



Women's Health Victoria

"facilitating access to quality women's health information"

Access to Women's Health Information

Issues for Opinion Leaders and Service Providers

**Market Research
2002-2003
for
Women's Health Victoria**

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Published by Women's Health Victoria
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First Published 2003

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Access to Women's Health Information Series:

1. A literature review of women as information seekers
2. A survey of Victorian women as information seekers
3. A literature review of health professionals as information providers
- 4. Issues for opinion leaders and service providers**
5. Research summary

ISBN: 0 9581297 4 6

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EXECUTIVE SUMMARY

Women's Health Victoria (WHV) commissioned Market Access, an independent market research company, to undertake a comprehensive study of the health information needs of Victorian women. The project involved several components, with the focus of the current report being related to an analysis of the needs that opinion leaders, policy influencers and service providers have of a women's health organisation.

The study incorporated a series of interviews with people from across the health sector, including:

- State Government departments
- Media
- Service Providers
- Professional organisations
- Academic organisations
- Non-Government Organisations and National and Statewide agencies

The main areas of inquiry during the consultations included assessing perceptions of the process of influencing health policy, gathering data about individuals' and organisations' means of collecting, analysing and utilising health information, and discussing awareness and perceptions of WHV.

A key finding of the study was the limited awareness that key people in the development of policy and the delivery of health services had of WHV and the limited understanding of the breadth of WHV's activities and of its role within the field of women's health. As a consequence it was apparent that the potential sphere of influence of the organisation was restricted. There is a need to clearly communicate WHV's purpose and expertise.

The consultation also raised a question with regard to the potentially conflicting roles of advocacy and information provision. Within an environment where credibility is critical, this potential conflict needs to be acknowledged.

There is a lack of understanding of WHV's relationships with other women's health organisations and of the role of Women's Health Association of Victoria as the peak body in the field. For the purposes of clarity and credibility, this needs to be addressed.

Several suggestions were documented where opportunities exist for WHV to enhance its profile and increase its influence amongst different segments of the health field. In undertaking many of these opportunities, it is apparent that the most efficient approach to the delivery of services for health consumers is through the development of partnerships that match relevant expertise of organisations.

The analysis identified that general practitioners are a primary source of health information for women. Hence, there is an opportunity for WHV to influence the provision of health information and services to a large number of Victorian women through enhancing its influence with GPs. This would be achieved most effectively in partnership with those organisations who provide training and information products for GPs.

There is currently an unmet need for the provision of gendered analysis of health data. Such information would be valuable to government, the bureaucracy, the media, other agencies and health service providers. However, the utility of this analysis for some will depend on communication of the value of a gendered approach.

There is potential for WHV to enhance its position and influence in the general community through a more pro-active approach to the provision of information, comment and advice regarding gendered health issues to the media. It is likely that such a strategy would provide indirect benefits associated with enhancing the profile of the organisation throughout the health community and improving the capacity of WHV to influence policy and program development.

It is important to recognise the political sphere as a critical element of influence in establishing the funding environment and the health policy agenda. Influence within this sphere is as much in the context of informal relationships as formal ones. In this regard, there is a need for WHV to seek to establish informal relationships with individuals identified as key influencers within political organisations, including Ministers, their Ministerial Advisers and media personnel, and with all women Members of Parliament.

The positive regard with which key WHV personnel are regarded should be used as a beginning point for increasing awareness of the range of roles and activities of the organisation.

A limitation of this analysis needs to be recognised: these observations and conclusions have been based on external perceptions of WHV and did not include an analysis of the organisation from within. To be complete, the analysis ultimately needs to be considered within the context of the philosophical approach and charter of WHV.

BACKGROUND

Women's Health Victoria (WHV) is a state-wide women's health information service that aims to provide high quality, independent and up-to-date information to women, health service providers, and policy makers. To assist WHV in its' strategic development, Market Access, an independent market research company, was commissioned to undertake a study of the health information needs of women. The overall aim of the project was to identify how WHV can ensure better quality access to health information for women.

The study involved several components, including:

- A review of the literature regarding issues associated with women's access to health information.
- A review of the literature regarding issues related to service provider's access to and use of health information.
- A survey of Victorian women to quantify issues related to accessing health information.
- A study of opinion leaders and influencers in the field of women's health.

Each of these components of the project has been reported separately. The current report relates to the latter component of the consultancy. In particular, this aspect of the review was designed to identify the needs that opinion leaders, policy influencers and service providers have of a statewide body or information provider, to evaluate their perceptions of WHV and thus to enable an analysis of how WHV could most effectively meet their needs.

OBJECTIVES

The following objectives were addressed in this element of the research:

- What sources of gendered health information do policy makers and opinion leaders use?
- How well do policy makers and opinion leaders feel that they are currently serviced with gendered health information?
- How do policy makers and opinion leaders prefer to access relevant gendered health information?
- What gaps exist in gendered health information needs?
- What awareness do policy makers and opinion leaders have of WHV and its function?
- How is WHV regarded in relation to advocacy on women's health matters?
- What factors affected the way that WHV is regarded as an advocate?

RESEARCH APPROACH AND METHOD

This component of the project was originally conceived as two separate studies: the first being of opinion leaders and influencers, and the second being a study of service providers. However, it became apparent during the course of the interviews and analysis that the issues for these two groups, while somewhat separate, have considerable overlap. Hence, the

analysis and reporting has been combined. Where issues are separate for each of these target groups, this has been documented within this report.

Approximately 30 people were interviewed. Participants were selected in conjunction with WHV, and comprised:

- Victorian Government departments, including the Department of Premier and Cabinet (DP&C) and a range of areas within the Department of Human Services (DHS)
- Non-Government Organisations, including those involved in areas of disabilities, mental illness, indigenous health and homeless
- Media, including health reporters and editors
- Service Providers, including community health centres, women's health providers and community nurses
- Professional organisations, including Victorian branch of the College of General Practitioners (RACGP) and Divisions of General Practice
- Academic, including Australian Institute for Primary Care, Melbourne University Department of General Practice
- National and statewide agencies, including Heart Foundation, Cancer Council of Victoria, Arthritis Victoria, VicHealth

Discussions centered around three key areas:

- Gendered health data, sources of, use of and needs for.
- Perceptions of health policy in terms of development processes, influences on and the use of data
- Perceptions of WHV, its role and activities.

Given the diversity of the roles of the people interviewed during this aspect of the project, the discussions varied widely, with the emphasis changing depending on the relevance to the interviewee.

With the permission of participants, each interview was recorded for the purposes of the research. Audio-tapes were then transcribed and coded into relevant themes. The emergent themes and issues are documented in this report.

REPORT STRUCTURE

This report has been structured into two main sections:

1. Detailed findings – this section documents the responses of the key informants to the topics discussed during the interviews. This has been divided into the main topic areas of the interviews, to reflect the range of objectives being addressed, namely:
 - Process of policy development
 - Health information sources
 - Awareness and perceptions of WHV.
2. Analysis of findings – this section provides an analysis of what these findings mean for WHV. In particular, the analysis provides a summary of the perceived strengths and weaknesses of the organisation and documentation of the opportunities that exist for WHV in relation to information provision and influencing the health policy agenda.

DETAILED FINDINGS

PROCESS OF POLICY DEVELOPMENT

Participants were asked to discuss their thoughts about the process of policy development in terms of how particular issues went from identification and conceptualisation to the establishment of specific policies and the development of related programs, and the factors that influenced this process.

There was a general acceptance across the range of interviewees that policy tended to derive from a combination of political forces and community needs, with a range of issues determining the relative influence of each of these factors.

Those directly involved in the development and drafting of policy reflected that any health policy would need to fit within the context of the current political agenda. Hence, the 'Women's Health and Wellbeing Strategy' was developed within the overall state government strategy of 'Growing Victoria Together'. In this context it was noted that timing was always a critical issue in terms of the drivers of the political agenda.

From the opposite direction, it was acknowledged that policy was also developed in response to the recognition of needs within the community. Such needs might be identified from consumer movements or they might be identified by those organisations that are in touch with or directly providing services to the community. However, it was noted that community need was usually not sufficient in itself to prompt policy development without a relevant political context.

In either case, there was agreement that policy development was strongly dependent on evidence. Whether the stimulus was from the political processes down or from community needs up, the framing of policy was based on data related to the existence of an issue, the needs of people affected by the issue and evidence related to programs designed to address the need. This finding highlights an issue of concern with regard to the observation, noted later in this report, that there was a dearth of appropriately gender analysed health data.

"There are a variety of approaches, but at the end of the day it is about influencing people on the basis of either, there's a powerful group of people out there ... and you want to get them on board ... or there's a rational argument for this and it's the right thing to do."

"The women's health and wellbeing strategy, it was very much in the context of the overall government policy. Overall government policy was Growing Victoria Together. ... the strategy of this project ... came directly from John Thwaites to our Ministerial Advisory Committee, which was a 22-woman committee of external women representing both health themes as well as expert representatives of communities of interest."

"I believe that a lot of the policy agenda is driven by politics and it's also a timing issue. So, you can have really convincing data about really specific issues, but it isn't a time or political environment in which to actually raise those issues."

"Essentially the way policy gets up is that somebody, somewhere, some group has a proposition that they want to put forward about some resources for a particular set of initiatives, or regulatory change, or whatever ... essentially what you are trying to do is lock the senior bureaucrats to the proposition and you're seeking to lock in a minister to the proposition. And the strategies that you have to use to achieve that are essentially those of personal influence and the media and research, so you can either argue it on the basis of either an analytic perspective, which says that you ought to do that, or you can argue it on the basis of 'I've got a lot of people who say I'm right'."

INFLUENCING THE POLICY PROCESS

Within this understanding of the processes by which issues became policy, was recognition that a critical factor was the role played by those who influenced the political agenda through relationships and partnerships. Several interviewees, especially those who have had involvement at the more senior levels of government and the bureaucracy, reported that individuals and organisations who sought to influence the policy agenda needed to have close personal relationships with those within the political parties and the bureaucrats responsible for the relevant policies. Both formal and informal relationships were considered to be important.

It was apparent during the interviews that being involved with groups, such as the committee that oversaw the development of the Women's Health and Wellbeing strategy, was a significant channel of influence. Several interviewees spoke about the range of people who had worked on this committee and how it had shaped the development of that policy development. WHV's involvement was acknowledged.

While the formal, structured relationships, such as involvement in committees and working parties, were recognised as essential aspects of influence, the more senior interviewees were adamant that influence was also about personal interactions and informal relationships. The importance of developing and maintaining workable and mutually beneficial relationships was acknowledged. Some spoke of other players in the health field who worked in this way and who were therefore able to exert influence when needed.

In this regard it was noted that the senior bureaucrats and political advisers tended to be involved in many different issues and, therefore, needed to rely to some degree on those for whom a particular issue was their primary area of interest.

It was also noted that in the area of women's health, the agenda was set as much within the context of women as it was within the specific health portfolio. Hence, it was noted that influence was likely to be demonstrated amongst women who were senior bureaucrats and policy advisers across the scope of government rather than solely in the field of health.

THE HEALTH POLICY AGENDA

It was commonly noted that women's health had lost some of its currency as a political issue in recent times. Various explanations and interpretations were provided as to why this might be so. As a consequence of this lowered priority on women's health, it was noted that obtaining funding for women's health related programs was more difficult now than it had been in the past.

Some of the issues that were perceived to be currently attracting most attention in relation to health policies and funding included chronic diseases, mental health, young people and a range of access issues such as rural services. This was considered to be the case at the State as well as at the Federal level.

Consequently, several opinion leaders commented that to obtain funding to target specific gender related health issues, it was necessary to do so within the context of priority health topics. For example, in the current policy environment, it was felt more likely that an organisation would be funded through budgets set aside for mental health to provide a program with a focus on women, than to be funded to provide a similar program through a women's health budget. It was noted that this had implications for the relationships that an organisation such as WHV needed to establish.

"I think that what's got the political constituency for women's health is the women's movement. Not the health consumer movement."

“The trick with an area like women’s health is, you know, you have to identify where the political force is. And I always thought it is with the women members of parliament, women trade’s unionists, women who are seeking to be in power and see health as part of that agenda.”

SOURCES OF HEALTH DATA & INFORMATION

Interviewees were prompted to discuss the role that health data played in their organisations and specifically how they used such information in their positions. They were also prompted to identify the sources that they used for gaining knowledge of health issues and to discuss how well the information that was available met their needs.

USE OF HEALTH DATA AND INFORMATION

Depending on their role, respondents varied somewhat in their descriptions of the way that health data was used. However, across all of those interviewed information on health was generally recognised as having the following functions:

- Monitoring population health status
- Monitoring service usage
- Providing evidence for development of policies
- Providing evidence for development of programs for health consumers
- Informing the development of training programs for service providers
- Informing the development of communications
- Providing assistance to health consumers

As noted in the previous section, there was a strong recognition of the notion of health policy and practice needing to be based in information, or evidence. In this regard, evidence was felt to have two distinct components. The first related to documentation of population statistics in terms of both health conditions and the usage of various health services. The second component of evidence was in relation to trials and evaluations of the effectiveness of various programs and strategies targeting health conditions.

PERCEPTION OF GENDERED HEALTH

Interviewees were prompted to discuss their impressions of gendered health in terms of what they considered gendered health to be, what sources they used for accessing gendered health data and their experiences of the utility and quality of gendered health data that was available to them.

The concept of what is gendered health ranged broadly: from some who thought of it as health conditions that were specifically relevant to women (eg reproductive health) to those who saw it as related to the broader socio-cultural context in which health issues were assessed, health data was analysed and programs and policies were developed.

For the former group, gendered health was based on a biological notion of the health conditions that men and women experience differentially.

For the latter group, gendered health was a reference to the notion that gender, and therefore gendered health issues, were broader than these biological constructs. This group of people tended to think of a gendered approach to health as one that takes into account the social and cultural factors that affect women’s health in addition to biological factors. They

referred to the notion of a gendered approach to health that incorporated consideration of women's different needs and experiences including factors associated with their living, family, working and financial status.

Interviewees' impressions of what constituted gendered health appeared to be related to the degree of their involvement with women's health and particularly with women's health policy. Those whose role required a specific focus on issues related to women's health tended to have a more social view of gendered health, while those whose role did not necessitate a separate or specific focus on the health of women tended to a more biological definition.

Within the bureaucracy it was apparent that those interviewees whose role included direct involvement in the development of general health policy or women specific health policy tended to have a broader social view of gendered health.

Notably, some of those in the community health sector who directly provided health services to women expressed a fairly limited, biological, view of gendered health. They considered gendered health primarily to be a reference to health issues such as menstruation, pregnancy, birthing, menopause, breast and cervical cancer, etc.

"[Gendered health information is] health information that breaks down figures between men and women... Unless [a breakdown of figures between men and women] was directly relevant to the question that we were addressing, it would be highly unlikely that we would worry too much about doing it."

"If you think of women's health as an issue that's broader than their physical body, and is influenced by environment and gender and stereotyping and things like that, then you will go to the Women's Health Services because that's their view of the world. It depends what you think women's health is about."

"You develop understandings of health ... dependent on who people are and where they're coming from. So, just as you'd need to understand issues around men and women, you also have to understand them across the life span and within cultural groups, etcetera. So, a gendered approach, all that means to me is that, you know, if you're focussing on specific men's health issues or women's health issues, then you understand that in terms of gender."

SOURCES AND RESOURCES USED FOR GENDERED HEALTH DATA

Participants were asked about how and from where they obtained the gendered health data that they used. Responses varied from those who reported having little need for gendered health data, and therefore not obtaining this specific information from anywhere, to those who reported collecting it themselves or having such data collected within their own organisation.

Those from within DHS tended to report that they relied heavily on departmental sources for this data. They reported either that there was a section within their departmental area that collected or collated relevant data, or that they had specific people within their areas responsible for keeping up to date with relevant data and data sources. Those from other departments also reported that they relied on specific officers to keep them up to date with relevant data. On the whole, departmental officers tended to feel that they knew exactly where to go when they wanted health data, including gendered health data.

Those at higher levels within the departments tended to report that they relied on specific officers to keep them informed of information in specific topic areas, such as women's health.

Within the media, health and medical reporters and editors tended to rely on a network of contacts who were recognised as experts on particular health topics or those who would be able to recommend appropriate experts. Reliable and established personal contacts were

considered very important within this context. These included Public and Media Relations personnel within health agencies, universities and hospitals, as well as individuals with whom the reporters had personal rapport.

Across the sample of Opinion Leaders, the Australian Bureau of Statistics (ABS) was commonly referred to as an independent source of data that included some gendered information. Those who had defined gendered health in terms of the simpler biological notion tended to report that ABS data was generally sufficient for their needs for gendered health data. The Burden of Disease data was also referred to as providing population information.

Some reported using sources whose reputation was in the assessment and validation of other primary data sources, such as the Cochrane database. Some also reported relying on the databases of other overarching health organisations and peak bodies such as VicHealth, the Victorian Mental Awareness Council, the Australian Institute of Health and Welfare, etc.

Some of those whose primary area of concern was other than women's health, for example, those involved in mental health or public health, reported that they might go to the peak body in their field for whatever gendered information they wanted prior to approaching the women's health services. That is, they would initially approach a source who could supply the relevant information from within their specific field of interest (eg, mental health) and would then look to that information for a gendered analysis. In several cases, people reported that they would not naturally think to go to a source of women's health information and expect to analyse that information in terms of their field of interest.

Those who reported that they would go to WHV or to any of the Regional Women's Health services for gendered data were those who had an experience of these organisations as having an important role in women's health. This included people directly involved in the drafting of women's health policy, and those who had dealings at management and committee levels with people from these women's health organisations.

"[We go to] departmental colleagues, both in terms of their experiences, their practice, what evidence that they've got. There are a whole range of consultancy structures and processes that we've used ... and people would do their own desk based research ... the Department is wonderful at collecting data ... not always terrific at then actually analysing it, but there is a rich source of data."

"The Council ... maintains a gendered perspective on the consumers of services, and there's the services themselves who keep clear accounts of service delivery to women, service delivery to men and the types of groups and programs they run for women."

"I would only go to [WHV] for gendered health information, whereas I'd go to the relevant peak body for generic information ... I'd see if [the topic] was in [WHV's] top ten if I was writing a speech or briefing a minister around gendered health ... I'd start there because they are funded to provide the state with gendered health information."

SATISFACTION WITH GENDERED HEALTH DATA

Interviewees were asked about their perceptions of the gendered health data that was available to them. Responses ranged considerably from those who felt they had relatively easy access to the type and quality of gendered data that they needed, through to those who felt that the data existed but that it was not always accessible, to those who believed that there was not adequate gendered data available to them.

Those who felt that they had sufficient access to the quality and detail of gendered health data tended to be those for whom gendered health was the relatively simpler biological

constructs. This group tended to refer to the availability of health data that was broken down by sex, rather than the more complex notions of gendered health that incorporated social and psychological constructs.

Of those who reported some dissatisfaction with the availability of gendered data, the main concern tended to be that, while some of the actual data existed, it was not available in the format that was needed. People spoke of gaps that existed in the data they were able to obtain relating to the broader social and cultural issues of gender and how these related to health conditions, health outcomes and health service usage. For some there was a perception that this data did not exist while some felt that it might exist, but that it was not readily available in an accessible and useful format. This response was more common from interviewees who were outside the DHS.

One person spoke of needing to employ project officers to specifically evaluate available data for a gendered understanding, and felt that such data should be more readily available. Several departmental (DHS) people felt that there was a considerable amount of relevant data collected by and through the department that was not adequately analysed.

One interviewee commented that there was a lack of qualitative information about women's experience of health and the health system, and that the implications of this were that the more complex and intricate notions of gender were not adequately understood in relation to health data.

Several interviewees discussed their belief that the lack of sufficiently gender analysed data had considerable implications for policy and program development. They felt that for policies and programs to have a thorough grounding in gender needs, as well as health needs, it was important that such data was available, accessible and used by those involved in the development of women's health. This was considered to be especially important in an environment of evidence based practice.

Several people noted that there was a specific lack of gendered information in relation to therapeutic trials. They commented that in some areas, for example, heart disease and arthritis, past drug trials had sometimes not taken sex into account, meaning that dosages and therapeutic regimes were often not gender specific. In some instances it was noted that new information was emerging in these areas documenting the need for different drug dosages for men and women.

"There is a storehouse of data that goes on unanalyzed around here, and the department is looking at ways to address that."

"I think we're quite well served from the point of view of data about, you know, utilisation of services, etc, by women and men. And the differences in population health outcomes, and so on, that data is quite good and easily available and there's plenty of academics about who are interested in those issues and writing about them. But, I think there's less good data on the quality of the experiences of the system for women and the nature of the issues that they confront and the choices that they're making ... I think, generally, data on people, on consumers of health and the nature of the power relationship and the nature of older women, younger women, you know, how generations have shifted their perspective ... that's less clear to me that there's great data on that."

"Well, I've had to put someone on the payroll for two or three days to actually pull [the gendered health data] out of the resources ... so that you can use it."

"I need more the macro, more the environmental context [of] women's health ... rates of working women, rates of pay, rates of child care responsibilities, rates of servicing family needs, rates of violence, rates of where women are living, umm, how many sole parent families make up all of that. So that you begin to understand the context in which women's health is actually playing out. WHV does have the socio-economic holistic approach to health, umm and the DHS would certainly articulate that, umm, but they don't have the mechanisms to understand it through the data."

"I'm appalled by the lack of capacity at a national level for the development of good data for the purposes of policy and program planning ... Trying to get the sort of data I need, it doesn't exist. I rang Premier and Cabinet, the women's unit, [they said] it doesn't exist. Rang DHS, it doesn't exist. Rang WHV, said doesn't exist in current form, but we might be able to work with you to get it. And I'm thinking, how do people actually macro policy plan without this data, and they're all going 'yes, it's terrible' and I'm thinking, well what are we going to do about it?"

"The data isn't particularly, as far as I'm concerned, very good at the moment. Ahm, I personally wouldn't know where to go for that data."

CONSUMER HEALTH INFORMATION FOR WOMEN

Those within community health organisations tended to have a range of mechanisms for informing themselves of relevant gendered health information. Some utilised formalised structures within their organisations that ensured relevant information was passed on to those who needed it, while others were dependent on personal relationships with other workers in the field. Commonly, those in this sector called on an array of organisations and individuals that they recognised as having expertise within the particular field that they were looking for information related to. Regional women's health services were commonly referred to in this regard.

Community health organisations also tended to rely largely on other national and statewide bodies for their literature and resources. This included agencies such as the Cancer Council, Quit, Breastscreen, etc, who produced resources targeted to specific needs groups relating to their particular health issues. The community health workers acknowledged that they could provide information most efficiently and effectively to their constituents through utilising the expertise of these agencies.

Some reported that they would go to specialist agencies, such as specialist data collection agencies or organisations involved within a particular field of health.

Several people spoke of their preferences for working in partnership when developing consumer and service provider information and resources, utilising a combination of people and organisations with specialist knowledge in the topic area of interest. In particular they spoke of working collaboratively with other statewide and peak organisations within the field of interest. Some examples included: the Cancer Council partnering with Breast Screen Victoria in providing information on mammograms; the Cancer Council and Arthritis Victoria collaborating with the Jean Hailes Foundation on issues of women's health; and the Heart Foundation collaborating with Beyond Blue on information that related to heart disease and mental health.

For some organisations it was noted that such collaborations, while useful, were often difficult because of the intricacies and complexities associated with identifying and explaining the philosophical match between the organisations. In the words of one interviewee, "we'd need a statement of what their processes and philosophies and givens were" before a partnership approach could be undertaken. In this regard, all organisations were conscious of the manner in which their associations reflected on their own image, and hence would only enter into partnerships when they were seen to reflect a philosophical match.

Several of those in the community health sector and in statewide and service delivery agencies noted that the most obvious gap in health information, from the perspective of their constituent health consumers, was for health information in different languages. This included health information for women from different language and cultural backgrounds.

AWARENESS & PERCEPTION OF WHV

Participants were asked about their impressions, knowledge and interactions with WHV. In response, different people spoke of WHV's advocacy, their clearinghouse role, their newsletter and their information provision services. It was notable, however, that few spoke of all of these roles and many of those interviewed reflected that they did not really have a full picture of what WHV did.

WHAT AWARENESS DO PEOPLE HAVE OF WHV?

As might be expected, interviewees tended to have a more comprehensive understanding of the aspects of WHV that they had direct dealings with. For some, the predominant impression was an awareness of the advocacy role of the organisation through joint involvement on various women's health related committees. For some others the predominant awareness of WHV was related to the provision of relevant research information, as this was what they had used WHV for in the past. For those whose role was associated with funding aspects of WHV work, awareness was predominantly related to those areas that they funded. For some of those in community health, it was the resource aspects of the WHV library, telephone information line and web site.

While such a response might be anticipated, to some degree this finding reflects an important issue faced by the organisation: that the breadth of its' activities are not effectively communicated across all levels of interactions with the organisation. The consequence appears to be that people think of WHV only in the context of their current relationship. Hence, the promotion and subsequent utilisation of the activities and services of WHV are not optimised. In this regard, it was apparent that some of the senior bureaucrats interviewed in this study had little direct experience of WHV and consequently had only a very limited knowledge of the organisation and its activities.

In a related manner, it was apparent that interviewees had a sense of WHV that was strongly related to their dealings with individuals from the organisation rather than with the organisation itself. While the WHV representatives were generally held in high regard for their work, it was notable that interviewees tended to perceive their relationships as being with these individuals, rather than with WHV. Again, this has implications for awareness of the organisations and impressions of its activities.

Some of those from the community health sector reported that they knew of WHV as a source of information for both them as health care providers and for the women in their community. They mentioned the Quality Information Health Issues Resources (QIHIRs) (now known as Independent Women's Health Information), the telephone information line and the library resources. However, it was also apparent that some community health professionals did not know about these aspects of WHV or that these facilities were available for their use.

WHAT PERCEPTIONS DO PEOPLE HAVE OF WHV?

When asked to describe their impressions of WHV, responses varied substantially, from those who considered it to be very much a community based organisation through to those who regarded it as a modern, professional advocacy body.

At one extreme, some were of the impression that WHV was in the mould of a community based organisation whose focus was on the translation of feminist principles into health policy and practices. While none overtly disagreed with this approach, some felt it was somewhat dated and not conducive to effective service provision or influence.

At another end of the spectrum of perceptions, a small number were of the opinion that WHV was quite modern and professional as an organisation, and that this potentially compromised its capacity to maintain connection with its constituency: women in the population and those who provide health services to them. One person felt that WHV was not sufficiently accessible because of its focus on the provision of services via the internet and because of its location and physical space.

Those who knew something of WHV commonly referred to it as a provider of quality information. It was apparent that people perceived this notion of quality as being peculiar to WHV. That is, they tended to believe that WHV had a particular interpretation of quality. It was evident that the word quality had come to be associated with WHV information, however, this response was seen to be as much related to WHV's promotion of its services as to any independent assessment of the information products. This is not to say that people did not think of WHV as providing quality information, but rather, those who knew something of WHV recognised that the organisation promoted itself as a provider of quality information.

Interviewees appreciated that WHV placed such high importance on the notion of quality and felt that they could rely on information they gained from WHV as having been exposed to this quality assessment, which provided them with a degree of confidence in WHV information. Certainly those in the community health sector who had some experience of WHV information services to women as health consumers, considered that the information provided was quality information.

Some views about WHV across the wide range of perceptions included:

- kind of hand-knitted, grass roots, slightly seventies, community based stuff
- WHV has a different feel about it, very much web based, so not accessible to many women who don't have access to the internet
- too middle class, the premises, the web, no other agencies would think to have their AGM at the Aquarium, its pretty flash
- don't have a sense of how many people staff the phones, don't have a sense of whether they have got generic material or more specialised material and what referral would be if that specialist stuff was required
- all the information that they cite as being good practice or the stuff they are prepared to champion, has been through and been analysed according to the quality criteria, at least you know up front what those criteria are.

WHV RELATIONSHIPS WITH OTHER ORGANISATIONS

One of the issues that commonly arose was the relationship between WHV and other women's health organisations, such as the regional organisations. It was apparent that there was a lack of clarity about these relationships. In particular, there was a lack of certainty about who was the peak body in relation to women's health. Some knew of the Women's Health Association of Victoria (WHAV) and its role as the peak body, while others had no knowledge of this body. Some regarded WHV as the peak body.

Those who knew something of the role of WHAV reported that this organisation itself had some difficulties in being a representative of women's organisations. In particular, it was noted that as WHAV was not funded it did not have the resources to effectively speak on

behalf of other women's health organisations or to advocate on behalf of women. It was noted that when those who were associated with WHAV spoke, it was assumed that they were speaking on behalf of their own organisations, rather than on behalf of WHAV as the peak body. Several people felt that this was unlikely to change as long as the peak body was an unfunded organisation.

As noted, some regarded WHV as the peak body, while some believed that comments or positions emanating from WHV were representative of all women's health organisations. However, some others were less sure about the relationships between WHV and other women's health organisations. Several people were not sure whether these were separate organisations, and referred to their own dealings with a regional service as being dealings with WHV.

In relation to the advocacy role, it was noted that when comments were made by WHV, it was not clear whether these were meant to be seen as reflecting the views of all women's health organisations or whether any consultation had been undertaken with other organisations. Several interviewees noted that they would appreciate knowing more about the consultation process that was undertaken between the various women's health organisations in the process of developing a statement or position.

The lack of clarity about the relationships between different women's health organisations was also evident in the opinion of some service providers who believed that WHV was a regional women's health organisation for women based in the CBD.

"The organisation is a Peak, and I think it's got a role in advocating and leading some of the community debate around this issue, around women's health."

"I don't think the relationships between the Statewides and the Regionals works well at all, and that's not just Women's Health Vic ... I think the relationship issues with the Regional Women's Health Services is critical. And the thing with the Peak's, I mean the positioning in terms of how they fit with the Peak and how the Peak fits with them, and clarity around who's doing what to whom."

"And I think often too, WHV say things sometimes, you know, public forum, and it's often, the name WHV implies they are the Peak, and in fact they're not. And it's never clear – are you talking as, you know, a pseudo Peak? Have you talked to the Regional Women's health Services? Is your view consistent with theirs? It's not clear who is saying what."

"I have a question about how well they are connected with all the specialist health peaks and whether there's actually working relationships ... I know they're quite well connected in terms of women's health, but how often are they talking to the Anti-Cancer Council and the Heart Foundation ... and all the other health peaks? And how do they get their referrals in and out? I don't know all those things."

BALANCING THE ROLES OF INFORMATION, ADVOCACY & SERVICE PROVISION

Several interviewees spoke about the importance of balancing the potentially conflicting roles of advocacy, information and service provision.

While all of these roles were assessed as being needed in the women's health field and WHV was recognised as having the experience and expertise to fill each of them, some were not sure that these functions were easily housed within the one organisation.

In particular, it was noted that the provision of information and the analysis of data required a degree of objectivity. By contrast, advocacy, while needing to be driven by empirical data, tended to reflect a particular belief or philosophical approach. Hence, many noted that it was difficult for an organisation to be regarded as a provider of objective data at the same time as being recognised as an advocate for a particular point of view. It was noted that those

organisations that successfully achieved this balance tended to be structured in such a way as to separate their information collection and analysis from their advocacy.

For some, the most apparent need was for a gendered analysis of health data. They felt that such a capacity would provide the evidence necessary for ensuring that women's health needs were recognised within the health policy agenda. Further, some of this group believed that such analysis could only have the desired impact if it was regarded as being independent – that is, if it was seen to be separate from any particular philosophy or political agenda.

On the other hand, some felt that the value of WHV's advocacy role was a consequence of its strength as a provider and interpreter of data and of its role in the provision of information services to women. This group of people felt that by providing services that ensured that the organisation kept in contact with the needs of women as health consumers, WHV was afforded a degree of credibility in its role as an advocate.

In a somewhat related matter, it was apparent that some of the statewide and national public health bodies were in the process of evaluating and restructuring their approaches to the provision of health information to consumers. This was driven by factors such as funding limitations, development of new technologies, a focus on efficiency in service delivery, and recognition that effectiveness could be enhanced through partnerships with external service delivery mechanisms. Specifically, some spoke of limiting the number and range of paper products and moving to web-based information provision. Some also spoke of focussing more on providing information and services to the service providers, rather than to health consumers. There was a general feeling that developing and utilising appropriate information channels and conduits was the way of the future in the provision of consumer health information and resources, and that focussing on paper resources was relatively inefficient.

“That’s the question that [WHV has] got to decide, whether they are essentially an advocacy, political force that’s seeking to have a service delivery function and be close to the grass roots and then network it back to a whole lot of political agendas, or whether they want to be the rational ... objective analyst.”

“I do believe they’ve got a very significant role in terms of data ... to be able to collect data and analyse data in a way that bureaucracies may not necessarily do, and they can make connections in ways that bureaucracies don’t ... as well as the data role, there’s the [need for a] shop front, sort of, for women’s health information delivery ... I reckon it’s quite complex because I reckon that you can’t do one without direct delivery ... I think that keeps you honest and grounded, and it keeps you familiar with what you’re dealing with.”

ANALYSIS OF FINDINGS

This project was conducted to provide information and insights that would inform WHV in the development of strategies and procedures for the provision of health information services to women. In particular, the project aimed to explore perceptions of WHV, its influence and direction, and to identify how WHV can facilitate and work with others to ensure better quality access to health information for women.

The study has involved an assessment of the role of WHV within the 'market' of health information providers. This has included an evaluation of the mechanisms by which WHV can effectively and efficiently achieve its goals of maintaining and promoting an

understanding of women's health information from a feminist perspective, of advocating for women and of working with service providers for better health outcomes for women.

One way of documenting this evaluation is as a situation analysis that reports the strengths and weaknesses of the organisation and the opportunities and threats that exist for it within the health services environment.

However, it must be noted that there are several limitations to such an analysis. Firstly, these interpretations are limited by the fact that the consultancy has focussed on the thoughts and experiences of people outside of WHV and has not included an analysis of the organisation from within. While data about the organisation has been taken into consideration, the analysis ultimately needs to include further consideration from those within the organisation to be complete. In particular, the issues discussed within this analysis need to be considered within the context of the philosophical approach of WHV and its people to the achievement of the organisation's charter.

Secondly, this analysis has not taken the funding context into account. That is, this consultancy has focussed on the issues related to the provision of health information and related services, and the scope of the research has not extended to an economic analysis of the needs of WHV in terms of ensuring ongoing funding.

STRENGTHS

This section presents WHV's strengths – factors that are recognised about the organisation that enable it to provide quality services. The consultancy identified the following key strengths of WHV:

- Provision of quality health information resources
- High regard for the organisation and the individuals within it
- Commitment of the organisation to women's health
- Influence that the organisation has in strategy development

PROVISION OF QUALITY HEALTH INFORMATION RESOURCES

Those who had experienced WHV's health information line, QIHIRs (now known as Independent Women's Health Information), web site or library reported that their impression of these resources was positive and indicated that they believed WHV resources were of a high quality standard.

That WHV placed quality high on its own agenda and had established protocols for assessing quality of information was also well regarded. This ensured that users of WHV information had confidence in the veracity and completeness of the information.

HIGH REGARD FOR THE ORGANISATION AND THE INDIVIDUALS WITHIN IT

The people of WHV, including staff, management and the board are considered to be a key strength of the organisation. Those who had interactions with WHV spoke positively of the individuals they had dealings with.

COMMITMENT OF THE ORGANISATION TO WOMEN'S HEALTH

The philosophical approach of the organisation and the commitment of WHV to women's health are considered to be key strengths. Amongst those who know of the work of WHV, it is recognised for being clear about its philosophical principles and for breadth of value that its bio-psycho-social approach to women's health provides.

INFLUENCE THAT THE ORGANISATION HAS IN POLICY & STRATEGY DEVELOPMENT

The involvement of WHV in policy and strategy development, through the provision of gendered health data analysis and membership of Advisory Committees and Reference Groups, is a key strength of the organisation. It is this aspect of the work of WHV that is best regarded amongst the bureaucracy and other agencies.

WEAKNESSES

This section identifies factors about WHV that were perceived to weaken the organisation's capacity to assert its influence and provide its services. The main weaknesses were identified as:

- Lack of awareness of the organisation
- Dependence on individuals within the organisation
- Unclear corporate image
- Unclear relationship with other women's health organisations

While somewhat distinct, these issues can all be understood as being related to awareness and knowledge of the organisation within the field of health providers.

LACK OF AWARENESS OF THE ORGANISATION

The most salient issue identified during this consultancy was that there was a low level of awareness of WHV and its activities. While some had a reasonable knowledge of the organisation through direct involvement, several people from across all of the segments included in these consultations knew little of the organisation other than its name. Specific things that people were unclear about included whether WHV was an advocacy body, a service provider or an information provider and what information, advice or assistance WHV provided to whom.

The most obvious implication of this lack of awareness of the organisation was that WHV was not top of mind when thinking of women's health issues, and therefore that WHV was not consulted or asked to provide input into areas that would be within its sphere of expertise. This included input into the media as well as into the programs and operations of other health organisations. Hence, the sphere of influence of the organisation was felt to be considerably restricted.

DEPENDENCE ON INDIVIDUALS WITHIN THE ORGANISATION

Related to the low level of awareness of WHV was the fact that many of those who did have dealings with the organisation tended to refer as much to the individuals within WHV that they had contact with as to the organisation itself. Similarly, in several cases people knew only of those aspects of WHV that they had previously had direct dealings with.

Again, the implications tended to be that people's perceptions of WHV were limited and therefore that the organisation was not fully utilised across the breadth of its capacities and expertise.

UNCLEAR CORPORATE IMAGE

While a few of the key informants included in this consultation had a comprehensive understanding of WHV, including an appreciation of its philosophy as well as its activities, others were unsure what the organisation stood for. Similarly to that noted above in relation to awareness of the organisation, a degree of confusion and misunderstanding was evident

in relation to what WHV's purpose was, who it represented, what it did and who its constituency were. This issue was most apparent amongst the key informants outside of DHS.

The impact of this lack of clarity included that some people did not utilise WHV services because they considered the organisation to be too professional and therefore not in touch with real people, while others made a similar choice because they thought it to be too grassroots and therefore not sufficiently modern. Again, the consequence is that WHV expertise is not fully utilised across the breadth of its potential relationships with other providers.

UNCLEAR RELATIONSHIP WITH OTHER WOMEN'S HEALTH ORGANISATIONS

A specific element of the poor awareness and understanding of WHV and its role was in terms of the relationships between the various women's health organisations.

An implication of this lack of clarity of roles and relationships was that people were unsure what authority or representation WHV spoke with when commenting on women's health issues. They did not know whether WHV was commenting from its own point of view or whether any consultation had been undertaken with other women's health organisations in the process of coming to a position

LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
CME	Continuing Medical Education
DHS	Department of Human Services
DP&C	Department of Premier and Cabinet
GP(s)	General Practitioner(s)
JHF	Jean Hailes Foundation
QIHIR	Quality Information Health Issues Resources
RACGP	Royal Australian College of General Practitioners
WHA	Women's Health Association of Victoria
WHV	Women's Health Victoria