

GENDER AND DIVERSITY

AN EQUITY APPROACH TO PRACTICE

A PILOT PROJECT
For Barwon South West Regional
Women's Health Program
(Training Portfolio)



*Bellarine Peninsula Community
Health Service*

Undertaken within the Adult Day Activity Program
Bellarine Peninsula Community Health Services

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¹ Dyson, S (2001) Gender and Diversity - A Workbook for an Equity Approach to Practice Women's Health in the South East, Frankston

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SYNOPSIS

This pilot project, undertaken in the Adult Day Activity (ADA) Program at Bellarine Peninsula Community Health Services in 2000 was an attempt to address issues of gender and diversity in a health service. The project used workshops to introduce the concepts of gender and diversity, to establish the backgrounds of the participants in the ADA Program and to examine the influence of personal values in professional practice and to apply a gender analysis to program and policy development.

The workshops were an opportunity to pilot the *Gender & Diversity - an Equity Approach to Practice Workbook*². Whilst the language used in the workbook and workshops provided some initial difficulty for some participants not familiar with formal participatory planning and program development processes, the pilot was successful in:

- involving ADA staff in establishing the ADA program's annual plan
- demonstrating the relevance of the BPCHS Value Statements to department and professional practice
- including in the annual ADA Program plan, specific commitments to the development of policies and programs that are gender sensitive and recognise the diversity of backgrounds of the people participating in the ADA Program.
- increasing the contribution ADA Program staff members make to BPCHS planning and program development processes.

² Dyson S, (2001) *Gender and Diversity - A Workbook for an Equity Approach to Practice* Women's Health in the South East, Frankston

LIST OF ABBREVIATIONS

ADA	Adult Day Activity
BOM	Board of Management
BPCHS	Bellarine Peninsula Community Health Service
BSWRWHP	Barwon South West Regional Women's Health Program
GSRG	Gender Sensitive Reference Group
GSSC	Gender Sensitive Steering Committee
KRAs	Key Result Areas
PCP	Primary Care Partnership
QICSA	Quality Improvement Standards Council Association
WHAV	Women's Health Association of Victoria
WHIN	Women's Health in the North
WHISE	Women's Health in the South East

INTRODUCTION

There is a growing awareness of the need for gender sensitivity and gender sensitive practice in health service delivery. The women's health movement is a leader in building partnerships with health services to develop gender sensitive frameworks for implementing models of gender sensitive health service delivery. The BPCHS and the BSWRWH Implementation Committee entered into just such a partnership in 2000 to pilot an equity approach to addressing systematic structural disadvantages that exist within the health system. The project concept was developed by the Women's Health Program at BPCHS and funded by the BSWRW Implementation Committee.

Underpinning this project is the belief that it is the right, not a privilege, for everyone to have access to a service that is inclusive and sensitive to her/his health needs or issues.

Whilst the project has a focus on service delivery in relation to gender issues generally, the rationale and language used frequently pertains to women. This is a project funded through the Barwon South Western Regional Women's Health Program (BSWRWHP),

and with many of the issues/barriers in health facing women today being the same as they were 15 years ago, they should not be diluted.

ASSUMPTIONS UNDERLYING THIS PROJECT

There are some key assumptions that are crucial to understanding this approach to developing a gender sensitive health system. Issues relating to gender and diversity influence these assumptions.

- Men and women are not a homogenous group.
- Men and women experience health and illness differently.
- Age, race, ability/disability, culture, language, class, sexual preference and access to resources complicate our ability to achieve equitable and optimal health outcomes.
- Equal treatment and equal access do not necessarily mean fair treatment or equal health outcomes.
- Systematic structural disadvantage exists within the health system. If we incorporate a structural process that ensures a commitment to and support for a *gender sensitive* approach to health service delivery, we will go a long way to address this systemic disadvantage.

KEY WORDS/DEFINITIONS:

There is a great deal of variation in the interpretation of language. This has been the case with words such as "gender" and "equity" particularly. A common understanding of the language used is essential for the clarity and purpose of this project.

Gender: refers to the different social and cultural roles, expectations and constraints placed on men and women by virtue of their sex.³ Age, race, ability/disability, culture, language, class, sexual preference and access to resources are all factors in gender.

Gender sensitivity: refers to being aware of the relationship of gender to health and illness across a number of dimensions, and

³ Gijsbers Van Wijk CMT, Van Vliet KP&Kolk AM., *Gender perspectives and quality of care: towards appropriate and adequate health care for women. Social science and medicine*, 1996; 43 (5): 711.

giving consideration to the different experiences and impacts of health and illness on men and women.⁴

Equity: refers to fairness and justice in outcomes. It recognises diversity and disadvantage, and redirects services and resources toward those in most need to ensure equal health outcomes for all.⁵

Equality: refers to the equal distribution of resources and to equal provision/access to services, for both men and women and other identified target groups.

Sex: refers to the fundamental biological and physiological differences between females and males.

Gender Sensitive Practice: acknowledges and understands the differing gender needs within a diverse community and develops flexible responses to ensure equity of access to services and resources, and ultimately health gains for both individuals and communities.⁶

Treatment: refers to the relationship or process of interaction between the user of a service and the service provider rather than the treatment of a disease or disorder.

Fairness: In this context, fairness refers to equitable distribution of resources and access to health services and treatment.

PURPOSE OF THE PROJECT:

The primary intention of this project was to facilitate a process that informed both health policy and practice regarding the provision of gender sensitive services. The process promotes equity and fairness in access and treatment for service users in order to achieve their health outcomes.

GENDER AND DIVERSITY - AN EQUITY APPROACH TO PRACTICE

The process was based on the Gender And Diversity - An Equity Approach To Practice Workbook, which was being developed by Sue Dyson of Women's Health in the South East (WHISE) during the

⁴ Dern L. Gender sensitive standards in the primary health and community services sector: a background paper by WHV. WHV, October, 1999; 4.1:12.

⁵ Dyson S, Gender & Diversity, Women's Health in the South East. 15/3/2001.

⁶ Dyson S, Gender & Diversity, Women's Health in the South East. 15/3/2001

period the pilot was being conducted. This provided the opportunity to trial and refine the Workbook in practice.

Implementation of this process involved three phases:

PHASE 1 - Planning and consultation, which involved members of the Bellarine Peninsula community, BPCHS Board of Management, BPCHS management team, BPCHS staff, BSWRWH Resource Worker, Women's Health Association of Victoria (WHAV) and consultants, Sue Dyson of WHISE and Sue Giffney from Women's Health in the North (WHIN).

PHASE 2 - Two one-day workshops were conducted with staff and volunteers from the Adult Day Activity Program and involved participants in quantitative research to do with the demographics of the catchment area and compared this data with both quantitative and qualitative data to do with current consumers of the ADA Program. Participants also participated in explorative projects to do with personal and social attitudes towards gender and diversity.

PHASE 3 - Evaluation of process, impact and outcomes included participant observation, formal and informal feedback relating to Phases 1 and 2 plus a post workshop focus meeting and questionnaires conducted four weeks after the second workshop to ascertain attitudinal and behavioural change amongst participants.

IMPLEMENTATION OF THE GENDER SENSITIVE PROCESS

PHASE 1 - PLANNING AND CONSULTATION

Establishment of a Gender Sensitive Steering Committee (GSSC):

Purpose: To guide the project

Membership included a representative from BPCHS management team, BPCHS staff, BSWRWH Implementation Committee, BSWRWH Training Portfolio, the BSWRWH Resource Worker and a consumer.

Establishment of a Gender Sensitive Reference Group (GSRG):

Purpose: To serve as a point of reference for the project, to explore local issues pertaining to gender sensitive service delivery and to test aspects of the proposed framework and process to be used.

Membership included six (6) local consumers, the Steering Committee and representation from the BPCHS Board of Management and three (3) interested staff.

Local consumers revealed that their experience as recipients of health care is still frequently one of feeling passive and powerless over their options, and outcomes. Experiences of feeling assumptions were frequently made about their condition and/or preferred choice of therapeutic path; feelings of being reduced to one health issue instead of a "whole woman" and of limited or resistive access to information were common themes. These issues largely pertained to medical services and doctors. Feeling listened to, and being well informed by the service provider, were identified as important common themes of good practice.

Consultations with BPCHS staff/departments.

These consultations were to determine:

- The extent to which BPCHS could make resources available
- The extent to which the BPCHS could commit to the process and its capacity for change
- Which department(s) and staff would participate in the process

-
- Which geographical areas or communities could be involved?

As a result of these consultations, consideration had to be given to staff replacement, whether the programs would be staffed by skeleton staff or closed for the duration of the workshops, relative cost to clients if program was closed, and cost to the Service for staff attendance.

Further consumer consultation.

The process and issues pertaining to gender sensitive practice were discussed with a number of women's health community groups.

The issues identified and discussed were similar to those identified by the GSRG. In addition, this group identified allied health practitioners as also tending to make similar assumptions about the client.

Selecting the participants

The ADA program nominated for the project because they perceived a need for formal program planning and program development.

Developing the Workshop format

In consultation with the GSSC, ADA Coordinator and the consultants, it was decided to facilitate two (2) full day workshops with a break between each of approximately three (3) weeks.

Because of the overlap between this proposal and the concurrent development of the *Gender and Diversity - An Equity Approach to Practice Workbook*, the consultants generously agreed to facilitate these workshops as part of the pilot of the workbook.

PHASE 2 - WORKSHOPS

This phase was designed to develop "a strategic approach to responding to clients and consumer groups within our organisation".⁷ Based on the *Workbook for an Equity Approach to Practice*⁸, the workshop process took the participants through the steps of:

⁷ Dyson, S (2001) *Gender and Diversity - A Workbook for an Equity Approach to Practice* Women's Health in the South East Frankston

⁸ As above

- Understanding gender and diversity issues and why the inclusion of these is important for an organisation's policy and program development process;
- Examining personal values and putting these values in context with external practice demands;
- Applying a gender inclusive analysis approach to the process of program and policy development, implementation and evaluation;
- Examining how the process contributes to best practice and continuous improvement in service delivery.

The *Gender & Diversity - an Equity Approach to Practice Workbook* was used to enable participants to incorporate this new knowledge into an ongoing, systematic approach to planning all new health service policy and programs.

Workshop 1.

This workshop included gender sensitive training and analysis, departmental and program development, self-assessment, and a detailed review and analysis of demographic trends. (See Attachment 1)

Activities Undertaken Between Workshops

Participants were required to undertake three activities during the break between the two workshops. These activities were designed to encourage participants to:

- Identify gender stereotypes in advertising and popular culture and discuss how these stereotypes might influence women and men.
- Identify the gender dynamics of the environment in which they operate.
- Collect information about who participates in their service and identify any gaps or absences. (See Attachment 2)

Workshop 2

This workshop involved:

- A review and analysis of the data collected from the activities conducted since the first workshop
- A review of BPCHS Value Statements and departmental Key Result Areas (KRAs)

-
- An introduction to a Planned Approach to Planning⁹ as a way to develop short, medium and long term goals (See Attachment 3)

PHASE 3 - EVALUATION

Both feminist and participatory action research theory influenced the methodology used for this project. Because of the complex multi-layered issues surrounding gender sensitive service delivery, it is best analysed from a holistic perspective. The methods of data collection and analysis involved the interpretation of qualitative data. They included direct and indirect observation, and structured and semi-structured interviews and meetings.

Process & Impact Evaluation:

1 Participation Observation

The project worker was fully immersed in the project from its inception to the final stage. She was a member of the Steering Group and Reference Group. She was the person nominated to obtain support for and interest in participating in the project. She also conducted consultations with a wider group of women living on the Bellarine Peninsula, was involved in the development of the Workshops, and participated in the workshops and the activities between workshops. She also developed the formal questionnaires in consultation with the consultants. Her observations and experiences were recorded, regularly, in her program notes throughout the process.

2 Informal feedback

Opportunities for informal feedback from participants, steering committee, reference group, staff and management were encouraged throughout the process. The project worker summarised these comments in her program notes.

3 Formal feedback

Post workshop questionnaires were given to participants upon completion of the workshop (See Attachment 4).

Participants were asked to confidentially assess their perceived value of each workshop separately and the process as a whole.

⁹ Dyson S, *Gender & Diversity-An Equity Approach to Practice Workbook*, Women's Health in the South East. 2001.

Outcome Evaluation:

Outcome evaluation involved participant observation and informal feedback as well as two formal activities. These included a post workshop focus meeting and questionnaires (See Attachment 5). Both were conducted four (4) weeks after completion of the second workshop.

Participants who were reluctant to complete the questionnaire individually answered the questions as part of the focus group.

ISSUES RELATING TO IMPLEMENTATION

DEFINING "GENDER SENSITIVE PRACTICE"

In the planning project the realisation that not a lot of work had been done in terms of defining and translating "gender sensitive practice" at the service delivery level, presented uncertainty for the project worker. Identifying and linking with the work being developed by the WHAV Gender Sensitive Advisory Committee and the extensive work being undertaken by Sue Dyson of Women's Health in the South East provided invaluable support in this case.

SERVICE OR DEPARTMENTAL INVOLVEMENT

Two options developed throughout the consultation process. Should the project be facilitated at:

- a) A health service level at an annual planning day for the purpose of education and policy development or
- b) In specific program areas, to influence program planning, development and delivery?

The Steering Committee guided this process and concluded that, whilst it would be ideal to target the entire service, the time frame and budget precluded this from happening. It was more practical to conduct the pilot at a single program or department.

GAINING ORGANISATIONAL SUPPORT FOR THE PROJECT

1. Staff Issues

Whilst the BPCHS was committed to this project, gaining the support of staff was an issue. Some expressed concern that the pilot was "just another assessment, project or training day" that staff may have to fit in to their already busy schedule. They had just completed an intensive review process through QICSA and many had been involved in Primary Care Partnership (PCP) specialist working party meetings. All had taken them from their service delivery. Participating in a gender and equity pilot project was therefore seen as another review process and another demand to be slotted in with the general growing workload everyone is experiencing in health.

Strategy: Through discussions with key people at BPCHS, the Adult Day Activity (ADA) Program, the Health Promotion Team and Reception staff were identified as possible participant departments.

The project worker started to listen for patterns of departmental or program issues. She asked questions like "are there barriers that you believe may be preventing you from achieving equity in outcomes for your client group?" She suggested that this gender sensitive approach might help to support them in identifying issues and bringing about change within their own area. This process took 10 to 12 weeks.

The gender sensitive process was promoted as a tool for practical and positive change, capable of being adapted to the individual needs of departments. The process would involve participants in developing the workshops to address their internal issues.

1.1 The relationship between gender sensitivity and the Social Model of Health

Prospective participants wanted to know how the *Gender and Diversity - an Equity Approach to Practice* pilot would differ from providing a quality service within the social model of health

Strategy: The project worker communicated the belief that the gender sensitive project would increase understanding of the social model of health and provide the service with the strategies to implement the Social Model of Health principles in a practical way.

1.2 The relationship between QICSA accreditation and the Gender Sensitive Pilot

How the project would relate to the QICSA standards was important to ensure internal support and to ensure recognition within the BPCHS competing priorities.

Strategy: QICSA standards and recommendations were reviewed with key people from prospective participating departments, particularly in relation to Planning, Quality Improvement and Evaluation, and Consumer and Community Participation. They were assured that the gender sensitive process would enhance their potential to implement KRAs and QICSA recommendations.

Through the collaborative process of workshop planning, we explored ways to apply a "gender lens" to the existing QICSA

recommendations and BPCHS Value Statement (see Attachment 9) as they apply to the ADA program.

1.3 Language

Health sector "jargon", particularly in relation to gender, equity and planning, proved to be a potential barrier.

Within a generalist health service the language used had the potential to alienate potential support from workers generally. At times it impeded the potential for understanding the project's capacity for relevant and effective change. Comments like "women's health, men's health, gender sensitivity, what next?" and "who will benefit from this anyhow?" were not uncommon.

Strategy: Throughout the negotiation, key staff members were assured that this project offered a valuable opportunity to address specifically identified issues, and that it could support both instant change and strategic planning that was gender sensitive and inclusive.

In addition to this language presented as a potential barrier in the implementation of the workshops. Because participants were from diverse educational backgrounds - volunteers, nurses, allied health workers and management, gaining a common understanding using terms such as gender sensitive service delivery, equity and equality, objectives goals and planning processes, was a challenge.

Strategy: Workshops were used to demystify the language - eg objectives became "what we can do about it".

1.4 Teamwork

Although the departmental culture was one of working as a team, some participants struggled with working in pairs.

Strategy: As an empowerment strategy, participants were asked to work in pairs for the research component. In the case of ADA however, a whole team approach was adopted. They were familiar with working in this type of environment and this approach supported the completion of projects.

2. Management Issues

Once again, whilst the BPCHS was committed to this project, a number of management issues arose that reflected tensions

between priorities within the organisation. These were to do with allocation of resources in the main.

2.1 Allocation of Staff to the Pilot

The project worker position was funded but the staff from the ADA program participated in the pilot as part of their work with BPCHS.

Strategy: The Steering Committee and project worker were aware that the process had to demonstrate that it could provide a direct benefit to the participating department's capacity to address its specifically identified issues, the KRAs, and the QICSA recommendations. They encouraged participant involvement in developing the Workshop content and structure, and negotiated for service provision to continue with skeleton staff.

2.2 Management's participation in the project.

Although BPCHS commitment to the project was unquestionable, it was difficult involving representation from management in every step of the workshop process. This service has many service outlets, and staff and managers are spread over a large geographical area. As a result, informal "corridor conversations" were limited, and specific meetings had to be arranged. Frequently, these meetings were taken over with other priorities.

Strategy: The Steering Committee and Project Worker accepted that there is never an ideal time to undertake such a project and were prepared to observe the effects of limited direct involvement by managers. They also took the opportunity to reflect upon the work commitments of their Management team and encouraged participants to consider that Managers supported their involvement in the project and trusted them to undertake the process effectively.

COMMUNITY ISSUES

Whilst community participation was active and they were keen to explore their own issues and to support change and the development of gender sensitive services in their own community, there was a tendency to focus on medical practitioners.

Strategy: Further consultation with individual consumers and consumer groups allowed more time to be spent exploring their

issues. This raised issues to do with a perceived medical model approach of allied health services also.

EVALUATION ISSUES

Arranging a separate evaluation meeting for participants proved difficult. At the end of their day, they were tired, and they had no time at the beginning of the day.

Strategy: A catered afternoon tea, where ADA staff could discuss issues whilst the Project Worker recorded comments proved successful. The post workshop questionnaire was used to guide the conversation over afternoon tea.

PROJECT EVALUATION

CONSULTATION AND PLANNING PROCESS

Evaluation of this process was undertaken through reflective practice and journaling. Issues recorded related to consumer and staff participation both before and during the preliminary workshop.

1. Reference Group

Journal entries reflected:

- Willingness to discuss the issue of gender sensitivity in service provision and practice
- Knowledge and experiences of issues relating to this, and
- Willingness to become involved in the project.

Generally, staff members involved in discussions were identified as being either key players or having demonstrated some interest in issues of equity and access issues. Consumers were approached based on a combination of their ongoing contact with the service and their health status not compromising their comfort should they participate. Consumers were willing to do whatever they could to improve services for both their own experiences and those of others. Their participation was keen and committed.

After initial consultation, the reference group was established and met for a preliminary workshop. Consumers participated actively until health service structures and processes were discussed. Whilst there was a sense amongst a few of the non-consumers in the group that the consumers had been silenced by these discussions, the consumers did contribute again when the agenda had moved on to planning the next phase in the process. During this phase, it was unanimous that a steering committee be developed which created a mechanism by which some of the organisational issues could be addressed within a more manageable context. Specific issues arising from the consultative phase are summarised in Attachment 6.

The exploration of the issues relating to engaging staff, management and BOM in the process was delegated to the Steering Committee (See Attachment 7).

2. Steering Committee

The Steering Committee was valuable both as a guide for the project, and in the process evaluation. Although the committee was integral to the project's function and outcomes, in itself it was not formally evaluated. Reflectively, it was crucial to the success of the process in its capacity to critically review and guide the process.

3. The Workshops

The process, impact and outcomes of the Workshops were evaluated. This was undertaken through a combination of:

- a) recording direct observation as a participant during the workshops and in corridor conversations following the workshops,
- b) reflective journaling and formal feedback through process and impact questionnaires
- c) post workshop questionnaire administered four (4) weeks after the second Workshop and
- d) focus meeting.

The post workshop questionnaires were given to participants upon completion of the workshops. Participants were asked to assess, confidentially, their perceived value of each workshop separately and the process as a whole. Results of the workshops impact, process and outcomes evaluation can be seen in Attachment 8.

Whilst some changes and modifications could be made to the workshop format, overall, participants reported that the process was extremely worthwhile. There have been significant positive shifts in participants' knowledge, confidence and perceived competence.

Frequently comments were made like "I learnt and now understand more about my own biases and belief systems and values, and how this impacts on what I plan and provide for my client group" and "I realise now how I have assumed that I am meeting my clients needs".

Other frequently made comments include "I feel much more able and confident to talk about clients' differing needs". This change in practice has been affirmed by observations made by other staff external to the process. Comments have been made that since the Gender Sensitive Workshop process, the participating ADA staff

have seemed notably more confident and vocal in contributing to the BPCHS's planning at general staff forums.

In terms of the relative use of the process as a planning and/or evaluation tool, the comment was made by the ADA coordinator that " we achieved more in these two days planning than we would have in a whole year". Other staff stated " it has been extremely useful to look at the BPCHS Value Statements and to really explore what they actually mean to our department and services in practice". This achievement was reported to the BOM and highlighted for their attention.

OUTCOMES

Questions about perceived shifts or changes in practice since the Workshop process were discussed. There was consensus that there had been a notable shift in thinking since the workshops. Generally, participants felt that the Workshops had put their good practice into a useful framework for further development. A number of staff commented, " We now frequently talk about improvements we can make to both our programs and processes".

Shifts in actual practice appeared more to do with planning. Apart from developing, short, medium and long-term goals, planning has become significantly more structured. Comment themes included:

" Culturally isolated people often require lots of home visits before they feel comfortable attending ADA. All staff members here have the skills"

"We are now broadening the assessment process to be more responsive and include more staff in the process"

"We are establishing a written and procedural review process of all clients that formalises the ongoing assessment process"

CONCLUSION

BPCHS clearly operates within a Social Model of Health. Its organisational values reflect the principles that underpin this model of health.

ADVANTAGES OF THE GENDER AND DIVERSITY FRAMEWORK AS A PLANNING TOOL

In an organisation with values that are consistent with the Social Model of Health, the gender sensitivity and diversity framework can be used at individual departmental or program levels to guide a gender and diversity planning process. The framework clarifies the concepts and principles of the Social Model of Health

Training in the concepts of gender and diversity was essential to the successful implementation of this process. Once these concepts were understood, application of the framework enabled staff to identify where services and practice did not address gender and diversity issues. The process also enabled staff to identify where change needs to occur in order to address gender and diversity issues.

The facilitators engaged in this pilot project were experienced practitioners, particularly in the areas of gender and diversity, which contributed to the success of the project. The workbook used in this project supports the framework for gender and diversity. Whilst this is not the only workbook available, its strength lies in its focus on training and activities based on adult learning principles.

The framework was also successful in making the values of BPCHS meaningful to staff in their day-to-day practice.

DIFFICULTIES WITH THE FRAMEWORK

The ADA program staff reported considerable difficulty with gender and diversity jargon and with terms such as goals, aims, objectives, strategies etc.

Reconciling the different expectations of staff and managers regarding the involvement of managers in the process was initially a difficulty but as participants gained confidence they identified some advantages of not having managers present. It is however, essential that management team conveys its support of the process

in some way that is meaningful to the participants in the project. One way would be for managers to actually undergo the process at managerial level.

The framework, by necessity, challenges the personal, professional and organisational values and work practices of health workers. It must be recognised that for some it could be more than they are prepared to address. Consequently, implementation needs to include informed consent and be supportive of staff who may face confrontational experiences.

RECOMMENDATIONS

For Bellarine Peninsula Community Health Service

- Disseminate the report of the Adult Day Activity Department's Gender and Diversity planning project throughout the organisation and Board of Management.
- BPCHS continue to implement this framework throughout the organisation as a model for ongoing organisational development linked to KRAs and quality improvement.
- BPCHS management team undertake this process before implementing the process in other departments as a means of demonstrating its commitment to gender and diversity planning

For BSWRWHP

- Support the training of the Women's Health Resource Workers to facilitate the Gender and Diversity and Equity Approach to Practice. With this in mind to then:
- Encourage further pilots of this project throughout the Barwon South Western Region.
- Encourage and support opportunities in which the language of gender and diversity can become part of normal health service discourse.
- Integrate this process with organisational quality accreditation programs for increased recognition.
- Support the training of facilitators who would be available to undertake this process in organisations who indicate a commitment to the Social Model of Health or a willingness to adopt a Social Model of Health

- Fund gender and diversity workshops for Primary Care Partnerships
- Continue to support the introduction of a Social Model of Health in health services in the Barwon-South West Region
- Use www.wholewoman.org.au to promote the this successes of this project and the Gender and Diversity Framework and Workbook.