way to feminine youth and eventually disease prevention rationalizations.

Stereotyping the Feminine

As discussed prior, the advertisements form a collective and stereotypically negative viewpoint of women. The advertisements generally reflect the social norms of the era in which the ads appear, so while they are consistently insulting to women, as I will show, ads from the 1950s and 1960s are particularly focused on portraying women as unstable, a threat to their family and in need of medical assistance. Two primary models that repetitively appear in the ads are the unhappy and depressed woman, alone in the world, and the irrational and crazy woman.

While several of the ads show unhappy women, several could be classified as showing women depressed beyond despair. A Marplan advertisement from 1960 displays, perhaps, the bleakest picture of menopause, an example that typifies almost everything the pharmaceutical companies are trying to achieve with this category of ads. The first thing that draws attention is a middle-aged white woman, standing in a white coat on the roof of a brick building. Her coat seems fairly heavy and it appears to be a windy and relatively bleak day outside. She is just close enough to the camera that we can see she is looking very gloomy, but at the same time is just far enough away to make her feel distant from us. She is looking slightly downward over the edge, perhaps thinking sad thoughts, perhaps contemplating throwing herself over the edge. She is gripping a roof antenna or pole, and we can see in the bleak/hazy grey and black background, a multitude of other roof antennas and poles sticking up like a sea of skeletal

boat masts. It is as if she is drifting by herself atop the lookout on the mast of the boat, alone in a sea of emptiness.

Although we are not certain what is on her mind, it is clear she is lost. Not leaving any chance that we might somehow interpret this scene in any positive way, the ad includes written dialogue directly below the picture and is just as explicit in its bleakness. The catch phrase says, “When “change of life” seems the end of life...” This line is the second largest text in the ad. The narrative, in much smaller font, goes on to say, “With the advancing years, woman’s vulnerability to depression often becomes intense. The future looms insecure...And as she faces losing a symbol of femininity, even suicidal panic may supervene.” Of course, this bleak message is accompanied by the reassuring fact that Marplan can alleviate such depression. The largest text alone near the bottom of the ad in black font that says MARPLAN. As typical from this era, there is no additional information of any kind. The message is clear; it almost seems a crime to not give women Marplan as a reprieve from certain mental anguish and pain.

Across the HRT advertisements that promote the depressed menopausal woman, a commonly used image is of a woman staring unhappily straight at the audience, as if she is giving us a confession of her unbearable ordeal. A Premarin ad from the 1960s exclaims, in the largest text, “Life Begins at Forty,” continuing in one quarter size text, “...but at 45, so do the early symptoms of estrogen deficiency.” Again, a middle-aged white woman stares directly at us, looking very serious, drained and tired of life. She has a long hardened face and clearly shows stress in the way her skin wrinkles. A graph is located just to her left, showing a declining amount of estrogen. Bulleted text mark undesirable menopause symptoms; irregular menses, hot flashes, sweats, nervousness,

anxiety, fatigue, depression and restless nights. The accompanying blurb states, “the time a woman should be looking forward to one of the most enjoyable periods of her life, her ovarian function begins to wane. And with this waning comes a decreasing supply of estrogen and often the distressing clinical symptoms of estrogen deficiency.” This highlights another continual theme, the estrogen deficiency theme, that women entering menopause are experiencing a medical condition, where their bodies are failing them.

Although there is ample research, narratives and testimonials to conclude that some women do in fact experience mood changes when they go through menopause, to inherently portray such changes as universal, negative and unmanageable is far beyond misleading. The portrayal of women as depressed is one of the primary lines of rhetoric that drug companies have created through advertisements. If stock were put in the validity of some of these ads, it would be a wonder that not all women committed suicide before the advent of medicalized HRT. These ads portray women as lost, unbearably unhappy, and in severe pain.

A third example of the depressed women ad is displayed in a somewhat different format, a format used more heavily in late 1960s and 1970s ads. This is the pre-HRT and post-HRT treatment comparison, over several pages. The first page of a Premarin ad from 1976 contains a relatively small, two by three-inch picture, which shows a very serious middle-aged woman looking again at the viewer. In bold large text, directly above the image, it states, “In the treatment of middle-age depression, there may be one thing to add.” The ad confesses, “Although the causes of depression in middle-aged women are varied, estrogen depletion is believed by many to be a significant contributing factor in depressions arising in the menopausal years.” This statement is followed by reference

numbers, denoting further support research on the third page of the ad, the prescribing information page. As with many ads beginning in this era, a medical information page or additional prescribing details are often included. However, the legitimacy of information on these pages is not necessarily credible since no actual clinic HRT trials would take place for another 25 years. This was simply drug companies interpreting field usage testing. When we flip to the second page of the ad, we are miraculously greeted by a full-page picture of the same women, very happily smiling, teaching an elementary school class. She looks younger, well dressed; energetically calling on one of her students whose hand is raised. The class is engaged in mathematics, with formulas written on the chalkboard. Premarin has restored her mental state and she is able to return to the work place. The message is clear; she could clearly never have been able to function without the benefit of HRT intervention. The third page of the ad is split in two, the left half primarily blank with same picture of the woman happy near the bottom. In the upper area, it says, "PREMARIN BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.", followed directly by "for estrogen-related depression." Below this, the ad proclaims, "contains natural estrogens exclusively." This is a message seen across many ads, an attempt to naturalize the use of HRT. On the right side of this last page, the long list of fine technical print exists. These details include, FDA authorized usages, contraindications, warnings, precautions, adverse reactions, dosage and administration, drug usage format and references.

Similar to the rhetoric of menopausal women as depressed, a second mode of medical HRT advertising rhetoric follows a similar line through portrayal of emotional (ir)rationalization. Again, while there is truth that emotional symptoms can be

experienced during menopause, the extreme messages in the ads portraying women as emotionally insane are absurd, showing that the irrational woman can become just as crazy as the depressed woman can become suicidal. The ads often convey menopausal women as experiencing a nearly unbearable level of sanity, particularly irritating to husbands who just want to see their feminine and dedicated wives back. The women appear not entirely aware of the degree to which they have fallen into irrationality. The irrationality ads very heavily challenge notions of femininity and how women are valued within North American society at the time these ads were being published. The crazy women universally appear old, wrinkled, dishevelled, with little or no makeup and usually dressed in unflattering clothing. Advertisements that show the cured irrational women more predominantly convey images of much younger women, in nicer, more feminine clothing, including jewellery, makeup and a smile on their face. As described in the prior ad, they are often shown with men giving them attention, either men within social settings or husbands happy to gain some sanctuary from the horrible wrath of menopause.

One late 1960s Premarin advertisement simply shows a white woman in her 50s staring absolutely bewildered at the reader, nervously fidgeting with her shirt collar with one hand, set against a simple grey background. Her stare makes her appear as if she is nearly begging for help, but is not conscious of the fact that she is even asking. In bold, large white lettering near the top, contrasting the dark background, the ad proclaims, "Adolescence... ..all over again." Counterbalancing this text is black text of an equal size, transposed against the white background of the bottom half of the ad, reading, "Premarin, when it's needed most." In standard size text, the ad displays a list of

“Emotional Displays.” These include flushing and sweating symptoms and the ad ensures the viewer that, “It can take years to adjust.” Considering the ad claims that it can take years to adjust, it would seem to imply that women should take this drug on a long-term basis, so perhaps, when she needs it most is always.

Another ad for Premarin from 1975, again, uses the technique of the comparative pre-HRT, post-HRT woman. The first of two pages shows the standard white 50 year old, staring directly at the reader, looking like what might be described as a crazed zombie-like mental patient. The picture is primarily focused on her head, her eyes stretched and strained wide-open, teeth gritting, pointing directly at the viewer. She has curlers in her hair, as if she is unfit to venture into the world. The picture occupies about 15 percent of the upper left area of the page; the remainder is simply a white background. Directly to the right of the picture, in black lettering, it says, “before” and “at odds with the world.” Near the bottom of the page, in black lettering lies the common slogan, “When symptoms point to estrogen deficiency,” followed in smaller black text, “gives her back something she’s lost.” When the reader turns the page, they are rewarded with the miraculous benefits of the “after” treatment effect. A picture taking up most of the page says near the top, in bold white lettering on the dark background, “Premarin...on top of the world.” The woman looks elegant and sophisticated. She is far more feminine, wearing lipstick and makeup, dressed very wealthy, with a scarf and pendant. She is sitting in a nice room, with fine silver utensils and meal plate behind her and she is leaning forward focusing on lighting a candle, perhaps suggesting a romantic dinner is about to ensue, now that she has reclaimed her sanity along with her femininity. The lower area of the ad contains a written rationale for how Premarin can dramatically improve the emotional state of the

woman and give her a renewed sense of well-being. Although this ad does not contain a dedicated medical information page, in very small text there exists a certain amount of dosage and administration, availability, cautionary, and usage info. In addition, typical of ads in this era, femininity becomes a more prominent and important rationale for why HRT is important for women.

Return to Womanhood

Not exclusively separate from the message of depressed and irrational women, many advertisements, especially in the 1950s and 1960s strongly play upon the stereotype of a woman's motherly duties and obligations as a wife. The fact that most doctors, whom were all males during this era, had wives at home, could have potentially played a factor in how these ads were interpreted. In this way, HRT advertisements have been designed to not only appeal to the doctors perceived professional duties, but their role as husband and father.

An excellent example of the cured woman, who was a major burden to her husband is an ad from the late 1960s. The first thing that jumps out is the large bold proclamation, "Menrium treats the menopausal symptoms that bother him most." The ad shows a husband proudly standing with his arms crossed, with a beaming smile on his face. He looks as if he has won something quite grand. His wife is also smiling (in a more conservative manner) and standing next to him, slightly leaning in, rapping her hands around his upper arm; clinging onto him as if he is her protector. She appears a dedicated and well-behaved wife, obviously having taken her HRT prescription. The only other thing contained in the ad; a small scripted narrative states, "His wife has a lot of different menopausal symptoms, but only a few really irritate him. Her hot flashes, her vertigo, her

palpitations...that's her problem...what really bothers him is her nervousness, her irritability and her excessive anxiety..." The ad makes in clear, while the HRT drugs have alleviated her symptoms, they have more importantly provided him with relief from her craziness and also restored her to a faithful and dutiful wife.

A series of Premarin ads from the late 1950s paints a supposedly wonderful picture of how HRT can benefit, doctors, women and the entire family. Each one-page ad is primarily a picture with a caption a blurb near the bottom, nothing else. The first ad contains a fairly young looking white woman in a swimming pool. She is at the edge of the pool, arms up on the pool deck, smiling at the reader. She has a swim cap on, and has red painted fingernails, and a noticeable wedding band. What appears to be her husband and children are relaxing and enjoying themselves in the cool blue water on a bright sunny day. She is "normal" and is not burdening her family with perceived by-products of low estrogen production. Directly below the picture is the caption, "Of course, women like "Premarkin." Below this is a few short paragraphs which state,

Therapy for the menopause syndrome should relieve not only the psychic instability attendant the condition, but vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarkin." The patient isn't alone in her devotion to this natural estrogen. Doctors husbands, and family all like what it does for the patient, the wife, and the homemaker. When, because of the menopause, the psyche needs nursing—"Premarkin" nurses. When hot flashes need suppressing, "Premarkin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarkin," a complete natural estrogen complex.

The second ad in the series pictures a family barbequing in their backyard. The mother stands next to the barbeque in a yellow dress, smiling and looking into her husband's eyes while wrapping her hand around one of his forearms. The husband, well dressed, is happily smiling back at his wife, clearly thrilled with her presence, while he flips a steak

on the barbeque. Their son, who is leaning on the barbeque, is also smiling and gleefully watching his parents stare at each other. In the background, the grandmother, also wearing a yellow, but less feminine dress, prepares the picnic table for their family meal. It is a natural, outdoor setting, on a sunny pleasant afternoon, a “perfect” family picture. The primary caption reads, “The whole family likes “Premarin”, while the information paragraphs states,

In a sense, when you prescribe “Premarin” for a wife and mother who is suffering in the menopause, chance are you’re treating the whole family. Junior, Sis, and Dad, just like Mom, can tell the difference right off. Mother isn’t just more tranquil on “Premarin” therapy. Hundreds of publishes reports tell us she takes a positive outlook on life. She feels *good*. And we all know that’s the single most important factor for a happy home. Women on “Premarin” receive treatment that covers every aspect of the menopause, including prompt relief of physical distress. Is it any wonder physicians say the woman suffering in the menopause deserves “Premarin”? Many a family would agree.

The third ad in the series turns it focus on doctors, showing three physicians in a break room at a hospital. The room has wood floors and white walls, cabinets and curtains. One doctor, in a full black suit and tie, stands in the corner of the room. A second doctor is sitting at a nearby table, holding his glasses in his hand and a third doctor is across from the other two in a reclining chair, holding a book at his side. They appear to be engaged in an important and professional conversation, one we have to assume focuses on Premarin. The caption concludes, “Doctors, too, like “Premarin.” The supporting story says,

The doctor’s room in the hospital is used for a variety of reasons. Most any morning, you will find the internist discussing a case with the gynaecologist, or the paediatrician in for a cigarette. It’s sort of a club, the room, and it’s a good place to get the low-down on “Premarin” therapy. If you listen, you’ll learn not only that doctors like “Premarin,” but *why* they like it. The reasons are fairly simple. Doctors like “Premarin,” in the first place, because it really relieves the symptoms of the menopause. It doesn’t just mask them – it replaces what the patient lacks – natural estrogen. Furthermore, if the patient is suffering from headache, insomnia and arthritic-like symptoms due to estrogen deficiency, “Premarin” takes care of that too.

This series of advertisement shows a full spectrum of HRT advertising devices. HRT is continually presented as a natural replacement for a medical illness. In the ads, women's essentialized role as wife and mother are threatened by menopause, as well as her daily happiness and well-being. Like most 1950s and 1960s ads, there is no attempt to provide technical medical information, real or not. The final ad in this series is important in that it represents the other primary message that historically runs across much HRT advertising, that of the physician as authoritarian caretaker.

Physician as Caretaker

Perhaps more than any other goal of HRT advertising, attempts to instill a patriarchal duty in the minds of the physicians is highly important in establishing prescription success. As with many overt and manipulative messages in HRT advertising, ads playing to the role of physician as caretaker were most prevalent in the 1950s and 1960s and beginning in the 1970s, the focus became more medical, or pseudo medical as the case may have been.

A HRT ad from the 1950s shows a woman clutching her pearl necklace while she describes something to her physician and appears to be pleading to her doctor for help. There is an emphasis on the pain in her face and we can only see the backside and corner of the doctor's head. "Recognize This Patient?" is what the primary caption reads, with the women telling her doctor, "I don't sleep well...I dream a lot...wake up tired and irritable. I don't have any appetite...I'll never be cured." The rhetoric again echoes the notion that menopause is a disease. A mid 1950s Milprem ad similarly shows a middle-aged woman, sitting at a table across from her doctor, resting her forehead on her hand,

with her arm resting on the table in front of her. She is wearing dark clothing and looking downward. Milprem is the largest text, in the bottom left corner, and across the top it reads, "Helps you take the misery out of menopause...as hormones alone often don't do." You can tell the doctors in both ads are well groomed, wearing glasses and paying close attention to their patients. Another HRT 1960s ad with the caption "Lifts depression..." simply shows a woman smiling and firmly shaking her doctor's hand. He has taken off his glasses and is smiling back at her, clearly showing genuine happiness that he has succeed in treating her menopausal symptoms. Little other information appears in these ads.

Since these ads are only seen by the medical community, it is clear that pharmaceutical companies are attempting to model doctor-patient relationships, but for whose benefit? What doctor wouldn't want to be looked upon with such gratefulness by his patients? These ads create such extreme arguments that doctors might have felt cruel and criminal if they did not help women by prescribing HRT.

Changes Across Time

As mentioned through this analysis, certain messages have been more or less prevalent during various decades. The most overt ads, playing directly into patriarchal stereotypes of women's roles in society as well as physicians roles were utilized in the 1950s and the 1960s. The 1970s saw a generally strong shift toward less dramatized images of menopause, and more directed focus on describing symptoms in length and greater attempts at conveying more scientific support for HRT. As mentioned this era utilized a great deal of before and after HRT comparisons. Virtually every HRT advertisement by the early 1970s contained an additional prescribing information page,

with cautions, warnings, dosages, and other industry supportive research. While the symptoms describe in ads of the 1970s and early 1980s do not differ that greatly from the symptoms described in ads from the decades before, the manner in which they are portrayed is different. The majority of ads from the 1970s and early 1980s have much longer narratives and rationalizes for why women need HRT.

The other major change in advertisements during this period was a focus on the threat to femininity. Women taking HRT in advertisements are much more feminized than those who were not and more than women in ads of the 1950s and 1960s. During this era, HRT ads started to become directly tied to beauty and youth. One Premarin ad from the early 1980s contains a full-page colour portrait; a professional studio portrait. The woman looks very young, much younger than in previous decades. She is gently smiling, wearing a business suite. The caption reads, "Journey through Womanhood, A Premarin Portrait..." The backside of the ad is almost entirely full text, with a small headshot of the woman, with a caption left of this stating, "Premarin therapy has benefited millions of women around the world. This photography is a portrait of the actual patient. This case history is one woman's story." The case history contains a breakdown of her medical and gynaecological history, describing hormone problems, growth and development problems and how HRT helped mould her into a healthy and attractive woman.

Another ad from 1980 for Premarin, presents a full-page close up headshot of an attractive middle-aged, but young looking woman. She has the look of an early 1980s business woman and appears strong but also very feminine. The largest text at the top of the ad states, "Something is terribly wrong," and in the bottom right corner, it says,

“Right?” The few small paragraphs on the left describe typical menopausal symptoms as they had appeared in ads for previous decades, the primary difference being the visual message going along with the symptom descriptions. Women in ads during this era were more independent and strong, a general reflection of the changing social climate.

What also changed in the 1980s and 1990s was the prevalence of medical HRT advertisements. Ads become noticeably much scarcer during this timeframe, which was likely due to two main factors. The FDA and other policing agency began enforcing stricter advertising rules and at the same time, the direct-to-consumer advertising market started to open up to pharmaceutical companies. Rosenthal and Donohue (2005) argue that, “in the 1990s...the introduction of more consumer-oriented pharmaceutical products, and the trend toward consumerism in healthcare led pharmaceutical manufacturers to invest in consumer-direct marketing strategies” (170). What ads did exist during this timeframe, suddenly shifted focus in 1985, with disease prevention suddenly becoming a major selling point for HRT.

Bones

While a 1985 Premarin ad at first glance looks typical, nothing could be further from the truth. The ad has a black background, with a white silhouette profile of the front side of a person’s face. The caption at the top, in large capitalized letters reads, “Treat the distressing symptoms...and you may arrest the devastating complications. To the left of the silhouette, are two graphs with represent the effects of Premarin and vasomotor symptoms. The dialogue on the front page states, “Hot flashes, usually the first and most common symptom of the menopause, can be an early warning sign that other, more serious medical problems may arise. Postmenopausal osteoporosis, an insidious disease,

affects one in four women over the age of 60.” Interestingly, the ad also claims that, “For more than 40 years, Premarin has been recommended for menopausal symptoms such as hot flashes, sweats, insomnia and treatment of osteoporosis.” The second medical information page now reads across the top, “A therapy of choice for menopausal symptoms and the treatment of osteoporosis.” Clearly, ads had not been recommending HRT for osteoporosis before this decade.

Another Premarin ad from the mid 1980s shows a young, middle-aged woman sitting cross legged in an aerobic outfit, the caption next to her proclaiming, “Calcium every day, Aerobics every week. Bone loss every year.” Clearly she represents a young and energetic woman, faced with a potentially crippling illness. The other primary captions state, “She needs PREMARIN to help prevent further bone loss,” “Early PREMARIN therapy offers the best protection,” and “Protection continues as long as estrogen therapy continues.” The back information page provides no new additional information. The message is clear though, not only is menopause an illness, but it leads to other chronic diseases. The ad implies that as long as women take HRT, they will be protected from osteoporosis.

Another HRT ad from the early 1990s conveys both a paternalistic doctor message and one of disease prevention. The first thing that jumps out is two pictures, side by side. One a pack of HRT pills, with the caption, “Take a Course of Prempak-C2.” The other picture is a wheel chair, with the caption, “Or Let Nature Take Its Course.” The large heading at the top asks the question, “Which would you rather prescribe to a potential osteoporosis sufferer?” The ad leaves little debate in making the right choice.

Conclusion

Although varying in images, text and specific messages, medical HRT advertisements have collectively worked to perpetuate stereotypes of women, physician authority and menopause as a medical condition, one supposedly curable through the use of HRT drugs. Whether public rhetoric, as historically prevalent, calls for physicians to be primary decision makers in women's health or the polar neo-liberal extreme that calls for complete consumer choice, autonomy and decision-making is in place, HRT advertisements have attempted to impact the information available for decision making. I have shown that medical advertisements have followed the historical critical feminist trajectory laid out by Hunt (1994), Coney (1994), and Wiley et al. (2003), signifying that understanding medical advertisements can add to a critical understanding of how menopause has been systematically medicalized. This, along with the decline in medical advertising through the 1980s and 1990s, raises further questions about the role direct-to-consumer advertising may have played, and continue to play in constructing menopausal knowledge.

The surprising NIH announcement in July of 2002 was very public and significant, sending manufacturers of medical HRT prescription drugs into, what can only be assumed to be, a severe panic about how this news would impact sales and what types of responses would be required. As Majumdar, Almasi, & Stafford (2004) describe, of the minor portion of HRT prescription promotion that was being spent on medical journal advertising and the more substantial amount of promotional dollars being spent on direct-

to-consumer advertising by mid-2002, a year and a half after the WHI findings, spending had radically changed. Advertising of higher doses of HRT prescriptions (the subject of the WHI findings) entirely disappeared, and advertisement of low dose HRT drugs increased. Pharmaceutical companies quickly tried to rebound, and by August, 2004, Wyeth revamped their Prempro line and launched a major direct-to-consumer ad campaign (Wyeth, 2004). Through this campaign, they attempted to address the WHI findings by promoting a different dosage as safe and encouraging women to discuss best options with their doctors. With images of independent, healthy women, a focus on typical symptoms, the heading, “Relieve menopausal symptoms with an even lower dose of hormone therapy,” and the new catchphrase, “Go low with Prempro”, it becomes apparent that, at a publicly critical point for medical HRT, pharmaceutical companies will use some new ideas and some typical advertising devices in an attempt to maintain some influence over the construction of menopause, and of course, prescription sales.

Through the early findings of the WHI HRT trials, HRT has finally experienced a more critical public debate, one that was long overdue. While much rhetoric around HRT continues to focus on choice, it becomes all the more important to understand and challenge information, who is controlling it and how it is being shared, both historically and currently. Whether women, as individuals, through social networks, or in partnership with physicians are to make decisions about menopause and possible HRT use, it is essential that information be available which actually puts women’s well being first and foremost. While it would be far from the truth to claim that advertisements are the sole means by which women and physicians gain knowledge about menopause and treatments, it would also be a shortcoming to completely ignore this media vehicle of the

pharmaceutical companies who have profited from record sales of prescription HRT medications, sometimes at the expense of women's health.

Bibliography

- Angell, M. (2004). *The truth about drug companies: How they deceive us and what to do about it*. New York: Random House Inc.
- Arnst, C. (2002, July 29). ...But don't run screaming from hormone therapy. *Business Week*, 3793, 73.
- Belkin, L. (2001). *Prime time pushers*. Retrieved August 23, 2004, from <http://www.motherjones.com/news/feature/2001/03/drug.html>
- Bell, S.E. (1995). Gendered medical science: producing a drug for women. *Feminist Studies*, 21(3), 469-500.
- Bowles, C.E. (1990). The menopausal experience: Sociocultural influences and theoretical models. In R. Formanek (Ed.), *The meanings of menopause: Historical, medical, and clinical perspectives* (pp. 157-175). Hillsdale, NJ: The Analytic Press Inc.
- Brody, H. (2007). *Hooked: Ethics, the medical profession, and the pharmaceutical industry*. Lanham, MD: Rowman & Littlefield Publishers Inc.
- Coney, S. (1994). *The menopause industry: How the medical establishment exploits women*. Alameda, CA: Hunter House Inc.
- Do-It-Yourself menopause remedies. (2001). *Prevention*, 53(7), 7.
- Findlay, D., & Miller, L. (1994). Through medical eyes: the medicalization of women's bodies and women's lives. In B. Singh Bolaria & H. Dickinson (Eds.), *Health, illness and health care in Canada* (pp. 276-306). Toronto: Harcourt Brace.
- Goodman, M.J. (1990). The biomedical study of menopause. In R. Formanek (Ed.), *The meanings of menopause: Historical, medical, and clinical perspectives* (pp. 133-155). Hillsdale, NJ: The Analytic Press, Inc.
- HealthDayNews. (2004). *Another HRT trial halted*. Retrieved August 4, 2004, from <http://www.health24.com/news/Menopause/1-928,26786.asp>
- Houck, J.A. (2006). *Hot and bothered: Women, medicine, and menopause in America*. Cambridge, MA: Harvard University Press.

- Houck, J.A. (2005). The medicalization of menopause in America, 1897-2000, mapping the terrain. In D.L. Kleinman, A.J. Kinchy & Jo Handelsman (Eds.), *Controversies in Science and Technology*. (pp. 198-218). Madison: University of Wisconsin Press.
- Hunt, K. (1994). A 'cure for all ills'? constructions of the menopause and the chequered fortunes of hormone replacement therapy. In S. Wilkinson & C. Kitzinger (Eds.), *Women and health: Feminist perspectives* (pp. 141-165). London: Taylor and Francis Ltd.
- Komesaroff, P.A, Rothfield, P., & Daly, J. (Eds.). (1997). *Reinterpreting menopause: Cultural and philosophical issues*. New York: Routledge.
- Lock, M. (1991). Contested meanings of the menopause. *The Lancet*, 337, 1270-1272.
- Lock, M. (1998). Anomalous ageing: Managing the postmenopausal body. *Body & Society*, 4(1), 35-61.
- Lonsdorf, N. (2004). Natural HRT: Herbal and ayurvedic approaches. *Positive Health*, 31-34.
- MacPherson, K.I. (1993). The false promises of hormone replacement therapy and current dilemmas. In J. Callahan (Ed.), *Menopause: A midlife passage* (pp. 145-159). Indianapolis: Indiana University Press.
- Majumdar, S.R, Almasi, E.A, & Stafford, R.S. (2004). Promotion and prescribing of hormone replacement therapy after report of harm by the Women's Health Initiative. *Journal of the American Medical Association*, 292(16), 1983-1988.
- Malterud, K. (1999). The (gendered) construction of diagnosis interpretation of medical signs in women patients. *Theoretical Medicine and Bioethics*, 20(3), 275-286.
- Off-Label drug use. (1997). *Harvard Women's Health Watch*, 5(2), 2-3.
- Patz, A. (2004). A women's health bible gets a makeover. *Health*, 18(5), 65-67.
- Ravnikar, V.A. (1987). Compliance with hormone therapy. *American Journal of Obstetricians Gynecology*, 156, 1332-1334.
- Richter, B., & Patton, C. (2007). Selling "The Change": A comparison of the dangers of hormone replacement therapies in profit versus national health care delivery systems. In M. Morrow, O. Hankivsky & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy*. (pp. 434-455). Toronto: University of Toronto Press.
- Risks vs. benefits. (1992). *National Women's Health Report*, 14(4), 1-4.

- Rosenthal, M.B., & Donohue, J.M. (2005). Direct-to-Consumer advertising of prescription drugs: A policy dilemma. In M.A. Santoro & T.M. Gorrie (Eds.), *Ethics and the pharmaceutical industry* (pp. 169-183). New York: Cambridge University Press.
- Seaman, B., & Seaman, G. (1977). *Women and the crisis in sex hormones*. New York: Bantam Books.
- Swann, J. P. (1999). *History of the FDA*. Retrieved July 28, 2004, from <http://www.fda.gov/oc/history/historyoffda/default.htm> (adapted from G. Kurian, Ed., *A Historical Guide to the U.S. Government* 1998)
- Ussher, J.M. (2006). *Managing the monstrous feminine: Regulating the reproductive body*. New York: Routledge.
- van Keep, P.A. (1990). The history and rationale of hormone replacement therapy. *Maturitas*, 12, 163–70.
- van Wijk, C., Vliet, K., & Kolk, A. (1996). Gender perspectives and quality of care: towards appropriate and adequate health care for women. *Social Science and Medicine*, 43(5), 707-720.
- Vanderhaeghe, L. (2004). Menopause misery sends women back to HRT. *Alive - Canadian Journal of Health & Nutrition*, 259.
- Weber, L.J. (2006). *Profits before people: Ethical standards and the marketing of prescription drugs*. Bloomington, IN: Indiana University Press.
- Wiley, T.S. with Taguchi, J., & Formby, B. (2003). *Sex, lies, and menopause*. New York: HarperCollins.
- Wilkinson, S., & Kitzinger C. (Eds). (1994). *Women and health: Feminist perspectives*. London: Taylor and Francis.
- Worcester, W., & Whatley, M. (1992). The selling of HRT: Playing on the fear factor. *Feminist Review*, 41, 1-26.
- Wyeth (2004). *Wyeth launches national advertising campaign for hormone therapy featuring the lowest effective dose of Prempro*. Retrieved August 10, 2004 from http://wyeth.com/news/archive?nav=display&navTo=/wyeth_html/home/news/pressreleases/2004/1145634843754.html
- Zola, I. (1972). Medicine as an institution of social control. *Sociological Review*, 20, 487-504.

**2:
COMMUNITY-UNIVERSITY CO-OPERATIVE
MODEL CASE STUDY: A REFLEXIVE AND
EXPLORATORY LOOK AT ONE CBR EXPERIENCE**

Introduction

On a cool sunny April day in Prince George, British Columbia, I sat diligently piecing together a slide show of pictures that I had taken over the prior three days, while people representing several groups from across Northern BC communities were presenting research plans and the beginnings of potential projects aiming to address rural Aboriginal HIV issues to Northern Health Authority officials.

After the excitement and relief of five successful group presentations, I was in charge of the weekend's closing slideshow. Even the most photo shy participants reacted positively to the photographs that recorded their activities and collaborations from the three day community-based research project. Though I was exhausted from the few days of intense work, not to mention the prior year spent planning the event, as I prepared the photo presentation, I felt a great sense of relief and satisfaction at our collective successes.

At the same time however, I began to reflect upon and analyze what exactly had transpired. Coming from the university side of a “community-university partnership,” had I honestly and productively engaged these Northern BC communities in CBR? After all, communities have for a very long time been successful at community-based research without the involvement of academics from universities. I wondered what, if anything, had my involvement and the university involvement done for—or against—the long-term processes of CBR?

In this essay, I present a detailed description of this project—*Three Days in the Fire Pit*—to demonstrate a particular vision of community-university collaboration that I

have helped develop. Through an examination of this example, and the model enacted, I hope to showcase one successful community-university collaborative experience, but also raise questions about a range of ways of thinking about and doing CBR that are represented in the current literature on community-university collaborations. In showing how this model compares to other community-university models, I hope to emphasize some important, but still overlooked aspects of the university's place in such projects. I will also suggest that the current granting agency system does not always work to foster productive working CBR relationships.

I have no intention of positing this model as the primary or only way to engage in community-university CBR partnerships. While the model will not appeal to everyone's sense of what CBR is or how it should work, it will provide an alternative that I hope can be useful and provide some insight for university-centred individuals undertaking community-based research. *Three Days in the Fire Pit* was a success due largely to the collaboration that was established between all parties—a success I hope to convey honestly and fairly. I will use a case study of *Three Days in the Fire Pit* to, as Reinharz (1992) says, “illustrate an idea, to explain the process of development over time...and to pose provocative questions.”

Over the last few years, talk and use of community-based research and community-university collaborations have become common in universities, particularly in Canada. At the same time, it is evident that there are widely different understandings among community and university practitioners of what community-based research is (or is not), and how a CBR alliance is formed and a research project carried out and completed. CBR models can range from enormous longitudinal university controlled top-

down research projects that merely “recruit” participants to very short term, small scale and organic research projects based in small or marginalized populations who may not even conceptualize their activity as “research.” For example, in relation to health CBR, the Vancouver Foundation (2007) states that, “community based health research...is conducted by community members... driven by the community and builds capacity within the community...research projects often have *no formal links* with an institution such as hospital or university (Italics my own).” On the other hand, from the Strategic Research Meeting Summary on Culture, Society and Human Behaviour (January 13, 2006), Simon Fraser University’s (SFU) VP Research states that “community-based research initiatives could include the following: Urban and community sustainability, particularly through the Centre for Sustainable Community Development *at SFU...* (Italics my own).” Thus, clear differences can be seen in how these approaches to CBR, particularly in terms of origin and control, vary.

While I believe community can be defined as generally as, a non-government, non-academic, public group held together through a common history, geography, issue or other shared social concern or reality, I do not believe this is good enough to successfully work with community. A clear understanding of various constructions of community is essential to collaborative CBR work (understanding one’s own position in relation to specific community partners and understanding all community and non-community collaborators relationships to each other). Community can include organizations, frontline workers, marginalized groups and individuals. Greater focus on levels of community and specific community history can be one way to help increase productive and balanced relationships. This understanding of all participants’ positions is to a large

degree, recognition of how power is held, distributed and used within collaborative relationships, something that is discussed differently across the existing literature.

Community-based research involves many complex relationships and responsibilities, increasingly so when universities becomes involved. Through my experience, I have come to believe that CBR projects that have university involvement of almost any kind risk disproportionate control by academics. I firmly believe that university-based researchers must engage in CBR that is both immediately and lastingly beneficial to community groups and members while refusing to create CBR grounded at the university level. If projects are not developed from the (often marginalized) communities that request and need assistance in addressing a variety of issues, I believe projects fundamentally lack what is needed to be called CBR. While I do not entirely dispute the usefulness of some university-based community research, my position on CBR, particularly with regards to ownership of project outcomes and both short- and long-term project benefits and support for communities, guides how I believe CBR relationships should be approached and formed. It is from this critical stance of university involvement that I approach this essay, being mindful of the varying ways that universities and communities can establish working CBR relationships that are neither exploitive nor harmful.

Community-University Collaborative CBR Models

Four Model Types

While academic literature across several disciplines reveals many constructions of community-university CBR, with several overlapping and opposing ideas of how these projects work, an important mode for classifying community-university CBR models is

apparent. Virtually all models utilize a variety of methods and tools, therefore, it is difficult to divide them across specific methodologies. Where models, regardless of discipline, show a noticeable division is with their assumptions about underlying structures and motivations that form the community-university relationships. Based on these assumptions, four primary community-university model types arise: 1) marginalized community models, 2) primarily service-learning models for students, 3) goal specific models designed to engage specific communities on individual projects (short or long-term in nature), and 4) models designed to create an institutional program for sustained community-university collaborations.

In an example of a marginalized community model, Austin (2003), discusses a collaborative project undertaken to understand the impacts of offshore oil and gas activities on individuals and families in southern Louisiana. In this project, Austin offers a model “for building relationships and achieving effective collaboration to address complex issues, especially when the motivation for the research originates outside the community” (143). In reference to applying for funding, Austin also admits that, “though we planned for community collaboration as well, and we talked with local contacts about what we were planning, we did not identify specific community partners prior to submission of our proposal” (145).

In the forward to Blumenthal and DiClemente’s (2004) *Community-based Research: Issues and Methods*, a book speaking to collaborative efforts, former Surgeon General David Satcher states, “community-based research is where medicine, public health, and science meet. Put another way, community-based research gives medicine the information it needs to serve communities as well as individuals...” (xi-xii). These

statements remain unclear about what methods CBR requires, but clearly nod to an understanding of community as secondary in project relationships. Marginalized community model articles engage in little analysis or commentary about the power within collaborative relationships. This absence is a prominent signal that these projects are not overly concerned with recognizing relationship inequalities. While projects, such as those undertaken by Austin, and other similar works may produce important research findings, I argue that CBR that is not first and foremost grounded in community violates the very rationale for CBR, which is to listen and work with communities on their own terms.¹

Service-learning models focus on providing an environment where students access and assist communities in an effort to provide real world work experiences. These models usually provide some type of academic evaluation and/or credit for students in exchange for their participation. One significant example of this type of collaborative effort is Campus Compact in the United States (2007), an organization that networks member university students with community groups to assist on needed projects. On their web page, Campus Compact states that, students look forward to experiencing “a culture of civic-mindedness that has a lasting impact,” and all the while, “higher education is seen as contributing to the public good.” Although Campus Compact claims to work toward supporting communities in need of assistance, their primary concern is focused on student and university gains. While Cipolle (2004) argues for changes in service-learning programs, including developing systems which recognize university-based power and students’ position of power and privilege, most service-learning articles completely fail to address notions of power. Eyler (2002) argues that students involved in service-learning

¹ While not invalidating the research, I dismiss marginalized community models as CBR. The other categorized models presented in the literature as well as the HeRMeT model recognize community as, at least theoretically, an equal or primary player in community-university CBR.

need a great deal of reflection to maximize benefits, and the ideal way to foster reflection is to have students present their reflective findings to the community. Although it is important for all partners in a collaborative model to share their thoughts on their roles, subjecting communities to student-centred thoughts and arguments may not be in the best interest of collaborative relationships or the communities themselves. Indeed, such an exercise risks positioning community members as observers of university processes and not as fully equal participants.

A third model type focuses on the creation of goal specific, partner specific and focused collaborative CBR. Individual scenarios can involve project building initiated from either the community or university, and aimed at addressing a commonly decided goal. These models develop a set of methods and tools to compliment the goals of the project and usually require obtaining funding that focuses on the specific goal with a specific timeline. Minore, Boone, Katt, Kinch, & Birch (2004) provide one demonstration of this model in undertaking a collaborative effort to address realities of health care for northern Aboriginal communities in Ontario. They note the importance of continued negotiations and flexibility that is required to build a functional relationship between Aboriginal communities and researchers. In their model, community partners work directly with academics to determine goals, funding, and how to best utilize research project outcomes. They argue, “inclusion and equality shift the balance of power, allowing communities to be in control of research into their lives that affects their lives” (365). Working together, they attempt to negotiate control of the product of the partnership.

Lastly, some community-university collaborative models attempt to establish an infrastructural entity (usually an institutional mechanism at the university) as a means of fostering ongoing collaborative efforts with community groups. These models often grow out of previous collaborative efforts and attempt to establish a centre where ongoing collaborative projects can be fostered, funding can be more easily sought, and stronger networks can be developed.

For example, the Community University Institute for Social Research at the University of Saskatchewan, as discussed by Williams, Labonte, Randall, & Muhajarine (2005), builds support through graduate scholarships (student participation), teaching release stipends, community research sabbaticals and community-based student internships. In their discussion, Williams et al. identify several key steps in developing collaborations, “initiation, formulation of research question(s), development of methodology and research instruments, data collection, data analysis, results interpretation and evaluation, and decision-making or action” (298). These steps allow for carefully constructed projects that maintain an awareness of power dynamics between partners. Williams et al. also point out that by creating an institution with several members and partners from the university and the community, it is more likely that community can initiate research collaborations, which is not normally the case with most partnerships. They write that the Institute for Social Research at the University of Saskatchewan,

“pursues research in three areas: community economic development, population health determinants and health policy, and quality of life. Each of the three research areas is co-led by both a community member and a university academic, all of which make up a management board led by two co-directors who similarly represent both the community and the university. Research support is provided through graduate scholarships, teaching release stipends, community research sabbaticals and community-based student internships” (292).

Another institutional type model, Sustainable Toronto, “models a balanced research collaboration, in which citizens’ groups and scholars share the direction of each research project, their precise roles being determined by the nature of the project and the time invested by the respective community and academic co-directors” (Savan & Sider 2003, 311). Developed through the University of Toronto and York University, this model relies upon a combination of academic faculty, graduate research assistants, undergrad per-credit involvement, and is mindful to avoid research *on* communities. The model, funded by the Social Sciences and Humanities Research Council’s Community University Research Alliance funding schema, attempts to foster several multi-year partnerships with community.

Issues of Relationship Building, Power, and Project Funding

The model types, as presented individually and comparatively, prove complex, particularly in relation to relationship establishment and power distribution, project duration, and funding. While three of the four models recognize power dynamics between academic and community partners on some level, they differ in certain ways. Where service-learning models acknowledge the importance of equal community participation in the collaborations, the critiques go no further. Goal specific models generally express a firm awareness of power dynamics and speak about the importance of equal participation, decision-making and control. Institutional models echo these concerns, but in general, go further by limiting academic control over projects.

Interestingly, but not surprisingly, researchers who discuss goal specific models report the most incidences of conflict and difficulty in establishing working relationships.

Goal specific models reflect the difficult nature of fostering positive community-university relationships. Both service-learning and institutional models have more guidelines and established partnerships with community. Goal specific projects often have more work to undertake, not only by establishing trusting relationships, but also in terms of negotiating power and decision making authority throughout projects.

In their attempt to construct health data maps through a community-university collaboration, Buckeridge et al. (2002) acknowledge power differentials. During their process they observed that, “a key realization for all of the participants in this study was that the partners were situated within and, therefore, familiar with two very distinct cultures, with attendant differences in expectation, values, outcomes, reward systems and work styles” (1200). They also acknowledge that some university partners felt community partners held power through their decision making on the project and that some community partners felt overwhelmed with the resources held by the academic partners. Additionally, Israel, Schulz, Parker, & Becker (1998) recognize that many conflicts arise over funding, including granting institution infrastructure not designed for CBR, health and university financial systems not designed to handle community oriented expenditures, and concern over how CBR funding is managed amongst the community and university partners. In general, models with more pre-existing relationships between the community and academy showed fewer conflicts.

As mentioned above, among the model types, institutional models most explicitly attempt to address issues of university control over collaborative CBR projects. The relative stability of these CBR institutes and at least marginal university acceptance may play a role in easing the motivation for academic control. Proponents of goal specific

models seem more heavily invested in discussing project control equity and less interested in acknowledging the university's unbalanced power within CBR relationships. Users of service-learning models make little mention of the community perspective or interests. Among model types though, project durations are similarly discussed. Short-term projects are usually discussed in terms of one or two years, while long-term projects are discussed in terms of three or many more years. Discussions of project duration in the literature often lead to discussions of funding.

Researchers using service-learning models mention funding very little, although this is most likely a reflection that service-learning models require fewer economic resources. Among those using goal specific and institutional models, funding is a consistent complaint, although the impacts differ across these two models. While both models rely upon consistent funding to support collaborations, users of the goal specific model have no or little foundation to build upon and without funds, projects will generally not happen. This also amplifies the relationship building process of CBR. The institutional model however, all works through various means to establish a base fund for the institute itself, providing stability, with additional funding often needed for specific projects. While institutional model projects are not as immediately hindered as goal specific model projects are without funding, it remains a priority. Williams et al. (2005) fully acknowledge granting agency problems, asserting that "despite the recent push by research granting agencies to fund community–university partnerships, we note three critical limitations with many funding arrangements," the first being "the short time period for such grants," and second a "failure of granting agencies to understand and accommodate the decision-making processes of community organizations in the grant

application process,” and lastly “that research funders have yet to grasp the importance of the ‘knowledge exchange’ aspect of partnered research” (297).

An Alternative Community-University Collaborative CBR Model

Relation to Existing Approaches

While not directly developing from any individual theoretical approach or applied research background, the model I have helped develop, at the Health Research & Methods Training Facility (HeRMeT), shares values with different approaches to research, including feminist participatory action research, Aboriginal and HIV community-based research models. Briefly discussing what similarities and differences the HeRMeT model shares with these will help place it within current discussions of community-based collaborative research.

Among feminist participatory action research goals, recognition of social imbalance of power and the desire to create openness of communication are the primary notions most closely shared with the HeRMeT model. Reinharz (1992) states participatory research, “is designed to create social and individual change by altering the role relations of people involved in the project...the distinction between researcher(s) and those on whom the research is done disappears” (181). HeRMeT strongly believes that a historical and current imbalance of power exists in research, particularly among marginalized groups. Although these values overlap, calling the HeRMeT model feminist participatory action research would fall considerably short of recognizing that the primary goals and ways of engaging community partners extend beyond reconciling power within research roles.

Allman, Myers, & Cockerill (1997) summarize the historical background of community-based HIV work, particularly in Canada, which also shares some relevance to the HeRMeT model, which has been primarily utilized to address HIV research needs. They argue that, early on, HIV research was not conceptualized solely as a medical or academic issue, but involved the inclusion of community as this was seen as a necessity to address prevention and treatment. In this sense, the HeRMeT model has followed a historical trajectory of working directly with community to address specific HIV related needs. However, in relation to the historical trajectory of HIV research projects, Allman, Myers, & Cockerill also note, “that most have been researcher-led, though not necessarily researcher-initiated, whereas very few have been conducted and controlled by community” (5). This strongly suggests that while HIV research may have long involved community, it has not always aimed to address issues of power among academics and community groups. Overall though, counter to many areas of health research, and particularly within Canada, Allman, Myers, & Cockerill note that, community-based research may be considered the paradigm for HIV/AIDS research” (22). This notion lends credibility to the HeRMeT model, because projects and models that address HIV issues through CBR are more readily accepted than projects might be that use CBR to address other health or social research areas.

Aboriginal community-based research is a third approach that the HeRMeT model reflects in some ways. Reflecting historical and current inequalities, as well as particular cultural histories, Aboriginal CBR assumes a very self-determinant position. As Marsden (2002) notes, one of the primary standards across most Aboriginal research are the principles of *ownership, access, control, and possession* (OCAP). Originated from

Aboriginal communities, OCAP directly addresses issues of power and practices within research collaborations. Although clearly run from a university position, the HeRMeT model most closely attempts to reflect and engage in projects which adhere to the general principles of OCAP. As identified by Marsden, Aboriginal research models often include partners due to social limitations on community control, such as requirements for university partnerships to obtain funds, ethics approval or access to resource, which would otherwise not be available. In this respect, Aboriginal approaches are far more critical of academics than HIV CBR, which has historically included academics and clinicians in models of research.

Although each of the preceding approaches share some aspects with the HeRMeT model, none have completely guided or dictated its development. Our model has developed through a range of individual and shared experiences, perspectives and social positions, which I will now address. These have added to some of the uniqueness of the HeRMeT model as well as created some of the difficulty in replicating the model.

Partners in the Model

As noted, the model and process that has been created depends upon the collaborative work of several individuals, organizations, and community groups. The primary players in this model are HeRMeT, a health oriented facility at Simon Fraser University, the British Columbia Research Technical Assistant (RTA) housed at the BC Persons with AIDS Society, and most importantly, the various organizations, members and community groups who are our partners in CBR projects. Again, this model was developed to address HIV/AIDS issues within communities. That said, it could be

utilized to work within other areas of health or social research and within a variety of communities.

How each of our respective positions was created, is funded, and how they function, has played a central and important role in creating our unique approach to CBR. HeRMeT (at Simon Fraser University) integrates community-based research with health promotion in real-world settings, and in particular, with investigations of applied research methodologies and their application to public health issues. The programs of research undertaken in the facility cross sectors and disciplines in health care and health education while increasing the ability of consumers to participate in and utilize the results of health research. HeRMeT is a physical and conceptual space created by Dr. Cindy Patton, Professor in Sociology/Anthropology and Women's Studies at Simon Fraser University and holder of a Canada Research Council (CRC) Chair in Community, Culture and Health. The facility was created and runs under the mandate of this CRC Chair position. The facility attempts to engage in CBR that is community-centred, community-directed, and focused primarily on directing benefits to the community rather than the University.

RTAs are funded through Canadian Institutes of Health Research and mandated to develop CBR capacity among AIDS service organizations (ASOs), academics, and other research partners. This mandate allows for and requires a great deal of flexibility in addressing all the requirements of the communities requesting assistance, and at the same time, places an extensive amount of work of the shoulders of whomever holds this position.

Forging Working Relationships

Although the model of community-based research that we have developed can be seen as having a few key components in how it functions, perhaps the most important component of all is building strong and trusting working relationships. This includes, first and foremost, open and clear communication between everyone involved. The model grew out of a pre-existing relationship between the BC RTA, Dr. Francisco Ibáñez-Carrasco and Dr. Cindy Patton, who had known each other in the past and had already developed a relationship of trust and common orientation toward communities and research. It can not be understated the importance that Dr. Ibáñez-Carrasco and Dr. Patton's backgrounds played in forging the HeRMeT model. Both having come from and having engaged in HIV/AIDS work in the community before moving into the academy, they brought a different set of experiences and perspectives than researchers who are purely products of the academy.

One of the most difficult aspects of engaging in this type of work is building strong and lasting relationships with community groups. These communities are often marginalized, ignored and have not had particularly positive relationship experiences with academic researchers. The RTA position is designed to be supportive and engage communities through provincial non-profit AIDS service organizations and groups. Existing relationships between the RTA and communities throughout the province of British Columbia have allowed this model of collaboration to develop.

Because there exists such a vast number of ASOs and communities that require assistance with a variety of research projects throughout BC, and because the RTA is one person operating on a shoestring budget, an opportunity to foster a relationship that would channel more assistance to communities was taken. However, it is not realistic for

HeRMeT to simply contact these communities and begin working with them. Regardless of HeRMeT's intentions, we are constructed through and situated within the university, and as previously discussed, for a variety of (good) reasons, including many exploitive research experiences perpetrated by the universities on communities, it is difficult to build and foster working relationships with many in the community. Relationships need to be strategically fostered, which is accomplished by having HeRMeT provide skilled students whom the RTA can supervise and develop the initial relationship bridge via the student and between HeRMeT and community.

In the most skeletal sense, the model works as follows. The RTA brings to the attention of HeRMeT, projects that he has been asked by community ASOs to support, and that may be able to benefit from HeRMeT's involvement. From there, it is determined whether HeRMeT has the necessary resources and skills to contribute to the community's needs. This entails asking a few questions. Is there a student (intern) within HeRMeT (paid as a research assistant – this is important, a point I will return to later) who has the skill set to match the required work of the project and if so, does HeRMeT have the monetary resources to sufficiently support both the intern throughout the project as well as provide possible support for the community following the official duration of the project?

Once it is established that a good “fit” will occur, the RTA takes the essential step of brokering a relationship between a HeRMeT intern and the ASO and community who requested assistance. It is essential to stress the importance of trust and respect in these relationships. Because the RTA has worked hard to establish trusting relationships with communities, it enables some degree of trust to be extended to the intern when the RTA

fosters this relationship. However, it still takes a great deal of effort to build upon this initial relationship. Once a relationship has been established, the project can move forward.

The RTA essentially works as the hub and coordinator for the intern duration of projects under this model. Once the project is established, the HeRMeT intern functions relatively separate from the actual HeRMeT facility. Their main objective is to fulfill the goals of the research project and support the community. The RTA is in charge of deciding the scope of the intern's involvement and may adjust it according to how the project is proceeding. This allows for the best possible support and outcome across various projects.

Economic Considerations

Funding for the HeRMeT facility is key to fostering the development and maintenance of this particular model of CBR. As with research at all levels, funding often dictates how much work can realistically be accomplished, and perhaps more importantly, exactly what work can be done and to whom results are beholden. Funding for the facility is obtained through both Dr. Patton's CRC position and her position as SFU faculty. Because grants are written with community-based research support built into them, and some are prepared to fulfill Dr. Patton's CRC mandate, there exists a degree of flexibility in fostering various types of community work. This monetary flexibility has been extremely important in allowing the specific model and process to develop and marks an important departure from many other community-university CBR models.

The Work

Given that the HeRMeT internship model is flexible, it allows for engagement in a wide range of projects, both in respect to the types of work undertaken and the duration of time needed to complete them. To date, HeRMeT has engaged in collaborative projects that are both relatively short, spanning a couple months, and projects that have been much longer, spanning over a year. Through the various projects HeRMeT has taken part in over the last couple years, a high degree of success based on our individual goals and feedback from our partners and communities involved in each of these projects has been experienced.

One example of project work that is shorter in duration is HeRMeT's involvement in helping communities complete needs assessments. Successfully determining a community's needs assessment can require the employment of a variety of tools, such as questionnaires, focus groups and interviews. There can exist a great deal of misconception over both the skills needed to successfully complete these assessments and the time and resources that are required. Our goal is to assist communities in completing what work they would like done while undertaking this in a collaborative manner, including maintaining community-focused decision making.

Because the time and resources it can take to carry out a needs assessment can be demanding, there is a need for a great deal of open discussion of project scope and limitations with community organizations and groups. After determining the extent of resources available to contribute through this CBR model (RTA's time, the student's time and skills as well as economic support capabilities), the important step of working collaboratively with the community through careful planning to determine how to best get a realistic and usable amount of work done can be undertaken. This can be a difficult

process because often not as much can be accomplished as desired, and tough decisions and sacrifices must be made. However, lesser amounts of usable work is a more desirable outcome than greater amounts of unusable work.

Another primary goal in our community-based research model is to engage in capacity building. Community groups are rich with skills and abilities, though they are often unrealized or conceptualized in alternative ways. Although this model is designed to provide varying levels of assistance in carrying out projects, the end goal is to provide assistance while building lasting supportive relationships and transferring as many skills as reasonably feasible.

Three Days in the Fire Pit – Description

In April of 2004, Positive Living North (PLN), a non-profit HIV ASO in Prince George BC, contacted the BC RTA and expressed their wish to put together a collaborative project with central and northern BC communities to discuss rural Aboriginal HIV issues—an underfunded and arguably epidemic issue in Northern BC. This project goal would require funding, and the RTA was aware of GlaxoSmithKline holding a grant contest for non-profit ASOs to apply for up to \$15,000. The RTA approached HeRMeT with the possibility of a student intern collaborating on the project. At that point I was serving as a HeRMeT intern and I joined the project with the goal of assisting PLN in writing a grant application and budget, as well as assisting with advancing and coordinating the development of the project if funding was obtained. The original collaborative team who formed to develop this plan was Positive Living North, Dr. Francisco Ibáñez-Carrasco, the BC RTA, Theresa Healey, a professor at the

University of Northern
 British Columbia, San
 Patten, the Alberta RTA,
 and Dr. Cindy Patton
 and I from HeRMeT.

The goal was to
 hold a three day
 educational, relationship
 networking and
 exploratory workshop in
 Prince George focusing
 on rural Aboriginal HIV
 issues in central and

northern BC as well as northern rural Alberta. We titled our collaborative team the
 Action Research Team (ART).

We started working together by partaking in several conference calls to discuss
 the construction of the grant application and what the actual structure, activities and
 agenda would be for the three-day workshop. After the goals for the grant were
 determined, I undertook the process of gathering all relevant information and writing the
 grant application proposal. The grant application was then circulated amongst the team
 with the understanding that PLN would have the ultimate control and final decision
 making authority on all things related to the grant.

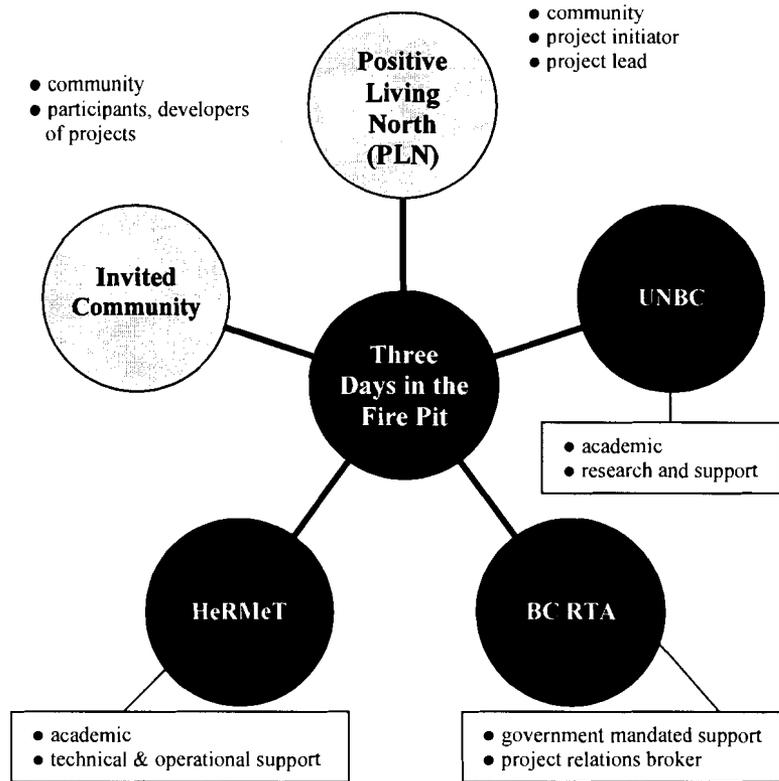


Figure 2.1: Three Days in the Fire Pit Structure

It should be pointed out that the seemingly simple steps of scheduling conference calls, circulating feedback in an organized manner, and obtaining all relevant information from the team to write the grant was a difficult process, which took considerable patience and flexibility from all of the collaborators. Fostering relationships during the first couple months played a crucial role in developing a stronger sense of trust and collaboration beyond what the RTA had initially established. This demonstrates one point of uniqueness with this model. Without having the RTA to jump start building a relationship between the community and the university, it would take much longer to achieve this working scenario. The grant was approved by PLN and submitted on June 11, 2004, with grant decisions due near the end of September. The collaborative team decided to not progress forward much on specific workshop details until the grant decision came in, so until the end of September, the team had only monthly communication.

With happy news shared among the team in late September that the grant was awarded (funds being distributed to PLN that November), the team turned toward preparation of the workshop specifics. Aside from the systemic marginalization of rural northern Aboriginal HIV issues, the process of undertaking the project proved challenging for two practical reasons. The first was that scheduling conference calls and/or physical meetings between all who were involved was difficult. Secondly, the weather and terrain of Northern BC created difficulties for transportation. PLN quickly decided that we would need to wait until the following spring to hold the workshop as the weather made flying and driving participants in from Northern BC too difficult and/or expensive. We decided to move forward slowly over the winter and revisit the project development in late January, 2005.

In early 2005, with substantial in-kind money contributions from the RTA and HeRMeT, the project moved forward. As we started to develop final curriculum and decide upon inviting participants, San Patten, the Alberta RTA, had to leave the collaborative effort due to work changes meaning that the Alberta portion of the collaboration was dropped for logistical timing reasons. This change serves as an important reminder that individual participants in the collaboration are of the utmost importance. The development of trust and hence good communication are not easily replicated or extended. A primary example of the importance of having pre-established networks to access and utilize in this model and CBR work in general. Following this development, the collaboration shifted toward putting together the workshop which involved creating structure, activities and curriculum as well as making decisions about inviting participants, and organizing all travel and accommodations. This portion of the project again involved a high degree of cooperation and collaboration between all members of the team.

The final workshop dates were set for April 18th through April 20th, 2005. PLN decided upon whom the invited participants would be, attempting to build a group of people representing several different Northern areas. Activities leading up to the workshop included sending out letters of invitation to community members, creating and sending out pre-workshop information requests, booking lodging, conference space, food and other accommodations and obtaining all necessary supplies and creating the final workshop schedule.

The workshop itself consisted of the ART presenting several key research mini training and sharing sessions, individual group research project development (topics were

pre-determined by participant feedback, Appendix A), and presentations to Northern government health authorities. The actual working schedule and participant schedule are contained in Appendix B and C respectively. The 16 participants were community members and frontline workers from cities and areas around Northern BC, such as Prince George, Terrace, Quesnel, Vanderhoof, and Smithers. This included several Aboriginal participants as well as an Elder who led daily opening and closing prayer and participated in all aspects of the workshop. Differences in social norms and research perspectives among the participants proved difficult at times. At one point, a Caucasian HIV+ guest speaker dropped in to address the workshop and was asked by one of the Aboriginal participants how he had contracted HIV. This resulted in a brief amount of tension and anxiety among everyone attending; different individuals having different perceptions about the acceptability of the question. This highlights one of the challenges of facilitating collaborative work with different communities, and the importance of open and positive communication. Caused by differences in social norms, and with no one at fault for creating a tense situation, the trust and openness that had been established allowed the group as a whole to, relatively quickly, verbally work our way through the situation and carry on in a positive and productive manner.

The workshop had three primary goals. Firstly, we set out to examine and understand the barriers faced by rural Aboriginal HIV+ individuals in accessing care and treatment. Secondly, we created a vehicle for shared identification of problems and discussion of strategies to address those problems. Thirdly, we initiated action research and/or program development plans to be pursued locally by participating organizations, in order to provide better treatment options to rural Aboriginal populations.

The mini lectures for presentation and discussion focused on ethics and community-based research, qualitative data and quantitative survey/questionnaire data. These were presented by the ART members and were designed to educate and facilitate discussion, with a particular focus on highlighting skills already held by participants that were not constructed as “research” skills and to help participants develop their own group research projects. The topics of interest the five groups focused on were HIV and sexual exploitation, HIV and community responsibility, Sexual exploitation of youth, Living with HIV (and Hep C and related conditions) in a fish-bowl environment, and Fetal Alcohol Syndrome and HIV. At the end of the third day, each group presented their topics, concerns about barriers, and next steps for action and research plans to Northern Health Authority officials. The officials were invited so they could experience direct input and have conversations with actual members of the communities they were mandated to oversee health decisions for.

Three Days in the Fire Pit was a great success due to the collaboration that was established between all parties, but also largely because the final decisions and ultimate control was left in the hands of Positive Living North, the community ASO. Beyond this, the topics or group focus and development of research plans were dictated by the community participants and allowed them to present relevant community issues to local health authorities.

HeRMeT Model Reflections

As I have stated previously, the HeRMeT model discussed in this paper is not meant to represent either the sole or best way to carry out community-university collaborative CBR, but is rather a demonstration of one successful model—a model that

in some ways functions differently from the ways in which many of the current academic discourses construct CBR. However, it is important to take a step back and discuss how this model fits in and compares to the existing models as well as to reflect upon some additional strengths and weaknesses that this model presents.

Like the service-learning, goal specific, and institutional models, HeRMeT shares little with the marginalized community model. The HeRMeT model is designed, in part, to address the university practices which take advantage of community as a means to advance academic careers. While we are university-centred and falter at times, we make every effort to not engage in projects which do not recognize power dynamics and put community in control.

The HeRMeT and service-learning models most clearly share the process of utilizing students (in HeRMeT's case, graduate students) to work on collaborative projects. Similar to the service-learning model, we recognize projects as an opportunity for students to develop new skills and abilities. However, unlike the service-learning model, HeRMeT does not place students' gains above those of the community. The HeRMeT model works well because it avoids potential conflicts in student participation by not granting academic credit or having a formal evaluation process. Students who engage in this work are part of the program because the research and style of the CBR work we are participating in is of interest to them and compatible with their skill sets. Granting academic credit or formal evaluation would provide no valuation to the goal of this model. Rather, it would create significant complications. Many community-university collaboration programs, including the Action Research eXchange (ARX) at SFU are for academic credit. Providing credit would be a burden to the student because

of the extra motivational concerns that typically result in distractions from the project at hand. While the model put forth certainly aims to achieve education for the students involved, assisting communities in carrying out research is first and foremost in priority. In addition to creating a distracting dimension for the student, having a for-credit, formal evaluation system, would burden the RTA with the need to take on an additional role. Because the RTA does work as the supervisory coordinator of how the student functions within the project, it would require that they then be asked to assess the students work from the university's perspective, adding a potentially conflictual aspect to each project.

The HeRMeT and goal specific models share more similarity in the way individual project plans are developed. They differ in how community partnerships are established and developed as well as how funding is utilized throughout projects. Like the goal specific model, we can at times engage in projects with community partners which we have had no previous communication with. A primary difference is that HeRMeT utilizes the RTA to create much faster and streamlined collaborative relationships, whereas goal specific model projects involve a more heavy investment of resources to establish working relationships. Through my experience, HeRMeT has experienced far less relationship conflict than many goal specific model projects describe. Once relationships are developed, the models can function similarly in needing to develop specific goals and methods to obtain those goals. However, goal specific model projects require funding to be obtained before projects can successfully move forward. HeRMeT CBR projects can involve applying for funding, such as with *Three Days in the Fire Pit*, but have also been involved in several projects which do not include this extra step.

Overall, the HeRMeT model most closely resembles the institutional model in the literature. Although not an official institution at the Simon Fraser University, it functions as a stand-alone entity, which is available to engage in various community CBR collaborations. In a somewhat diminished way, HeRMeT has held operating funds like that of the institutional model. In terms of relationship building, from its inception this has allowed HeRMeT to function much like the institutional model, despite its relative lack of institutional infrastructure or history of collaborations. The HeRMeT model is able to quickly establish relationships with community groups through the RTA without having to build them without the support of a previously established foundation. With *Three Days in the Fire Pit*, neither PLN nor HeRMeT would have been aware that a collaborative effort was a possibility for this project, and even had we, the speed at which we developed and formed a trusting relationship could never have occurred. The HeRMeT model also recognizes somewhat different relationship building and maintenance than the institutional model. Like the institutional model, HeRMeT maintains relationships with community members and groups. But unlike the institutional model, this is not for undertaking projects but as the basis for being supportive. We do not maintain relationships for the purpose of doing research together. Project may or may not grow out of these continued friendship-like networks that have been developed.

HeRMeT has also intentionally designed a model that acknowledges the university's historical and continued exploitation of community, and which allows community control over projects through a fully open and collaborative process, and well understood HeRMeT support role. This mode of operation is seen only among some of the institutional models, such as Williams et al. (2005), but very few authors go this far.

The majority, while arguing equal partnership, do not express the inherent power that universities often hold. I object to the common theme that acknowledging power differentials between academic and community partners absolves the model or academic of problematic power dynamic construction. It is true that community members can have power, particularly within their own community, which academics do not have nor often understand. However, I suggest that academics that cannot understand community and relationships outside the boundaries of university power dynamics, or feel threatened by these issues, dismiss themselves from participating in community-university collaborative CBR.

While I discussed shorter and longer term HeRMeT CBR projects earlier, these distinctions differ from the other model types. HeRMeT has not collaborated on one continuous CBR project using this model for longer than a year and a half. Some of our shorter term projects mirror service-learning model projects which can be built around semester timelines. The body of literature on goal specific and institutional models suggest short-term projects last a couple years while long-term projects last many more years. They also suggest that long-term collaborative support is strongly desired by communities. While the HeRMeT model has proven effective for helping to assist communities with specific and relatively short term goals, the model is limited in its ability to engage communities in long-term CBR projects by the standard of goal specific and institutional models.

As I have discussed, though showing similarities and difference among other model types, funding has played a very important and central role in how the HeRMeT model is constructed and functions. The funding structure has allowed HeRMeT to run on

little funding, preserving the modest amount of funding held to be used on specific projects. Even though current funding of the HeRMeT model is restricted in its ability to allow participation in anything but smaller projects by other model standards, the facility's ability to function outside specific institutional research guidelines, timelines, or expectations allows collaborations to develop and function with a degree of freedom not realized through many community-university CBR models. While the majority of literature on the community-university collaborations has something (usually frustrating) to say, I think it is, at times, understated how much funding dictates what types of community-university CBR projects are able to be pursued. Having been involved in a variety of typical university grant application processes with organizations such as Canadian Institutes for Health Research and Social Sciences and Humanities Research Council, it has become abundantly clear that community-centred projects will see little contribution from these agencies. Although funding organizations are becoming increasingly aware of the disproportionate CBR support dollars that are given to university faculty, infrastructural procedures seem slow to change at best. Some of these issues could be addressed by providing government agency funding directly to community groups while changing certain guidelines. These changes could include, allowing community organizations to apply for funding without the formal involvement of universities, ensuring that all funding outcomes are owned solely by community and shifting away from project specific funding, allowing for open ended funds tagged for operation and undefined goals.

A strength that I have not fully addressed thus far, and one that is not thoroughly discussed in the literature, but one that sets the HeRMeT model apart from most other

community-university collaborative CBR models, is the model's informality. While informality may at first sound like a weakness, given the reality of community relationships, it can in fact be a great benefit. Because work and relationships within communities by nature vary, an approach that is rigid, formal and inflexible would result in only occasional success. A more rigid approach may work well for developing one primary longitudinal relationship, but having a model that can engage different community partners in different research scenarios is far more difficult. Maintaining the ability to exercise flexibility in forming working relationships, and around ethical issues, has been vital toward participating in productive CBR.

The major weaknesses of this model are a reflection of this model's biggest strengths. The desired flexibility and informality can also be seen as a weakness with regards to judging model success in a quantifiable manner. We do not have a universal tool for measuring our success or a systematic way of collecting feedback and assessment. We have primarily judged success by the direct feedback we have received from all the collaborative partners on projects, primarily the community partners. Community organizations have been readily able to communicate feedback on specific projects, while individual community participants in projects have given us feedback directly following projects, although not over time. Although I view our ability to continue to build new relationships through reputation and to continue building upon previous partnerships as a sign of success, this is not absolute and the lack of formal assessment may allow certain flaws carried over from project to project to go unnoticed. It also leaves the model removed from normal university mechanisms for value judgment, although this is not what we have been concerned about through our work.

While this informal process is a direct by-product of distancing the model from academic control, it may none-the-less be seen as de-legitimized from the viewpoint of many academics.

Although I strongly push for this model, and caution against certain faculty and students who are not willing to rescind a dedication to the academy to engage its methods, it very well may be limited because there are relatively few faculty who may want to participate. Students too, particularly those focused on integrating into the university and tenure track positions may not find a great deal of benefit from the model, at least not by participating in the way the model is designed to focus on community. Interestingly, in a fair amount of the literature written on community-university CBR, even when the most critical stances toward university involvement were absent, the threat to tenure track faculty and incompatibility of CBR goals and university expectations were repeatedly mentioned.

Since this model is not presented based on a static relationship or goal, I think it is important to attempt to summarize what each of the partners involved would generally expect to gain from their participation in this way of undertaking collaborative CBR. The partners to consider are the broader community and the individual community participants, the university and the academics and students who may identify themselves in a variety of ways. What is it that each participant stands to gain from the collaboration?

Most importantly, community-university collaborative CBR must ensure that the community's interests and goals are paramount. The model works toward achieving this objective. In the most basic sense, the community receives specialized work and

resources. This is not magically achieved, but must be accomplished through strong and open communication with the community partners involved, so that when resources and individual skills are put to use, they are focused on achieving what is best and desired by the community. Not only can the community benefit from direct skilled labour and economic support, but it also benefits from assistance with how to request further resources or help to show how existing skills in the community are directly applicable and translatable to the academy, funders, and other agencies and organizations.

Although the HeRMeT CBR model has worked well on several levels, it certainly is not the only way to engage in good community-based projects, and not every academic would be suited to engage in this style work. There are realistic limitations with regards to who can comfortably engage in the model describe above. Because this model is intentionally designed to steer away from university control and a focus on the primary benefits going to the university, by participating in this model, some faculty and university career individuals may be engaging in professional harm. Academics that are well established, who hold tenured positions, have been involved in successful research and are able to maintain financial research stability may be encouraged by experience and standing to head up this type of internship model. This does not mean other academics should be discouraged from participating in this model, but perhaps should not spearhead it.

The university may not heavily reward this style CBR and therefore, academics could experience negative consequences. Evidence exists that faculty agenda's are shaped by the realities of their profession and their particular disciplines, that applied work is not encouraged by the peer-review and tenure-track system, and that research

funding “often support more traditional, academically oriented as opposed to applied types of research. Thus, faculty faces very concrete pressure to mould their research, or to avoid certain kinds of research such as community-based research, to fit academic requirements for rewards and advancement within the field” (Ferman & Hill, 245).

Another major tenet of the HeRMeT model is that the underlying purpose of this work is to help communities that are in need of addressing a variety of HIV/AIDS issues. Although all the players in this model should benefit on multiple levels from being part of it, the university should not be putting their interests before that of the community. Even though there may exist no issue with benefiting from a CBR project, universities must not be an impediment or diversion to community interests. This would essentially be a breach of the standards by which we judge the success of our model.

Lastly, what benefits do the student as intern receive from the HeRMeT model? I admittedly have more insight into this role as I have experienced it several times. The student intern has a great deal to gain from participating in the CBR model. These include learning and expanding a vast number of skills and building strong community ties and relationships. While these gains can be substantial, they require a great deal of work and should be accompanied by a careful understanding of the sometimes complicated set up circumstances the student can experience.

As mentioned above, students involved in this model of community-based work are selected and placed in projects based on how their skills best fit the needs of the projects. We have attempted to create a balance whereby the students are able to complete all necessary work, but are challenged in a way which requires that they expand their skills. On the one hand, the student intern is supposed to serve as skilled, free labour

in the eyes of the community. On the other hand, they are very much a student, engaging in skill building and learning about how to successfully and respectfully engage in CBR.

Many of the skills attained by the student are transferable between academic and non-academic work. Tools like questionnaire creation and analysis, curriculum building, working in groups and building long-term relationships can be utilized in future CBR or within university-based research projects. Students may find, however, that not all skills and lessons are transferable to academic life because of potential conflicts with university values and practices.

Research ownership and ethical standards can dramatically differ inside and outside the university. Students may learn a very different style of collaborative work, such as how to negotiate ethical practices throughout projects. For example, negotiating informed consent in many communities may entail verbal consent where written consent may be unacceptable or violate a particular community's standards. This runs contradictory to university practices, which have rigidly developed ethical standards that are first and foremost designed to protect the university from liability, and in that way, less designed to intelligently protect those involved in research projects.

Aside from several value conflicts that may arise, students might also experience challenges by the competing expectations of all the stakeholders in any given project. As described earlier, the student should, in the eyes of the community, be a cost free resource. By design, community groups and community members should not be burdened with the knowledge of paying the student. The student, having direct ties to the university, is pressured to have certain interests in mind. The student may also have a personal set of goals in each given situation. For this model to be effective, the student

must be aware of these competing interests. The student must maintain good communication with the RTA to check that the demands of the community are within reason and also maintain good communication with HeRMeT supervisor to ensure that the interests of the facility and hence the university are within reason and being met. Ultimately, the student has to make some decisions about how to balance conflicting interests.

Conclusion

Although I present a project example and model that I feel has, overall, had positive results with engaging communities in collaborative projects, I do so from a cautious position. I feel there are strong reasons why this model has succeeded, yet I also feel there are many other models that both in practice and theory can succeed at forming productive working relationships. I do believe the HeRMeT model is a strong example of alternative friendship-like relationship building and maintenance. This is evident in both the beginnings of the model's development as well as with community partners.

Beyond this specific aspect, I also recognize other particular challenges inherent in this model that may make it difficult to reproduce; both the challenge to create such a flexible funding structure at the university level and also the fact that a number of academics, faculty and students, will not want to be involved. It is unfortunate that the academic and granting environment foster and seemly perpetuate its own existence for the sake of doing so. I feel that community-university CBR models that by design place community interests and control first, and in a diminished capacity find ways to ethically and creatively benefit academics and challenge notions of what type of work should be valued, are the most important types of models to pursue.

Bibliography

- Allman, D., Myers, T., & Cockerill, R. (1997). *Concepts, definitions and models for community-based HIV prevention research in Canada*. Toronto: University of Toronto.
- Austin, D.E. (2003). Community-based collaborative team ethnography: A community-agency partnership. *Human Organization*, 62(2), 143-152.
- Blumenthal, D.S., & DiClemente, R.J. (Eds.). (2004). *Community-based health research: Issues and methods*. New York: Springer Pub.
- Blumenthal, D.S., & Yancey, E. (2004). Community-based research: An introduction. In D.S. Blumenthal & R.J. DiClemente (Eds.), *Community-based Health Research: Issues and Methods* (3-24). New York: Springer Pub.
- Bourdages, J., Sauvageau, L., & Lepage, C. (2003). Factors in creating sustainable intersectoral community mobilization for prevention of heart and lung disease. *Health Promotion International*, 18(2), 135-144.
- Bradshaw, T.K. (2000). Complex community development projects: Collaboration, comprehensive programs, and community coalitions in complex society. *Community Development Journal*, 35(2), 133-145.
- Buckeridge, D.L., Mason, R., Robertson, A., Frank, J., Glazier, R., Purdon, L., et al. (2002). Making health data maps: A case study of a community/university research collaboration. *Social Science and Medicine*, 55(7), 1189-1206.
- Campus Compact (2007). *About Us*. Retrieved June 13, 2007, from <http://www.compact.org/about/>
- Cipolle, S. (2004). Service-Learning as a counter-hegemonic practice: Evidence pro and con. *Multicultural Education*, 11(3), 12-23.
- Cortes, M. (1998). Public-policy partnerships between universities and communities. *National Civic Review*, 87(2), 163-168.
- Eyler, J. (2002). Reflection: Linking service and learning—linking students and communities. *Journal of Social Issues*, 58(3) 517-518.

- Ferman, B., & Hill, L. (2004). The challenge of agenda conflict in higher-education-community research partnerships: Views from the community side. *Journal of Urban Affairs*, 26(2), 241-257.
- Fraser, H. (2005). Four different approaches to community participation. *Community Development Journal*, 40(3), 286-300.
- Gilchrist, A. (2000). The well-connected community: Networking to the edge of chaos. *Community Development Journal*, 35(3), 264-275.
- Green, L.W., & Mercer, S. L. (2001). Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities? *American Journal of Public Health*, 91(12), 1926-1929.
- Hecht, D. (1999). Peer help through service: Learned helpfulness. *Social Policy*, 30(1), 34-41.
- Israel, B.A., Schulz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19, 173-202.
- Labonte, R., Polanyi, M., Muhajarine, N., McIntosh, T., & Williams, A. (2005). Beyond the divides: Towards critical population health research. *Critical Public Health*, 15(1), 5-17.
- Lemkau, J.P., Ahmed, S.M., & Cauley, K. (2000). The history of health in Dayton: A community-academic partnership. *American Journal of Public Health*, 90(8), 1216-1217.
- Loka Institute, The. (2004). *About the CRN: What is Community Based Research?* Retrieved May 22, 2007, from <http://www.loka.org/crn/About%20CRN.htm>
- Marsden, N. (2002). *An overview of models for community based Aboriginal HIV/AIDS research.* Retrieved July 15, 2007, from www.healingourspirit.org/pdfs/research/cbroverview2002.pdf
- McWilliam, C.L., Desai, K., & Greig, B. (1997). Bridging town and gown: Building research partnerships between community-based professional providers and academia. *Journal of Professional Nursing*, 13(5), 307-315.
- Minkler, M. (2000). Using participatory action research to build healthy communities. *Public Health Reports*, 115(2/3), 191-197.

- Minore, B., Boone, M., Katt, M., Kinch, P., Birch, S. (2004). Addressing the realities of health care in northern Aboriginal communities through participatory action research. *Journal of Interprofessional Care*, 18(4), 360-368.
- Poland, B., Graham, H., Walsh, E., Williams, P., Fell, L., Lum, J.M., et al. (2005). 'Working at the margins' or 'leading from behind'? A Canadian study of hospital-community collaboration. *Health and Social Care in the Community*, 13(2), 125-135.
- Reardon, K.M. (2000). An experimental approach to creating an effective community-university partnership: The East St. Louis action research project. *Cityscape: A Journal of Policy Development and Research*, 5(1), 59-74.
- Reinharz, S. (1992). *Feminist Methods in Social Research*. New York: Oxford.
- Saltmarsh, J. (2005). The civic promise of service learning. *Liberal Education*, 91(2), 50-55.
- Savan, B. (2004). Community–university partnerships: Linking research and action for sustainable community development. *Community Development Journal*, 39(4), 372-384.
- Savan, B., & Sider, D. (2003). Contrasting approaches to community-based research and a case study of community sustainability in Toronto, Canada. *Local Environment*, 8(3), 303-316.
- Savan, B., Morgan, A.J., & Gore, C. (2003). Volunteer environmental monitoring and the role of the universities: The case of Citizens' Environment Watch. *Environmental Management*, 31(5), 561-568.
- Schnarch, B. (2004). Ownership, control, access & possession (OCAP) on self determination applied to research: A critical analysis of contemporary First Nations research & some options for First Nations communities. *Journal of Aboriginal Health*, 1(1), 80-95.
- Simon Fraser University VP Research. (2006). *Strategic Research Meetings*. Retrieved May 23, 2007, from http://www.sfu.ca/vpresearch/CTEF/srp_summaries.html
- Vancouver Foundation. (2007). *Community Based Health Research Funding*. Retrieved May 22, 2007, from <http://www.vancouverfoundation.bc.ca/GrantInformation/BC%20Medical/BCMCommunityResearch.shtml>

Williams, A., Labonte, R., Randall, J.E., & Muhajarine, N. (2005). Establishing and sustaining community-university partnerships: A case study of quality of life research. *Critical Public Health*, 15(3), 291-302.

Appendices

Appendix A

Pre-workshop participant questions

Please, briefly answer the following questions.

- 1) What are the most pressing concerns for people living with HIV in regards to HIV anti-retroviral treatment, treatment and rehabilitation*? (*Rehabilitation in the context of HIV ranges from helping with physical restrictions to increasing social participation for an individual)**
- 2) If you had to identify one issue that need special attention, what would it be? (e.g. lack of sensitive and knowledgeable family physicians)**
- 3) List five or more factors that contribute to this problem (e.g. physicians do not have enough training about HIV medications).**
- 4) List all those affected by the issue you have selected and briefly describe how (e.g. patients and frontline workers scramble to get necessary information).**
- 5) What kinds of "evidence" would "move" some of the stakeholders (e.g. physicians, nurses, frontline workers from other social agencies, school workers, etc.) to act on this situation?**

Appendix B

General Plan Leading Up to *Three Days in the Fire Pit*:

Enhancing Access to Treatment through Action Research: A Community Based Research Workshop for Action Oriented Options in Treatment and Care in Remote and Rural Areas

March 2005							April 2005						
S	M	T	W	T	F	S	S	M	T	W	T	F	S
		1	2	3	4	5						1	2
6	7	8	9	10	11	12	3	4	5	6	7	8	9
13	14	15	16	17	18	19	10	11	12	13	14	15	16
20	21	22	23	24	25	26	17	18	19	20	21	22	23
27	28	29	30	31			24	25	26	27	28	29	30

Known Events: (Please Add any suggestions to the List)

March 14th or 15th (Monday or Tuesday), 11am – Noon. Conference Call

April 17th – 20th (Sunday - Wednesday) – Full 3-day Institute

Work Steps prior to Workshop:

- Send Out Letters of Invitation (Community Members and Others)
- Create and Send out Pre-Institute Templates
- Book Lodging, Conference Space, Food, and other Accommodations
- Attain Appropriate Supplies
- Schedule Appropriate Support Staff for Workshop

Workshop Architecture

[The names next to each activity are tentative; if you decide to accept your mission, say “yeah!”]

*we are planning on putting the UNBC students to work by taking notes of things people say, etc.

Meeting on Sunday, the 17th, at 5:00 pm at the Coast Inn of the North

Day 1:

9:00 AM: ART Team Arrives and Meets to Prepare

9:30 AM – 10:00 AM: Breakfast

10:00 AM: Institute Commences

- **Opening Prayer**
- **Housekeeping (Carlene, introduction of Francisco)**

10:00 AM – 10:40 AM: Orientation Part 1

- Introductions: interviews in pairs; with debrief on the hows. Opening of research ethics/ground rules, introduce the research consent. (Theresa and Carlene)(Francisco can do physical icebreaker)

10:40 AM – 11:30 AM: Orientation Part 2

- Examine who we are, purpose and multiple roles (research participants, researchers and observers) (Theresa & Francisco) (30 minutes)
 - * What is the difference between doing something through programming and doing something through research
 - * What is a project?
 - * Limitations and advantages of trying to create change in the community and in organization through research

11:30 AM – 11:50 AM: Break

11:50 AM – 12:30 PM: Applied Research Ethics

- Examine ethical issues in local research (Theresa) (one hour with a hands-on activity)
- OCAP principles

12:30 PM – 1:30 PM: Lunch Break!!

1:30 PM – 1:45 PM: ART Team Regroup for Afternoon

1:45 PM – 4:00 PM: Case Studies

- Detailed examination of how they can be used in research with examples being carried forward later for data analysis.
 - * Using **templates** sent by participants in advance (needs to be done and sent to participants by March 1)
 - * Five easy questions
 - * Identify the issue: E.g. from the perspective of the HIV+ First Nations people you work with, and understanding that this is a very diverse group in generation and social situation, what are the three most pressing issues in relation to access to anti-retroviral treatment?

* Describe five main factors

* E.g. stigma in social services

- ***What will the participants and we do with the templates?*** (interactive, really!)
 - Each group finishes template and presents
 - Web search for examples, documents (might need a live connection to Internet)

4:00 PM – 4:30 PM: Closing Prayer & Comments – Conclusion of Day 1

- Field any questions, get feedback, and briefly describe activities planned for day 2

4:30 PM – 5:30 PM: ART Team Meets for Discussion

- Debriefing meeting to adapt case studies and other emerging issues

Day 2:

9:00 AM: ART Team Arrives and Meets to Prepare

9:30 AM – 10:00 AM: Breakfast

10:00 AM: Day 2 Commences with Opening Prayer

10:00 AM – 10:20 AM: Opening Day Activities

- Icebreaker and Checking In with Participants
- Parking lot with Theresa

10:20 AM – 12:30 AM: How to Collect Useful Data that fits our Purpose (e.g. focus group)

- based on the case study templates, begin to define questions/issues and choose most appropriate, ethical, relevant, reliable, etc. methods. (Cindy) (hands-on activity)
 - * Break participants into 3 groups and have ART team lead each one to start defining issues related to access to anti-HIV drugs in remote and rural areas
 - * Other ART to work as satellite to aid in activity.

12:30 PM – 1:30 PM: Lunch Break!! (MAD participants to talk about their experience with CBR)

1:15 PM – 1:30 PM: ART Team Regroup for Afternoon

1:30 PM – 2:50 PM: What to do with Quantitative Data

- Present on how to understand and utilize epidemiological information. Will then transition into mini survey construction, implementation and then collation of data for Data Analysis Session. (Brian)

2:50 PM – 3:10 PM: Break

3:10 PM – 4:15 PM: What to do with Qualitative Data

- Present on how to understand and utilize the qualitative stuff. (Francisco)

4:15 PM – 4:45 PM: Closing Prayer & Comments – Conclusion of Day 2

- Field any questions, get feedback, and briefly describe activities planned for day 3

4:45 PM – 6:00 PM: ART Team Meets for Discussion

- Debriefing meeting to adapt case studies and other emerging issues. Prepare for final day.

Day 3:

9:00 AM: ART Team Arrives and Meets to Prepare

9:30 AM – 10:00 AM: Breakfast

10:00 AM: Day 3 Commences with Opening Prayer

10:00 AM – 10:20 AM: Opening Day Activities

- Icebreaker and Again Checking In with Participants

10:20 AM – 12:00 PM: Data Analysis/What to do with the info we collect?

- Demystify the process. Using data for prior training activities, work through models of data analysis with full participation. (Theresa)(with hands-on activity)

12:00 PM – 12:15 PM: Break

12:15 PM – 1:30 PM: Resources and Support

- Distribution of support information along with explanations of the hows and whys of getting research money into communities for their benefit as well as resources that are available in helping communities develop and conduct research. (Carlene)
 - * How to get money?
 - * How to get others to “buy-in” or champion your idea?
 - * How to speak to “authorities” and appear “together”?
 - * How to speak to local media
 - * How to become champions and spokespersons for research issues?

1:30 PM – 3:00 PM: Extended Lunch

- Extended break for groups to finish “action Plans” to present to each other and authorities

2:00 PM – 3:00 PM: ART Team Support

- ART Team returns from quick lunch to make themselves available to help groups put together “action Plans”

3:00 PM: Invited Authorities Arrive (Katharina Patterson, Lorna Medd, Mary Lea Penrose)

3:00 PM – 4:30 PM: Translation into Action

- Present Action Plans with feasible and realistic ways that researching needs can be put into action. Create plan for addressing identified barriers.

* Recommendations for actions are presented by the groups in Action Plan form with tentative dates to put ideas forward (say to present at a local health authority meeting).

4:30 PM: Invited Authorities are excused for Dinner

4:30 PM – 5:30 PM: Feedback from Participants and Closing Prayer & Comments

- Get full range of feedback from all participants and answer any questions. Closing comments, explanation of dissemination of institute information.

5:30 PM – *When Done*: ART Team Meets

Appendix C

Participants Schedule

Day 1

9:30 AM – 10:00 AM:	Breakfast
10:00 AM – 10:40 AM:	Orientation Part 1
10:40 AM – 11:30 AM:	Orientation Part 2
11:30 AM – 11:50 AM:	Break
11:50 AM – 1:00 PM:	Applied Research Ethics
1:00 PM – 2:00 PM:	Lunch Break!!
2:00 PM – 4:00 PM:	Case Studies
4:00 PM – 4:30 PM:	Closing Comments – Conclusion of Day 1

Day 2

9:30 AM – 10:00 AM:	Breakfast
10:00 AM – 10:20 AM:	Opening Day Activities
10:20 AM – 12:30 AM:	How to Collect Useful Data (focus groups)
12:30 PM – 1:30 PM:	Lunch Break!!
1:30 PM – 2:50 PM:	What to do with Quantitative Data
2:50 PM – 3:10 PM:	Break
3:10 PM – 4:15 PM:	What to do with Qualitative Data
4:15 PM – 4:45 PM:	Closing Comments – Conclusion of Day 2

Day 3

9:30 AM – 10:00 AM:	Breakfast
10:00 AM – 10:20 AM:	Opening Day Activities
10:20 AM – 12:15 PM:	Data Analysis/What to do with Info Collected?
12:15 PM – 12:30 PM:	Break
12:30 PM – 1:30 PM:	Understanding and Accessing Resources and Support
1:30 PM – 3:00 PM:	Extended Lunch
2:00 PM – 3:00 PM:	ART Team Support for Building Action Plans
3:00 PM – 4:30 PM:	Translation into Action – Presentations w/ Health Authorities
4:30 PM – 5:30 PM:	Feedback and Closing Comments