National Women's Council of Ireland
Women's Health Project:
Evaluation

The evaluation was undertaken by Tríona NicGiolla Choille from the Women's Studies Centre at the National University of Ireland, Galway during August - October 2000.

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GLOSSARY OF TERMS

DoHC - Department of Health and Children

NWCI - National Women's Council of Ireland

NAPS - National Anti-Poverty Strategy

NOW - New Opportunities for Women - an EU funded initiative

WHP - Women's Health Project

WHAC - Women's Health Advisory Committees

WHIG - Women's Health Implementation Group (the WHAC in the North Eastern Health Board subsequently became the WHIG)

WHC - Women's Health Council

EHB - Eastern Health Board, disbanded in 2000 and reconstituted as

ERHA - Eastern Regional Health Authority consisting of three Health Boards - the South Western Area Health Board, the Northern Area Board and the East Coast Health Board

MHB - Midland Health Board

NEHB - North Eastern Health Board

NWHB - North Western Health Board

MWHB - Mid Western Health Board

SHB - Southern Health Board

SEHB - South Eastern Health Board

WHB - Western Health Board

1: EXECUTIVE SUMMARY

INTRODUCTION

Following an extensive national consultation a **Plan for Women's Health** was published by the Department of Health in 1997. The Plan proposed a new approach to the development of health services for women, incorporating a commitment to ongoing consultation with women's organisations. The Plan envisaged a significant role for the National Women's Council of Ireland at regional level on women's health advisory committees and at national level on the Women's Health Council and other bodies.

In order to support the participation of the NWCI counterparts at national and regional level the Department of Health and Children agreed to fund a three year pilot project at the NWCI. The Women's Health Project was established to deepen the expertise of representatives in women's health issues, to provide leadership training to enhance that participation, to provide administrative back-up and to support the development and maintenance of accountable structures with women's groups.

EVALUATION

During 2000 it was decided to commission an evaluation of the work of the Women's Health Project. The evaluation was undertaken in order to identify and evaluate the Women's Health Project from the perspectives of the NWCI, the NWCI health counterparts, the Health Boards and the Department of Health and Children, to examine the effectiveness of the NWCI counterparts on the various committees and to contribute to future NWCI women's health strategy and policy. The evaluation was carried out from August to October 2000 and involved interviews with a wide range of players in the Project - staff and counterparts at the NWCI, Chairs of the WHACs throughout the country and statutory personnel at regional and national level.

SUMMARY OF SECTIONS

- **Section One** outlines the background to the development of the Women's Health Project at the National Women's Council of Ireland.

- **Section Two** outlines the Support Structure which developed at the NWCI. It traces the development of the Project from the initial phase where it was managed by an external consultant to the second phase when it was brought into the mainstream of NWCI activities. The main elements of the Support

Structure are examined - the support to participants, liaison with Chairs of WHACs, policy development, linkages with the Health Panel, publicity, development of relationship with the Department of Health and Children, representation on national committees and support for networking.

- **Section Three** examines the impact of the Project from the perspectives of the counterparts and the Chairs (of the WHACs) throughout the country. In addition to these perspectives , the positive outcomes of the Women's Health Project are discussed, aspects of the Project which could be improved are presented and an overall assessment of the impact of the Project is made.

- **Section Four** examines issues arising from the Evaluation - consultation, model of partnership, monitoring and evaluation and networking with local groups.

- **Section Five** makes general recommendations as well as specific recommendations to the partners in the Women's Health Project, i.e. the Department of Health and Children and the NWCI.

RECOMMENDATIONS

Overall, it is recommended that the Women's Health Project be funded to continue the work on the implementation of the various women's health plans and other health initiatives.

Recommendations to the NWCI[1]

It is recommended:

- That the NWCI develop a model for consultation with women (in relation to health issues).

- That the NWCI develop greater integration between the work of the various sections of the organisation (in relation to health issues).

- That the NWCI support counterparts in developing feedback mechanisms throughout the country so that the work of the organisation on regional bodies such as the WHACs can be promoted.

- That the Women's Health Project review the support/training needs of counterparts on the Committees.

- That the NWCI review the needs and expectations of affiliates outside Dublin (in relation to health issues).

[1] Recommendations referring to health issues specifically are indicated in brackets.

Recommendations to the Department of Health and Children

It is recommended:

- That the Department of Health and Children take greater ownership of the Women's Health process.

- That the Department of Health and Children allocate a realistic budget to the WHACs to support innovative work in relation to women's health.

- That the Department ensure that the funds for women's health projects are ringfenced so that they are not used to support existing work but should clearly be designated as supporting innovation or pilot projects.

- That the Department of Health and Children ensure that personnel nominated to the various advisory committees, including the Women's Health Advisory Committees, should include senior management personnel who will be able to make decisions and input directly into the Service Planning process.

- That the Department of Health show its commitment to the Women's Health process by issuing standard terms of reference to the WHACs to guide them in the implementation phase.

- That the Department of Health and Children ensure that the Chairs of the WHACs are given adequate resources, support and opportunities to meet as a group to share experiences, learn from each others work and develop common themes and strategies.

- That the Department and Health and Children ensure that the monitoring and evaluation of the work of the WHACs is carried out.

- That the Department of Health and Children allocate adequate resources to the Women's Health Project so that the Support Structure can meet the needs of participants, support local and regional networking and promote the work on women's health issues.

2: INTRODUCTION

OBJECTIVES

Women's health issues have been a priority for the NWCI for many years. In 1996 the Council collaborated with the Department of Health on a national consultation process regarding women's health needs and the services required. The outcomes of the consultation process were contained in the subsequent Plan for Women's Health which was published in 1997. One of the outcomes of the Plan was the establishment of Women's Health Advisory Committees in each of the eight health board areas. The Committees were to be made up of senior medical personnel, senior health board personnel, counterparts from the National Women's Council of Ireland and representatives of other voluntary organisations. The NWCI was also invited to nominate representatives to two national screening programmes and the newly established Women's Health Council. The functions and the membership of the Women's health Council are contained in Appendix Five.

In order to support its representatives in their work at national and regional level the NWCI secured funding from the Department of Health to develop the Women's Health Project which is the subject of this report.

The objectives of the evaluation which were identified by the NWCI were the following:

- To identify and evaluate the Women's Health Project from the perspective of the NWCI, the NWCI health representatives, Health Boards and the Department of Health and Children;
- To interpret the outcomes of the Women's Health Project at regional and national level;
- To evaluate the effectiveness of the NWCI representatives' participation and contribution on both regional and national women's health committees;
- To establish how the participation of the NWCI health representatives has contributed to the regional and national committees' meeting their objectives;
- To contribute to future NWCI women's health strategy and policy.

The evaluation was undertaken by Tríona NicGiolla Choille from the Women's Studies Centre at the National University of Ireland, Galway during August - October 2000.

METHODOLOGY

It was intended that there would be four main elements to this evaluation:

- Desk Research
- Interviews with key individuals and agencies
- Postal survey
- Analysis/Report Writing

The desk research involved the study of the documentation related to the Women's Health Plan and Project. Details of the documents consulted are attached as Appendix One.

INTERVIEWS

The second element of this evaluation was a series of interviews carried out with the participants in the Women's Health Project. In all but four instances these interviews were conducted in person. The interviews were conducted with the following:

1) Current and former staff of the NWCI and Executive Members;
2) NWCI counterparts[2] on the Women's Health Advisory Committees;
3) Chairs of the regional Women's Health Advisory Committees;
4) The Assistant Principal Officer, Women's Health Section, Department of Health personnel with responsibility for the Women's Health Plan and the national women's health organisations.

A full list of those interviewed during the course of the Evaluation is attached as Appendix Two. A Glossary of Terms/Acronyms is also attached as Appendix 3.

Interviews were conducted with NWCI counterparts in all of the health board regions and with Chairs of the WHACs in all but one of the health board areas. The researcher was unable to interview personnel in the NWHB due to the death of the Chairperson. Despite repeated efforts it did not prove possible to interview another member of the WHAC.

1) Interviews with NWCI Staff and NWCI Board Members

Interviews were conducted with staff and Board members of the National Women's Council of Ireland who were involved with the Women's Health Project from the outset. The current Chair of the NWCI and Chair of the Health Panel and Board member since 1994 was also interviewed. In addition the consultant employed by the NWCI to assist in the original national consultation

[2] Counterpart was the term used by the NWCI representatives to describe themselves and is used throughout this report.

(1995-1996) and who worked on the Project between 1997-1998 was interviewed. The focus of these interviews was as follows:

- To document the background to the development of the Women's Health Project
- To review the Project Plan
- To review the implementation of the Project Plan
- To evaluate the impact of the Plan

2) Interviews with the Counterparts

Interviews were conducted with the NWCI counterparts at regional and national level who participated in the Women's Health Project on the Women's Health Advisory Committees, the Women's Health Council and the National Screening Programmes Advisory Groups on Breast and Cervical Cancer. These interviews focused on:

- Participation in the Women's Health Project
- Participation on the WHACs and other Committees
- The establishment of aims/objectives for the WHACs
- The process of developing regional Plans for Women's Health - the working methods/ setting of priorities/formulation of plans/consultation/partnership
- The involvement of NWCI counterparts in the process
- The achievement of the objectives on the WHACs
- Monitoring/evaluation of the work of the WHACs
- Evaluation of participation/contribution of NWCI reps,
- Issues arising from the work
- Proposals/Recommendations

3) Interviews with the Chairs of the Women's Health Advisory Committees

Interviews with all but one of the Chairs of Women's Health Advisory Committees[3]/Specialist Groups focussed on the following issues:

- Aims and objectives of the Committees/Advisory Groups
- Working methods of the Committees/Advisory Groups
- Representation by NWCI counterparts
- NWCI inputs and impact
- Monitoring/evaluation of the work
- Evaluation of participation

[3] In the South East due to the unavailability of the Chair the interview was conducted with the person at health board level with responsibility for the Plan. In the North East the Chair recommended another health board representative who was a member of the WHAC for interview.

4) Interviews with the Department of Health and Children

As one of the key players in relation to Women's Health and as funder of the Women's Health Project the Department of Health and Children was interviewed in the course of this Evaluation. The interview was conducted with the Assistant Principal with responsibility for Women's Health.

The focus of the interview was on :

- The development of the partnership with the NWCI
- The rationale for the support of the Women's Health Project
- The operation of the Women's Health Project
- Impact of the Women's Health Project
- The role of the Women's Health Council and the Department of Health and Children
- Future developments

POSTAL QUESTIONNAIRE

It was originally intended to send out a postal questionnaire to NWCI health panel members and affiliated organisations with a health focus to ascertain their awareness of and involvement with the Women's Health Project. It was intended that the questionnaire would identify the visibility of the Project within the broader membership of the NWCI with an interest in women's health as well as identifying the links established. However, having read the documentation and discussed this issue with the Health Co-Ordinator it was decided not to proceed with this element of the Evaluation as it was apparent from initial interviews that there was little interaction between the Women's Health Project and the Health Panels. Further discussion of the relationship of the Women's Health Project to the work of the Health Panel arose during the course of the interviews and this will be discussed later in the context of the issues arising for the NWCI from this Evaluation.

ANALYSIS OF THE FINDINGS

Analysis of the findings are set out as follows:

1. Background and context of the Women's Health Project
2. The Women's Health Project Support Structure
3. Impact of the Project
4. Issues emerging from the Evaluation
5. Recommendations
6. Appendices

3. BACKGROUND TO THE WOMEN'S HEALTH PROJECT

The background to the Women's Health Project at the National Women's Council of Ireland is to be found in a series of developments which took place during the 1990s. This period was characterised as a time of growing interest in women's health issues.

The first document to draw particular attention to the issues of women's health was the report of the Second Commission on the Status of Women. This Commission was established by government to review the implementation of the first Commission and to consider and report on the means whereby women would be able to participate on equal terms and conditions with men in economic, social, political and cultural life.

In this context the Second Commission addressed the issue of women's health. The Commission observed in its consideration of women's health:

> **'It must be said that women, especially women with dependent children, are represented disproportionately among the ranks of the poor and disadvantaged and as a direct consequence among the ranks of the sick. For that reason health policies which may in principle be gender blind can, in fact, affect women more severely than men and the Commission proposes to comment and make recommendations in those areas.'[4]**

The Commission recommended, therefore, that the Department of Health should review the health services and their delivery to examine how they can best meet the needs of women. This review was to be carried out in consultation with women's groups, Health Boards, medical representatives and social partners. The review was to be carried out by the end of 1993 and its findings were to be incorporated into a national plan for women's health which was then to be brought to Government for decision and implementation.

The Commission also recommended that differential effects of policy decisions on women and men should be assessed by the Department of Health when policy changes are being proposed, with a routine Ministerial requirement that all health proposals are examined for their gender related implications.

The first of these recommendations was implemented in the following years. The recommendations of the second Commission on the Status of Women were taken on board by the Department of Health and in June 1995 they published a Discussion Document - **Developing a Policy for Women's Health**. This report examined the health services and outlined a range of priorities from the health providers point of view. The priorities suggested by the Department of Health document were as follows:

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[4] **Report of the Second Commission on the Status of Women (1993)**

- A reduction in smoking;
- The introduction of national screening programmes for breast and cervical cancer;
- Improvements in the maternity services;
- Better services for victims of domestic violence;
- Better access by Traveller women to health services;
- Increased representation of women in the health service;
- Increased research on aspects of women's health.

Following the publication of this report the Department of Health undertook a process of nationwide consultation with women about their health issues working in partnership with the National Women's Council of Ireland. This relationship resulted in the appointment of a consultant by the NWCI to work with the Department of Health and the Health Boards to develop the process of consultation.

The consultation process which was undertaken over the years 1995-1997 stimulated a debate and discussion about women's health issues. The consultation which was organised in each of the eight health board areas took many forms with opportunities for participation by women's groups offered through the means of workshops, written submissions, taped submissions, public advertisements and discussions in the national and local media. The process itself stimulated tremendous excitement and energy amongst women's groups which is still remembered many years later.

The overall conclusion from the consultative process was that women were keen to become involved in a discussion about their health and to contribute to the development of policy and practices which would enhance the delivery of health services for them. However, the process also raised issues which had not surfaced in the Department's own consultation document. These issues were related to the expectations which women have of the health services and which are, in many instances, not understood or met by the service providers. These issues raised key points such as access to information, the availability of counseling and other complementary services and the development of a woman friendly health service. Other issues which were strongly supported in the consultation phase were the need for the health services to make a commitment to engage in consultation with women on an ongoing basis and also to ensure that there should be greater representation of women at all levels of the health services.

The results of the regional consultation process fed into the document which subsequently became the Plan for Women's Health. The Plan identified the actions which were to be taken at national and regional level and committed itself to the process of consultation on an ongoing basis. One of its key proposals was the establishment of a Women's Health Council on a statutory basis to

become a centre of expertise on women's health issues, to foster research on women's health, to evaluate the success of the Plan, and to advise the Minister on women's health issues generally.

The Plan outlined four main objectives for women's health:

- To maximise the health and social gain of Irish women;
- To create a woman friendly health service;
- To increase consultation and representation of women in the health services;
- To enhance the contribution of the health services to promoting women's health in the developing world.

These objectives were to be achieved at regional level by the health boards and by the Department of Health at national level. It was also envisaged that these objectives would also be addressed by the Women's Health Council.

As part of its commitment to embed consultation within the health board structures the Plan announced that each of the eight health boards was to establish health advisory committees with representation from the National Women's Council of Ireland. These committees were tasked to advise the boards on the implementation of the issues which emerged during the consultative process. The Plan declared that:

> **'it was essential, if the health services are to respond to the needs of women as outlined in this Plan, and the partnership of women is to be given expression, that each board provides a mechanism by which women can be consulted about health issues and priorities, either by way of a single advisory committee or consumer groups.'[5]**

The Plan envisaged a significant role for the National Women's Council of Ireland at regional level on the health advisory committees and at national level on the Women's Health Council and other bodies. The NWCI was to be involved as a partner in the process of addressing the health needs of women throughout the country.

The background, therefore, to the current project within the National Women's Council of Ireland is one of increased interest by the Council and others in addressing women's health needs, a greater commitment by statutory bodies - reflected in the Plan for Women's Health - to consulting women about their health needs and their experiences of health provision and an interest from both

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[5] **Plan for Women's Health (1997) p. 75**

the Department of Health and the NWCI in developing the partnership which had been initiated during the consultation phase.

NATIONAL WOMEN'S COUNCIL OF IRELAND

The National Women's Council of Ireland is the national representative organisation for women and women's groups in Ireland and was founded in 1973 as the Council for the Status of Women. It is a non-governmental organisation with a current membership of over 150 women's organisations and groups from all parts of Ireland. In 1995 the Council adopted a new organisational structure and changed its name to the National Women's Council of Ireland.

4: THE WOMEN'S HEALTH PROJECT SUPPORT STRUCTURE

In November 1996 the National Women's Council put a proposal to the Department of Health and Children which envisaged the development of a partnership which had begun on the consultation process on women's health.

Following the nationwide consultation process the NWCI itself foresaw the need for a support structure to assist its counterparts in their work on the advisory committees which would be set up throughout the regions. The task of representation required a designated person to support and facilitate the participation of the counterparts on these committees.

Therefore, the NWCI proposed to the Department of Health that the innovative partnership which developed during the consultation phase be continued:

> **'We recognise that for innovation to develop and grow requires resources, strategic thinking and careful management,'**

and the NWCI proposed that it should offer this service.

The objectives of the support services proposed by the NWCI were:

- To deepen the expertise of representatives in women's health issues;
- To provide leadership training which would enhance the quality of their participation;
- To provide administrative back-up and support;
- To support the development and maintenance of accountable structures with women's groups at local level.

It was envisaged that this support service would be offered under the auspices of the NWCI and delivered by an external consultant on a day to day basis. The cost of the support service over the three years was £80,000.00.

The Department of Health and Children agreed to fund the project and to develop further the partnership with the Council.

The proposal to establish such a project was a significant development in the relationship between the Department of Health and Children and the NWCI. It permitted the development of a stronger partnership arrangement between the two bodies. Both organisations were now committed to working together - nationally and regionally - on women's health issues over a three year period. The NWCI would provide a support structure to its representatives to enable them to participate effectively on the various committees and the Department of

Health and Children would meet regularly with the Council to review progress in relation to the Plan as well as addressing other policy issues.

In its first phase of the Women's Health Project the work was co-ordinated by an external consultant who had worked with the NWCI and the DoHC on the consultation process. The work during this initial phase consisted of recruiting counterparts throughout the country to participate on the Women's Health Advisory Committees and the national bodies. This task was a difficult one in some parts of the country as the NWCI was stronger in some areas than others.

The consultant was particularly anxious to retain those NWCI members who had engaged with the consultation process during 1995-6 so that their skills and experience would not be lost to the Project. Of the 21 participants who were recruited to the Project eleven had formerly been involved in the consultation phase.

PHASE 1 – DEVELOPMENT OF SUPPORTS

When the counterparts had been recruited to the various committees the consultant engaged in supporting them in their participation on the WHACs. This support was offered on an individual basis to counterparts throughout the country and to the counterparts as a group. The individual support offered included meeting their information needs - about the women's health process, the consultation process, the issues to be addressed in the plans, the health board structures and personnel; it also included support to the counterparts in what was a very frustrating period for them as the WHAC were in the process of being set up. The frustration for many counterparts at that time related to the lack of clarity about the role of the Committees and the delays in commencing work on the women's health plans.

This support was offered by the consultant by means of telephone contact and regular visits to the counterparts and the Committees. Support was also offered to the counterparts as a group and included the development of common positions on terms of reference - a common source of frustration to counterparts as few WHACs had such terms of reference - and a Values and Principles document[6] - which were to be tabled at the Committees.

The consultant also worked on developing relationships with the Chairs of the various Committees throughout the country.

APPOINTMENT OF HEALTH CO-ORDINATOR

[6] reference was made by many counterparts to this document; however, it was not possible to obtain a copy.

Towards the end of this first phase of the Women's Health Project there was a growing realisation within the NWCI that there was a need to bring the work of the Project into the mainstream activities of the Council. The rationale for bringing the project in-house was that it would become more strategically located in the organisation. At the end of 1998 a Health Co-Ordinator was appointed on a part-time basis within the Council.

At this stage - November 1998 - it was clear that the progress on the preparation of the Women's Health Plans at regional level was falling behind schedule and considerable frustration was being experienced by the counterparts around the country. A brief review of the status of the Plans in November of that year indicated that only three regional health plans had been drafted. It was noted that some Health Boards were experiencing delays and some counterparts appeared unclear as to their exact remit. In order to expedite and progress this work the NWCI proposed the following steps:

- That the NWCI establish and maintain relationships with the CEOs of the Health Boards as well as the Women's Health Co-ordinator's/Chairs of the WHACs. This work had formerly been carried out by the external consultant but was now to be put on a more regular footing particularly in light of the difficulties and delays which were being experienced by the WHACs. This arrangement was agreed by the Health Co-ordinator at NWCI and the Assistant Principal Officer with responsibility for the women's health plans and regular contact was to be maintained between them on the progress/status/ problems being encountered by the Committees.

- The Council would also ensure that the health boards be clear about the remit of the WHACs, the requirement to monitor and evaluate the plans, that the process of consultation be maintained and that the budgets be spent accordingly.

- That the NWCI continue to monitor and feedback to the Department of Health the progress, or lack of same, re the regional Plans

- That the counterparts role and objectives on the WHACs be disseminated to a range of organisations in the region and that a process of feedback to these organisations be facilitated

- That a communications and information strategy be implemented at a local level to ensure that there is an awareness and knowledge locally about the work of the counterparts

- That a local media strategy be initiated whereby awareness of the Women's Health Plan and the NWCI's role in progressing it is developed

- Facilitation of local involvement and activism around women's health issues where necessary and/or appropriate.

PHASE 2 – ELEMENTS OF THE SUPPORT STRUCTURE

It was envisaged that these activities, which would be delivered by the NWCI and primarily by one part-time Co-Ordinator, would constitute the core of the support structure to the Women's Health Project. As the Women's Health Project moved into the second phase the following elements of the Support Structure were identified:

a) Provision of support to the health counterparts
b) The establishment of links with the Chairs of the WHACs
c) Policy development: at NWCI
d) Linkages between the counterparts and Health Panel members
e) Information dissemination with the various publics -affiliates/ social partners
f) Partnership to be developed with the Department of Health
g) Representation of the organisation on national committees

In addition to these activities the Health Co-Ordinator also took on the task of recording and documenting the work of the WHP. This aspect of the WHP had not been addressed while the Project was being externally managed.

The Health Co-Ordinator devised selection criteria for counterparts which were subsequently adopted by the NWCI. These included the following as essential:

- Member of an NWCI affiliate organisation
- Experience and understanding of gender issues, especially in relation to women's health
- Resident/working/active in the geographic area

Experience of lobbying at local, regional and national level were also regarded as desirable as was an understanding of statutory structures. The counterparts were also expected to demonstrate a commitment to work on women's health issues.
The Health Co-Ordinator also produced an undertaking which counterparts were required to agree to which outlined the NWCI's expectations. One of the key requirements in this document was a commitment to organising feedback to local groups so that they could feed into the regional health plans.

The Health Co-Ordinator also provided counterparts with a checklist to enable them to monitor progress, or the lack of it, in the preparation of the regional plan for women's health.

The key areas of the Support Structure will now be discussed:

a) Support to the Counterparts

The support offered to the counterparts was the main feature of the work of the Health Co-Ordinator. This was offered primarily to those on the WHACs as they were a large group dispersed throughout the country. The NWCI representatives on the other committees were also involved in this process but the focus of this section, and throughout the report, will be on the counterparts on the WHACs.

This support was offered in a variety of ways to assist them in their work on the WHACs and other Committees.

There were two main forms of support:

- Regular, monthly telephone contact with the counterparts throughout the country; these contacts took place before and after WHACs meetings and frequently necessitated follow up on the part of the Co-Ordinator e.g. seeking clarification about funds
- The organisation of Quarterly Meetings to review and plan the work of the WHACs throughout the country.

In addition to the two mentioned above the following were also offered to counterparts:

- Regular mailings with information about developments in relation to women's health issues in particular and other health issues
- Regular review of progress on the preparation of the health plans for women
- Regular meetings with the counterparts throughout the country
- Advice and information as required

The support offered also included personal support and encouragement as the counterparts became increasingly frustrated and demoralised by the slow rate of progress on the Plans.

b) Liaison with the Chairs

Towards the end of 1998 the NWCI identified the need to establish more regular contact with the Chairs of the WHACs. The Council recognised that there was a need for greater clarity about the role of the NWCI in the work on health issues as a certain degree of confusion had emerged on the Committees about the roles of the respective bodies involved with women's health. It was also recognised that there was a need for more systematic contact to be maintained by the WHP with the Chairs of the WHACs.

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summary of the work of the WHACs is attached as Appendix Four

The establishment of this relationship with each of the Chairs was undertaken by the Health Co-Ordinator. This involved visiting the Chair of each of the WHACs during the years 1999 and 2000. The purpose of the visits was to introduce the NWCI, clarify its role at national and regional level and to support the work of the counterparts and Chairs in the process.

These visits often coincided with invitations to attend the WHAC meetings and to introduce the work of the Women's Health Project at the NWCI.

Contact was increased throughout 1999 and 2000 as the WHACs received funds which had to be spent. The availability of funds presented some difficulties for the WHACs as priorities had to be established for their use and the counterparts were not always in agreement with the way in which the monies were spent. The Health Co-Ordinator was in regular contact with the Chairs as these decisions were being made.

c) Policy Development

The Women's Health Project also contributed to the development of policy on women's health. One of the priorities which the NWCI had identified was the production of a Women's Health Policy Document. This document was drawn up by the Health Co-Ordinator in 1999. This work was carried out in conjunction with the NWCI counterparts and other sections of the NWCI with an interest in health issues. e.g. the membership of the Health Panel by the use of a questionnaire circulated to all affiliates throughout the country in spring 1999. This questionnaire was circulated to enable affiliates to contribute to the development of policy.

The issues which were focussed on in the survey were family planning, maternity services and the needs of carers. In all 39 member organisations responded to the questionnaire and reported the views of women throughout the country on these services. The issues highlighted in the survey were the lack of services, the lack of control which women experienced during childbirth and the lack of choice in relation to family planning services.

The Health Policy document addressed these three issues in the context of a wider discussion about health policy for women. The Policy Document set out the framework in which the services were provided. It also highlighted the key issues which emerged from the consultation process - consultation, choice, information, access to services and the development of a woman friendly service. It flagged the NWCI's commitment to the ongoing monitoring and evaluation of the WHACs and raised concerns about the failure to date (October 1999) to adequately address the monitoring and evaluation of targets to reduce social exclusion and minority groups. The Document expressed fears that this process of monitoring and evaluation had still not got underway.

The Policy Document examined the current status of research on women's health in Ireland. It concluded that there was a dearth of work on women's health issues and anticipated that the Women's Health Council would begin to address this deficit once it established itself. It also advocated gender proofing all health research to be carried out by all Government departments and statutory agencies as well as calling for the inclusion of additional questions on health to be included in the next Census (2001).

The three issues which were examined in the NWCI questionnaire - Carers, Family Planning services and Maternity Services - were the main focus of the Policy Document which was prepared by the Health Co-Ordinator. A range of specific policy proposals were made in relation to each of the three policy issues mentioned above.

This Document was subsequently adopted as policy by the NWCI and used in the discussions within the Voluntary and Community Pillar and Platform, and within the broader national partnership process. The commitments which were made on health in the Partnership for Prosperity and Fairness included a specific commitment to monitoring and evaluation of the Plan for Women's Health by the Women's Health Council.

This Document was also submitted by the NWCI to the Department for Health and Children who circulated it within the relevant sections for comment and feedback. It appears to still be in the process of review within the Department.

d)The Health Counterparts and the Health Panel

When the Women's Health Project was devised it was envisaged that linkages between the health counterparts would be established with the other sections of the NWCI. This referred primarily to the Health Panel which was a forum for discussion about women's health issues within the NWCI.

It was believed that this linkage would be important to ensure the success of the project. At one of the early Quarterly Meetings of counterparts (June 1998) reference was made to the need for the NWCI counterparts on the WHACs to work with the Health Panel to ensure the success of the project. One of the means of securing this synergy between the work of the two sections of the NWCI was for health counterparts to regularly attend Health Panel meetings. Although not a popular suggestion with counterparts as the Panel Meetings usually took place on Saturdays, initially it was agreed that one of the counterparts would attend these meetings in order to facilitate better communications.

In September 1998 a joint meeting took place between the NWCI health counterparts and members of the Health Panel. One of the aims of this meeting was to increase linkages and communications between the work of Health Panel

and the NWCI on regional and national committees. The Co-Ordinator had referred to the need for the health counterparts to engage in a two way dialogue - with the WHACs and the other national committees and with local and member organisations. In this context the linkage with the Health Panel members would be crucial.

The meeting offered an opportunity for the health counterparts to update the Health Panel members on the progress - or lack of same - on the preparation of the regional health plans. There was considerable discussion about the need for women to engage locally and regionally in communicating with the health counterparts. One of the counterparts spoke of the need to "connect back with the primary consultation process".

However, following this meeting the health counterparts and the Health Panel members never met together again. In discussions with the health counterparts it transpired that only one of them had attended a Panel Meeting. All of the other counterparts stated their views about the health panel system within the NWCI. The Health Panel was not seen as a useful forum for progressing discussions about women's health policy. It was perceived as meeting too infrequently to develop policy, having a constantly changing membership resulting in difficulties in progressing issues.

Another issue which was of considerable importance in the views of the counterparts was the meeting day and time. Those who chose not to attend these meeting stated that one of the main inhibiting factors preventing their participation was the holding of these meetings on Saturdays. This was a huge disincentive to all participants but especially to those from outside Dublin. Most of the women were already involved on a number of other committees and forums and were reluctant to commit one of their Saturdays to a process which was not seen as useful to them in their work on the Women's Health Advisory Committees. The counterparts therefore, made a judgement not to attend Panel Meetings in furtherance of the work on women's health issues.

The operation of the Health Panel has been the subject of considerable discussion within the NWCI and its membership for some years now. Some changes to the Panel system have been introduced more recently in response to members feedback. These changes should lead to a clearer focus in the work of the Panel but the relationship with the WHP needs to be re-established.

Originally it had been intended as part of this evaluation to circulate a questionnaire to members of the Health Panel in order to ascertain the extent of their involvement and engagement with the health project. However, it was decided not to proceed with this part of the evaluation as it was clear that there was little contact between the health counterparts and the panel members.

Although one of the counterparts initially agreed to attend the Panel Meetings on a regular basis, ultimately the meetings were attended by the Health Co-Ordinator who kept panel members informed about developments in the Women's Health Project.

e) Publicity

The Women's Health Project was also engaged in raising awareness amongst different publics about its activities. The different publics were the NWCI's own membership, a broader range of women's organisations and other organisations engaged in community development, the projects involved in EU funded initiatives (NOW), the social partners and the media and general public.

The work of the Women's Health Project was reported upon internally, through verbal and written reports, at the regular staff meetings. This work was subsequently reported on at Board level through the CEO and to the Health Panel through the attendance and updates from the counterparts and/or the Health Co-Ordinator.

f) Relationship with the Department of Health and Children

The partnership which had developed between the DoHC and the NWCI had, during the initial phase of the Project, been conducted between the consultant and officials at the Department. As the WHP moved into its second phase the NWCI sought to establish a firmer basis for the relationship between the two bodies. Regular contacts were established between official(s) at the Department and the Health Co-Ordinator of the Women's Health Project. Meetings also took place between the NWCI, the Minister for Health and officials of the Department.

The focus of much of the contact between the DoHC and the Women's Health Co-Ordinator was on the progress, or lack of same, in the work of the regional advisory committees. The pace of development of these committees varied considerably. For example, some of the WHACs had completed their reports in late 1997 or early 1998 whilst another WHAC had yet to meet.

Therefore, much of the contact between the DoHC and the Health Co-Ordinator focussed necessarily on issues arising from the work of the WHACs. These issues included the establishment of the WHACs, discussions around the terms of reference, composition of the Committees, procedures, preparation and publication of plans, monitoring and evaluation and issues related to budgets and expenditure of the funds allocated to the WHACs. The issue of terms of reference became problematic as the Department of health and Children in following principles of subsidiarity did not see it as appropriate that they would issue terms of reference. However, it is clear from the interviews held that the counterparts

and Chairs expected that standard terms of reference should have been issued to each WHAC.

Meetings between the Department and the NWCI also focussed on the issues arising from the work of the WHACs. One of the items regularly on the agenda for these meetings was the feedback from the counterparts around the country. Other issues which featured on the agendas of the meetings were examples of good practice arising from the work of the WHACs, recommendations from the NWCI re funding for their work and the monitoring and evaluation of the Women's Health Plan.

g) Representation on national committees.

Representation on the Women's Health Council and the two National Screening Programmes was undertaken by the former consultant to the women's health Project, the former Chair of the NWCI and a counterpart from the North West (WHC). These three representatives experienced much of the frustration which regional counterparts experienced because, despite being legally established relatively quickly, the operationalisation phase of the WHC was delayed. Expectations were raised that the WHC would quickly become an active participant in the discussions about the Plan for Women's Health. However, due to the delay in recruiting staff, agreeing a programme of work and starting the strategic planning process resulted in the contribution of the NWCI representatives being focussed on these areas.

h) Support for Networking

One of the key objectives established for the Women's Health Project was that of supporting feedback to a range of organisations, both NWCI members and a broader range of women's organisations. It was envisaged that this networking would enable the NWCI counterparts to feedback to local and regional groups about the work of the Women's Health Advisory Committees and thereby establish greater awareness and credibility for the process. It was also believed that this would give a greater legitimacy to the counterparts on the WHACs as they would be able to demonstrate to the health boards that they had the backing of a broad range of organisations within the region and provide a forum where local/regional groups could input their concerns.

The development of such a feedback mechanism would have:

- Ensured a greater awareness of the Plan for Women's Health in general and the local initiatives in particular
- Achieved a greater awareness of the role of the NWCI in the process
- Supported and enhanced the contribution of the counterparts
- Afforded women's organisations and groups an opportunity to make a Contribution to the process

However, the establishment of such feedback mechanisms did not take place during the course of the Women's Health Project. All of the counterparts publicised the work of the WHACs and the NWCI's role within their own organisations and within their regions. This work was done through informal contacts and discussions, at local and regional workshops, conferences and other networking events and in local and regional newsletters and media.

Counterparts in a number of regions were able to engage in a more systematic process of feedback about the WHACs. For example, counterparts in the North West and West regions were able to access funds within their own organisations which enabled them to engage in a process of feedback and consultation with women's organisations in their counties/regions about the work of the WHACs.

5: IMPACT OF THE PROJECT

As part of the evaluation of the Women's Health Project interviews were conducted with counterparts in each region throughout the country and with the Chairs/representative of six of WHACs (see Appendix 2). The role of the Women's Health Project Support Structure was discussed as part of the interviews and the conclusions from those discussions are reported here. In addition to these perspectives , the positive outcomes of the WHP will be discussed, aspects of the WHP which could be improved will be presented and an overall assessment of the impact of the Project will be made.

THE COUNTERPARTS' PERSPECTIVE

During the three years of the Women's Health Project 30 counterparts were involved in the work on the various committees throughout the country. The counterparts were all members of affiliates of the NWCI, engaged in a range of different organisations working with women. These organisations reflected a broad range of interests including women's training and development groups, women's networks, Traveller organisations, organisations concerned with domestic violence and local development organisations.

The presence of a Support Structure which was targeted at their needs was a vital element in maintaining the counterparts commitment to a process that was at times difficult and frustrating, One counterpart remarked of the Support Structure:

> **"I would never have stayed with the WHAC if it hadn't been for the National Women's Council - I'd have given up on it."**

Another counterpart noted the benefit of the support from the NWCI:

> **"It helped us to have the support from the NWCI and I think it also helped improve our status on the Committee - the fact that we were seen as having the NWCI behind us was important."**

The counterparts mentioned that the assistance and advice they had received in relation to dealing with difficulties on the Committees was very useful and important. They spoke of being unsure about how to proceed in relation to particular issues which had arisen on the Committees; due to the ease of access to the Health Co-Ordinator - who was always available for contact by phone - they were able to deal with issues very quickly. The immediacy of this support and advice was a feature which was much remarked upon:

"Yes, I did get a lot of encouragement from the meetings in Dublin - it helped when you heard how other people had got around the difficulties they had on their WHAC."

The Quarterly Meetings which were organised by the Health Co-Ordinator in Dublin brought all the counterparts together from all the regions throughout the country. The meetings afforded an opportunity to the counterparts to update the Co-Ordinator, and each other, on the work of their respective WHACs. The meetings were also used as an opportunity to review and develop strategies for dealing with the difficulties arising from the work on the WHACs.

The Quarterly Meetings were regarded as being more useful by some participants than others. There were different levels of skills and experience amongst the counterparts with some having considerable experience of negotiating, advocacy and campaigning. These counterparts regarded the Quarterly Meetings as being more helpful to those starting out on representation and advocacy on behalf of women's interests.

One of the difficulties which counterparts experienced was that of most effectively representing the needs and concerns of women in their region. Some counterparts expressed their confidence in representing their own interest group e.g. counterparts working with Travellers felt comfortable addressing the health needs of Traveller women and other minority groups but were less sure about the broader health needs of women.

Another issue which they raised was that of giving feedback to a range of organisations within their areas. To continue with the example cited above the counterpart working with Travellers gave feedback to groups/organisations working with Travellers on the progress on the WHACs but queried whether and how she was to give feedback to a broader range of organisations. This raises the issue of networking/feedback within the WHP and will be discussed again later in this report.

The counterparts regarded the links between the Health Co-Ordinator and the Chairs of the WHACs and the Department of Health as being extremely important. This contact afforded an opportunity for contentious issues to be raised and discussed with the appropriate personnel. In the event that this did not sort out the difficult issues the Health Co-Ordinator was available to attend meeting with the Chairs, the WHACs and the Department of Health.

One of the difficulties which the counterparts did mention was the difficulty of developing common positions and strategies on women's health at the Quarterly Meetings. This difficulty arose partly because of the changes in personnel; because the meetings were only held every three months or so and because the same counterparts did not attend each meeting continuity was difficult to establish.

Counterparts also mentioned the importance of the sharing of information and skills amongst the participants. They mentioned how useful it was to hear about the experiences of other counterparts and how they addressed particular difficulties on their WHACs.

Counterparts made a number of suggestions for improving the effectiveness of the Quarterly Meetings:

- develop more strategic thinking amongst the counterparts
- develop negotiation skills
- focus on a number of common issues
- focus on the development of feedback/consultation mechanisms for members

THE CHAIRS' PERSPECTIVE

The Chairs of the WHACs in all instances except one worked for the health boards. They were employed in a range of capacities - in public health departments, in health promotion departments and in Primary Care Units. The position of Chair of the WHAC was in all cases additional to the existing range of responsibilities which these individuals carried.

The Chairs of the WHACs acknowledged that the NWCI counterparts played an extremely important role on the Committees. Some Chairs recognised that there were difficulties at first as this was the first time many of the health board personnel had worked with representatives of the voluntary sector. There were differences in attitudes and ethos, some of which were dispelled during the course of the work undertaken but others which were more deep seated and which would take longer to overcome.

The Chair's welcomed the NWCI counterparts on the WHACs as representing the views and concerns of women throughout their regions. There was a recognition that these voices had to be heard within the process, even if what they had to say was uncomfortable for the health board personnel to hear. The word most frequently used to describe the contribution of the counterparts was "challenging." They were described by the Chairs as being unwilling to accept the status quo, questioning and challenging long held views and perceptions and representing the views of women very effectively. One Chair described the counterparts as "the only active participants on the Committees". They were seen as being clear about what they wanted to achieve on the Committees. Another Chair described how the counterparts attended the WHACs meetings with great regularity, put forward proposals which were more focussed, specific and clearly defined and advocated and pressed for their adoption and promotion.

The Chairs did however, believe that the counterparts did not always fully understand health board procedures and protocols. They acknowledged the differences between the voluntary and statutory sectors and perceived the voluntary sector to be more informal and flexible in terms of organisation and deadlines etc.

With regard to the NWCI nationally some of the Chairs expressed their confusion as to the roles of the various bodies who are engaged with women's health issues. For example, some were still confused about the respective roles of the Women's Health Council and the National Women's Council of Ireland. Others were not clear at all about the involvement of the NWCI in the WHACs. There was a divergence of opinion amongst the chairs on this issue:
More than half of the Chairs welcomed the involvement of the NWCI in the WHACs, referring to the involvement of the Health Co-Ordinator in their work. She was in regular contact with them about the work of the Committees; she offered support/assistance with regard to a variety of issues. She also attended meetings regularly throughout the country and briefed the WHACs about the NWCI's involvement in the process. They expressed their appreciation of the support and assistance of the Health Co-Ordinator in the work they were trying to progress on the Committees and would have welcomed similar support from within the health board structures.

However, a small number of WHAC Chairs did not share these views. They perceived the NWCI to be checking up on them, making sure they were on target and doing what the NWCI expected of them. They stated that members of the Committee were most unhappy with the attendance of the Health Co-Ordinator at their own meetings, not understanding her role or the rationale for her presence. One Chair stated that she felt that the presence of the Health Co-Ordinator at regional meetings was inappropriate and not understood by the Committee.

In general however, the Chairs acknowledged that the support offered to the counterparts enhanced their contributions to the WHACs. One Chair remarked ruefully that she wished that the Chairs had a support structure like the one the counterparts had.[7]

[7] A more detailed analysis of the interviews with counterparts and Chair is available on request.

WHAT WORKED WELL?

1.Support Structure

The Support Structure to counterparts throughout the country worked well in terms of supporting the participants in their roles as representatives of the NWCI on the WHACs and other committees. The Support Structure was important to counterparts in keeping them up to date about developments, giving them a framework for charting progress on the Committees, maintaining a flow of information to counterparts and to the national organisation alike and also in terms of offering personal support and encouragement to individuals who were engaged in a process which was new, challenging, lacking clarity initially and time consuming for counterparts who were already committed to a wide range of other interests and organisations.

Counterparts were provided with background information and briefings about the Women's Health Process as well as a check list for monitoring progress at the various stages of development of the Plans. The Support Structure also maintained a focus on progress at national level and counterparts were able to draw from the experience and actions of other committees to suggest initiatives in their own areas.

In addition to the support in terms of the work on the women's health plans the Support Structure offered encouragement and advice to counterparts who frequently experienced frustration and disappointment at the delays and the difficulties in bringing about real, tangible change for women.

2.Liaison with the Chairs

The establishment of contact with the Chairs of the WHACs and other Committees was helpful in terms of developing the WHP. It helped to clarify the role of the NWCI in the process, clarifying and promoting the NWCI interests in the process and kept a focus on the key issues of concern to the Council - access, choice, consultation, counselling and the development of a woman friendly health service.
The links established with the Chairs also offered opportunities to discuss difficulties as they arose. For example, when there was a slippage in the timescale for the completion and publication of the plans this was brought to the attention of the Health Co-Ordinator and discussed with the Chairs; similarly the difficulties which arose as decisions were being made about how to spend the funds were discussed with the Chairs and also with the Department of Health.

3.The Counterparts

The counterparts themselves made an enormous contribution to the WHP through their participation on the various committees. All of them were already over-committed in terms of their workload and voluntary/community activities and the work on the WHP represented an additional voluntary commitment for many. It also necessitated a great deal of extra work in terms of attendance at meetings of the Committees, with the NWCI, with other counterparts as well as a great deal of additional travel in order to participate in a process which, at times, was most frustrating for them.

WHAT COULD HAVE BEEN IMPROVED?

Suggestions are now made which would enhance the effectiveness of the Women's Health Project at the National Women's Council of Ireland.

1.Support Structure

The counterparts who participated in the WHP were all members of the NWCI and engaged in a wide range of organisations throughout the country. They had a wide range of skills in lobbying/advocacy/campaigning with some counterparts having considerably more experience than others. This meant that the support offered to counterparts at Quarterly Meetings and on an individual level was more suited to some counterparts than others. Due to the variety of skills and experience it would have been helpful to provide training and capacity building which would have recognised these differences. Training for participation on the Committees could have been more targeted and focussed on the needs of participants. Training which focussed on the development of negotiation and strategic planning skills, and the use of methods such as role play and others, were identified by participants as the key areas they wished to develop.

2.Integration of the WHP into the NWCI

When the WHP was established it was envisaged that its work would link in with the other health related activities of the organisation and in particular with the Health Panel. For a variety of reasons this did not take place and the WHP and the Health Panel worked independently of each other during this period.
Since the WHP was established a number of changes have taken place internally at the NWCI. The most significant of which in this context is the setting up of the Policy Team. This Team works on the development of policy within the various levels of the organisation and is involved in the representation of the NWCI in a number of policy arenas. For example, the Policy Team was centrally involved in the preparation of policy for the negotiations which led to the agreement,

"Partnership for Prosperity and Fairness". However, the Policy Team only met the health counterparts for the first time in September 2000.
The work of the WHP should have been better integrated into the work of the Policy Team so that the work/issues being progressed by the counterparts could be included in policy development at national level. Better communications should also be established between the Health Panel and the WHP to maximise the effort and effectiveness of the work at national and regional level on health issues.

3.Feedback and Networking

The main area of the work envisaged for the Support Structure which was not addressed was that of developing a feedback mechanism with local organisations - both NWCI affiliated groups and other locally based women's groups - and facilitating networking around women's health issues. The establishment of such a feedback mechanism could have enhanced the work of the WHACs and the role of the NWCI within it, the profile of the organisation (NWCI) would have been raised and the potential to draw in new organisations and groups into membership of the organisation could have been realised. This feedback mechanism could also have supported the counterparts in their efforts to represent the interests of a broad range of women on the WHACs and could also have afforded opportunities for the Health Panel members to become involved regionally in the process.

4.Media and Communications Strategy

There were a number of proposals to develop a media and communications campaign focussing on the women's health plan. The National Women's Council of Ireland originally proposed that it should undertake this campaign and sought funding to enable it to do so. However, this campaign did not take place due to a lack of time and the resources which would have been necessary to support such a process. The opportunity to promote discussion and debate about women's health plans internally within the NWCI and with the general public was missed.

This does, however, raise the issue of whose responsibility it was to promote, or to resource the promotion of, the women's health plans nationally and regionally.

The responsibility for the promotion of the plans should rest with the health boards regionally and the Women's Health Council nationally. A greater effort should have been made to promote an awareness of the existence and content of the plans.

WHAT HAS BEEN ACHIEVED BY THE WOMEN'S HEALTH PROJECT?

1.A Partnership between the NWCI and the Department of Health

The Women's Health Project established the NWCI as a partner with the Department of Health and Children on women's health issues. This was a significant development in the partnership which began in 1995 with the national consultation process on women's health. The establishment of the Women's Health Project acknowledged the NWCI's role as the representative organisation for women in Ireland and created opportunities for the Council to input directly, at national and regional level, into the planning and implementation process on women' s health issues. Crucially the organisation was resourced by the Department to carry out this role as a partner in the process; this resourcing facilitated the participation of a wide range of women's organisations to become involved in the drawing up of plans for their regions.

2.Participation on the Committees

The partnership between the Council and the Department which led to the establishment of the Women's Health Project enabled a wide range of women's organisations to become involved in putting the concerns and issues raised by women during the consultation process on the agendas of the health boards for the first time and enabled them to make a direct input into the planning of services and policies.

The National Women's Council had two counterparts on each of the WHACs throughout the country as well as three representatives on the Women's Health Council and one representative on the two National Screening Programmes (for Breast and Cervical Cancer). The counterparts represented the views and experiences of women users of the health services and presented a critical, challenging voice at the discussions on the WHACs.

3.Publication of the Plans

The counterparts, the Health Co-Ordinator and the NWCI ensured through the application of consistent pressure that the regional plans for women's health were completed. At various times during the last three years the WHACs experienced a number of difficulties and delays in proceeding with their work. The NWCI maintained constant pressure on the WHACs and the Department of Health to ensure that the work on the preparation of the plans was brought to a conclusion. Ensuring the completion, publication and in some instances launch of the plans meant that a greater level of awareness was created, especially at health board level, about the existence of the WHACs, the national and regional plans for women's health and the involvement of the NWCI in the process. The publication of the plans raised an awareness regionally of the health needs of women and the services, or lack of same, to meet these needs.

4.Profile of the NWCI

Participation in the partnership around women's health has raised the profile of the NWCI, especially with agencies/statutory bodies with whom it has had little contact in the past. The level of awareness of the role of the NWCI was raised by the work of the counterparts at national and regional level and by the work of the Support Structure in supporting the counterparts and chairs throughout the country.

5.Examples of Good Practice

The Women's Health Project also produced a number of examples of good practice which could be replicated in other health boards and other settings throughout the country. Examples of such initiatives include:

- The grants scheme to women's organisations to pilot innovative work on women's health issues.
- The employment of Women's Health Development Workers.
- The commissioning of research by the WHACs which was subsequently adopted by the health board e.g. the research on carers in Mayo.
- The model of consultation being developed by health boards e.g. the model in the west has developed a partnership between the health board, the counterparts on the WHAC and the Health Co-Ordinator of the Women's Health Project.
- The Sub-Committee structures which were set up by the WHACs; these brought a varied range of interests and voices - and new issues - onto the agendas of the WHACs and into the process of developing the plans.

6.Issues from the Consultation Phase

The key issues raised by women during the consultation process prior to the publication of the Plan for Women's Health have still to be addressed and the counterparts have played an important role in keeping those issues on the agenda whilst the WHACs proceeded to tackle the more tangible, concrete issues. For example, all of the WHACs addressed the need to provide more accessible, user friendly information materials for women. However, the counterparts maintained a focus on the key concerns of women - issues such as choice, access to services, consultation, counselling, equality, respect for diversity and the development of women friendly services - which had arisen in the nationwide consultation process.

7.Networking

The counterparts working on the WHP succeeded in doing some limited work on promoting and publicising the existence of the Plan for Women's Health and the process which was being engaged in by the Women's Health Advisory Committees and the NWCI's role within that process at regional level. The counterparts also used the occasions of the publication of the regional plans as opportunities to publicise the work on women's health. Similarly the decision by some WHACs to make small grants available to women's organisations to develop innovative work on health issues involved promoting an awareness of the existence of the women's health process at regional level.
Some of the counterparts succeeded in securing funds to engage in that process of feedback and accountability to the women of the regions. The availability of funding enabled the counterparts to promote an awareness of the Women's Health Plans, to learn more about the work of the WHACs and to create opportunities for women's groups to input ideas/proposals through the counterparts.

6: ISSUES ARISING FROM THE EVALUATION

The Evaluation of the Women's Health Project has raised a number of issues which will now be considered.

CONSULTATION

A key issue within the consultation process and indeed one prioritised in the Plan for Women's Health is that of consultation:

> **'The single most important recommendation (from the consultation process) must be that the model of consulting with and getting feedback from the public on the services we provide, must continue.'**[8]

However, although this commitment was contained in the National Plan the reality was that only one of the health boards had actually undertaken any extensive consultation with women's groups since the plans were adopted. All of the Committees recognised that it was now time to revisit the consultation process since a considerable period of time had elapsed since the first consultation.

However, the failure to maintain the focus on consultation, and the development of appropriate mechanisms to enable this to happen, indicate that the commitment to consultation is not as wholehearted as might appear in the above statement.

The counterparts had advocated an emphasis on consultation on the WHACs but perceived that the health boards were not fully committed to this approach. They believed that the health boards viewed consultation "as a task to be undertaken rather than a process which must be engaged in ". The counterparts also believed that the NWCI could have taken a stronger line with the Department of Health and Children on the issue of consultation. The chairs of the Committees did express a commitment to consultation but indicated an uncertainty about how to incorporate the process into the ongoing work of the boards.
Consultation with women's groups - **real** consultation which involves their active, resourced participation in planning, implementation and monitoring of services - should be central to the women's health process. This is an issue which must be central to the development of real partnership and the focus (on consultation) must be maintained.

PARTNERSHIP

[8] **A Plan for Women's Health,** Department of Health 1997 p75

The work on the National Plan for Women's Health was based on the concept of partnership. The Department of Health envisaged the key players coming together to work on developing initiatives at local, regional and national level to progress the work on women's health. The Department committed itself to developing a partnership with the NWCI in advancing this work and the NWCI counterparts were to engage with the health board personnel at regional level to devise regional plans for women's health.

However, the concept of partnership which was developed, and the commitment of the various partners, needs to be reassessed.

During interviews carried out with the various participants in the process the understanding and commitment to the process was challenged. The key to bringing women's health issues to the main health board agendas, where change can happen and where resources can be committed to effect that change, was identified as being the presence of senior management personnel on the WHACs. With one or two exceptions this had not taken place. Therefore, the health boards commitment to the process was queried. In addition both chairs and counterparts alike noted the sporadic attendance of health board personnel at WHAC meetings; this questioned the level of commitment to the partnership process. In addition reference was made to the absence of clear guidelines or directions - from either the health boards or the Department of Health - to the Chairs of the WHACs as indicative of a lack of commitment to the process. Although some Chairs were able to access administrative support on an ad hoc basis the absence of committed personnel to support the process was also instanced as a lack of commitment to partnership in delaying progress.

The Department of Health and Children, however, also noted that it had not received any requests from any of the Committees for guidance in respect of terms of reference or in relation to other matters. As far as the Department was concerned the Plan for Women’s Health was the guideline or basic terms of reference for the work of the Committees.

Counterparts also referred to the model of partnership being developed on the WHACs and other bodies. They spoke of the need to broaden the understanding of partnership to include respect for different views, recognition of the role of the voluntary/community sector and the importance of resourcing them to participate as equal partners.

The context for partnership in women's health has also changed with the establishment of the Women's Health Council and the devolving of powers to the Council by the Department of Health. The model of partnership developed at the outset of the WHP needs to be revisited and the respective roles of each of the partners clarified.

MONITORING AND EVALUATION

The monitoring and evaluation of the Plan for Women's Health was an issue of contention from the start of this process. The NWCI were anxious that the Department clarify where the responsibility for the monitoring and evaluation of the Plan for Women's Health lay. The Plan declares that the Women's Health Council will have a key role to play in evaluating its success in achieving its objectives and the Partnership for Prosperity and Fairness also envisages a key role for the Women's Health Council in evaluating the Plan.

The Women's Health Council has commissioned research about the national Plan for Women's Health but the NWCI is still concerned about the monitoring and evaluation of the work of the WHACs regionally; in particular the Council is concerned that the impact of the plan on poverty and social exclusion should be documented. This issue still requires clarification amongst the parties to the Women's Health Plan.

The priority now is to ensure that the monitoring and evaluation be carried out and that the results of that process feed back into the actions, practice and policy of the Boards.

FEEDBACK/ NETWORKING

The expectation of the National Women's Council of Ireland was that the counterparts would fulfill a dual mandate on the WHACs. The first obligation was to represent the interests and views of women and the NWCI on the WHACs. The second requirement was that they network locally and regionally with women's organisations, affiliates and other community groups about the progress of the work on the preparation of the women's health plan and also to facilitate a process of feedback and input into the process. The Health Co-Ordinator required that the counterparts give an undertaking that they:

- Organise and participate in local activities to publicise the Women's Health Project to women's groups in the local area
- Commit to ongoing dialogue and consultation with local women's groups ensuring that they feed into the regional Women's Health Plan

All of the counterparts were committed to this work but the reality, however, was that most were unable to fulfill the requirement that they feedback and network locally. There were a number of reasons for this:

- there was no mechanism for feedback either to NWCI affiliates or to the wider community of groups interested in women's health.
- all of the counterparts were extremely over-committed in terms of their work and did not have time available to carry out this feedback.

- resources were not made available to facilitate this work; resources referred to included finance but also administrative support within their own organisations, logistical support from the NWCI and most importantly an NWCI presence at regional level to facilitate the networking.

All of the counterparts had given informal feedback within their own organisations locally and also at any occasions where it was appropriate or possible to do so. Other opportunities to give feedback through the use of newsletters or local media were also used to highlight the work of the WHACs. However, this process was part of the overall work of their various organisations and it was not possible for them to systematically work on publicising the regional Women's Health Plans. The scale of the work involved was beyond the limited resources of most of the organisations involved. In addition to the organisational difficulties the logistical difficulties which the counterparts outside Dublin experienced must be mentioned. For example, counterparts who were active in large rural health boards faced enormous logistical difficulties. The resources required - personnel, finance and time - to network in such an area would be quite substantial.

'I could have done with a bit of help in my work here locally - how to keep women informed about the plan. We didn't have the time or the money in our organisation to keep that kind of feedback going on; it would also have helped me keep in touch and make sure that I was representing the needs and views of women in this region.'

7. RECOMMENDATIONS

This section of the Report will review the Women's Health Project and make recommendations about its future. In addition recommendations will be made to the partners in the Women's Health Project - the Department of Health and Children and the National Women's Council of Ireland. Finally recommendations will be made specifically for the Health Boards.

Following the evaluation of the Women's Health Project over the last three years a number of general comments must be made:

- The pace of development of the process was much slower than any of the partners anticipated. It was hoped that the health boards would have completed their plans for women's health much sooner and that the WHACs would be well on the way to the implementation of their proposals.

- One of the main reasons for the delays in progressing the work on the committees was a lack of clarity initially about the exact role and remit of the WHACs. The absence of standard terms of reference to guide their efforts had an adverse impact on the process.

- There was a low level of awareness of the existence of the Plan for Women's Health and the partnership developed between the Department of Health and the NWCI at health board level and within the wider community

- Insufficient resources were available to the counterparts to enable them to develop the feedback and networking to women in their regions

The above considerations should be borne in mind in considering the future of the Women's Health Project and in the event of a continuation of the WHP measures should be taken to address them by the partners.

The continuation of the work of the Women's Health Project is recommended. The rationale for its continuation is:

- The Department of Health and Children committed itself to an ongoing partnership with women about their health needs. This commitment was articulated in the Plan for Women's Health and the DoHC is pledged to include the views and concerns of women into their planning for the health services.
- Little real change has taken place in the health services for women. A more sustained process of engagement with health agencies will be required to bring about meaningful change for women.

- The priority issues for women remain to be addressed; these include tackling issues of access to services, inequality, choice, respect for diversity, counselling and the development of a woman friendly health service. Although some work was initiated on these issues more sustained attention and action is required to bring about meaningful change in health services for women.
- The work on the regional health plans is ongoing; the implementation phase of the Plans which is getting underway will be crucial in terms of addressing the concerns of women's organisations
- The Plan for Women's Health was drawn up based on a consultation process engaged in over five years ago. The economic and social context has changed considerably over that period and consultation will be required again around the achievements of the first phase and the new needs and issues which are arising.

In addition to the above considerations there are two further reasons why the Women's Health Project should continue to be supported. Firstly, the government recently engaged in a review of the themes and targets for the National Anti-Poverty Strategy. This Strategy requires that all government departments target poverty and social exclusion in the planning and delivery of its services. Health has been selected as one of the priority themes for this year and in that context there will be a national consultation on health issues. The exact shape of the consultation is still in the process of development but women's health issues and the established links between gender, ill health and poverty will certainly be addressed. Therefore, it will be important to have a structure in place to support women's organisations, and especially those who engaging with anti- poverty and exclusion issues, to make their input into that process.

The NWCI is well placed to draw on its earlier experience of consultation and its participation on regional health committees to, drawing on the work of the WHP, the Health Panel, the Policy Team and the Millennium Project to make a significant contribution to the development of the NAPS work

Secondly, the Minister for Health announced in October 2000 that a wider national health consultation will take place which affords another opportunity to the organisation to make an input into policy at local and national level.
The Women's Health Project should be restructured to:

- Identify the skills and experiences of counterparts at the outset
- Increase the focus on capacity building with counterparts
- Establish feedback/support mechanisms locally and regionally

RECOMMENDATIONS TO THE NATIONAL WOMEN'S COUNCIL OF IRELAND

It is recommended:

1. That the NWCI develop a model for consultation with women's organisations. The NWCI is well placed, based on its experience of the consultation phase and the WHP, to develop this model. As the Plan for Women's Health is implemented and as other initiatives are put in place there is a need for a model for consultation to be developed; the statutory agencies acknowledge that they are not well placed to provide this and the opportunity exists for NWCI to develop such a model.
2. That the NWCI seek funding from the Department of Health to develop the Support Structure to counterparts, with a particular focus on local and regional networking.
3. That the NWCI develop greater integration between the work of the various sections of the organisation - specifically the Women's Health Panel, the Policy Team and the Women's Health Project.
4. That the NWCI support counterparts in developing feedback mechanisms throughout the country so that the work of the organisation on regional bodies such as the WHACs can be promoted.
5. That the Women's Health Project review the support/training needs of counterparts on the Committees. An audit should be conducted of the skills which the counterparts have and those which they see as necessary for effective participation on the WHACs and other Committees. The provision of induction modules for new counterparts should be considered; during the WHP there was a considerable turnover of counterparts with new recruits joining the process at various stages. The provision of such a module would save time as counterparts could more quickly acquaint themselves with the background to the project, the NWCI and the structures and agencies with which they will have to engage.
6. That the NWCI review the needs and expectations of affiliates outside Dublin. Counterparts expressed concerns about the organisation being too Dublin focussed and not having a presence at regional level. They identified the need for support for regional work as being essential for them as affiliates in trying to promote the NWCI and in trying to encourage organisations and groups active on women's issues to join the organisation.

RECOMMENDATIONS TO THE DEPARTMENT OF HEALTH AND CHILDREN

It is recommended:

2. That the Department of Health and Children, in the context of the Strategic Management Initiative and other policy developments, take a lead role in encouraging the promotion and publicizing of the Women's Health Plan.
3. That the Department of Health and Children commit itself to increase the level of funding for the innovative work of the WHACs.
4. That the funds for the work of the Women's Health Advisory Committees be ringfenced so that they are not used to support existing work but should clearly be designated as supporting innovation or pilot projects.
5. That the Department of Health and Children show its commitment to the work of the Women's Health Advisory Committees by ensuring that standard terms of reference are prepared for the WHACs to guide them in the implementation phase. The example offered by the Department of the Environment could usefully be adopted. The Department has issued explicit guidelines to local authorities, instructing the City and County Development Boards about how to proceed with the drawing up of comprehensive social, economic and cultural strategies for their areas.
6. That the Department and Health and Children ensure that the monitoring and evaluation of the work of the WHACs is carried out.
7. That the Department of Health and Children allocate adequate resources to the Women's Health Project so that the Support Structure can meet the needs of participants, support local and regional networking and promote the work on women's health issues.

RECOMMENDATIONS TO THE HEALTH BOARDS

1. That the Health Boards issues standard terms of reference to the Women's Health Advisory Committees
2. That the CEO of each Health Board ensures that the personnel nominated to the various advisory committees, in particular the Women's Health Advisory Committees, should include senior management personnel who will be able to make decisions and input directly into the Service Planning process.
3. That the CEO of each Health Board ensures that the Chairs of the WHACs are given adequate resources, support and opportunities to meet as a group to share experiences, learn from each others work and develop common themes and strategies.

APPENDIX 1: LIST OF DOCUMENTS CONSULTED FOR THE NWCI WOMEN'S HEALTH PROJECT EVALUATION

1. Programme for Conference on Women's Health: 30th June 1995 (UCD)
2. Submission to the Forum for Peace and Reconciliation: 13th October 1995
3. Building Partnership between Women and Statutory Health Providers: a Proposal to the Department of Health (Rita Burtonshaw) November 1996
4. Counterparts Action Plan Check List (undated)
5. NWCI Health Representatives Selection Criteria (undated)
6. Report from Health Co-Ordinator (May 1998)
7. Health Campaign Proposal from Health Co-Ordinator to Executive Board (Nov 1998)
8. Report from Health Co-Ordinator (undated but probably end of '98)
9. Briefing note (confidential) from A. Deane to WHP Meeting (March 1999)
10. Status report of Project to Department of Health (May 1999)
11. Report to Minister (July 1999)
12. Notes of meeting with Minister for Health (July 1999)
13. Report from Health Co-Ordinator (May-September 1999)
14. NOW Newsletter article (August 1999)
15. Survey report (summer 1999)
16. Women's Health - a Policy Paper from the NWCI (October 1999)
17. Presentation by A. Deane to Department of Health Seminar (Nov 1999)
18. Report from Health Co-Ordinator to Executive (February 2000)
19. Summary of Counterparts National Meeting, 1st April 1998
20. Summary of Counterparts National Meeting, 17th June 1998
21. Notes of Health Panel & NWCI Health Counterparts Meeting, 12th September 1998
22 Summary of Counterparts Meeting, 27th January 1999
22. Summary of Counterparts National Meeting, 7th July 1999
23. Summary of Counterparts National Meeting, 29th September 1999
24. Summary of Counterparts National Meeting, 8th December 1999
25. Summary of Counterparts National Meeting, 23rd March 2000
26. A Plan for Women's Health (Department of Health and Children) 1997

APPENDIX 2: LIST OF THOSE INTERVIEWED FOR THE NWCI WOMEN'S HEALTH PROJECT EVALUATION

National Women's Council of Ireland:

- Audry Deane, Women's Health Co-Ordinator, NWCI
- Noreen Byrne, former Chair of NWCI and current NWCI Representative on Women's Health Council
- Rita Burtenshaw, former consultant to the Women's Health Project and one of three NWCI Representatives on the Women's Health Council
- Tess Murphy, Executive Member NWCI
- Mary O'Hara, Executive Member NWCI
- Gráinne Healy, Chair of the National Women's Council of Ireland, NWCI Board member and Chair of the Health Panel

Women's Health Council:

- Geraldine Luddy, Director

Women's Health Counterparts:

- Mary O'Hara, Midland Health Board
- Maura Bradshaw, Southern Health Board
- Sheila Vereker, South Eastern Health Board
- Jan Tocher and Margaret Daly, Mid-Western Health Board
- Martina Queally, Eastern Health Board
- Marion Flannery, Western Health Board
- Janice Ransom, Midland Health Board
- Nora Newell, North Western Health Board
- Paula Gribben, North Eastern Health Board

Chairs/Members of the Women's Health Advisory Committees:

- Freida O'Neill, Eastern Health Board
- Mary Troy, Women's Health Development Officer, EHB
- Marian O'Reilly, Mid-Western Health Board
- Margaret Sweeney, Secretary to Mid Western Health Board WHAC
- Sharon Foley, Midland Health Board
- Julie Heslin, South Eastern Health Board
- Deirdre Murray, Southern Health Board
- Catherine Duffy, Western Health Board
- Cornelia Stuart, North Eastern Health Board

Department of Health and Children:

- Dolores Moran, Assistant Principal, Women's Health Section, Department of Health

APPENDIX 3: THE WOMEN'S HEALTH ADVISORY COMMITTEES

Supporting counterparts on the various WHACs throughout the country was a central part of the work of the Health Co-Ordinator. There were 30 counterparts on the WHACs over the three years of the Women's Health Project and supporting their ongoing participation on the Committees was the priority for the Health Co-ordinators. The WHACs did experience considerable difficulties during their start up and development phases and this resulted in many difficulties for the counterparts, necessitating constant contact with the Co-Ordinator.

A brief overview of the WHACs follows to highlight the difficulties experienced by the counterparts and the demands placed upon the Support Structure as a consequence.

The Plan for Women's Health recommended the establishment of advisory committees on women's health on a regional basis. Each of the eight health boards set about establishing these WHACs but there was a considerable degree of variation in how they set about and understood the task before them.

The WHACs were set up by the CEOs of the health boards and varied greatly in terms of their composition, structures, location within the health board structures, working methods, frequency of meetings, administrative backup, publication of reports, budgets, implementation and
approaches to consultation.

For example, in a report from the NWCI in March 1998 it was noted that one of the WHACs had already completed its report and one committee had still to meet!

Standard terms of reference were not issued to the WHACs. This resulted in some WHACs working to terms of reference received from their own health board, others drawing up their own terms of reference and others adapting terms of reference received from elsewhere.

Each of the WHACs set about the task of drawing up a plan for women's health for their region using the framework of the Plan for Women's Health as a template. Some of the committees also addressed some of the issues which had arisen during the consultation phase which had preceded the WHACs but others adhered more rigidly to the template offered by the Plan.

The WHACs drew their membership primarily from within the health boards. A range of personnel with medical, health promotion and administrative experience and responsibilities were represented on the Committees. Some of the health

board personnel who were on the Committees were senior managers who were members of the health boards management teams with a direct input into the preparation of the Service Plans.
The National Women's Council of Ireland had two representatives on each of the WHACs. Some of the Committees had additional voluntary sector representatives

The WHACs generally met on a monthly basis; occasionally the Committees met more frequently when the Plan was being prepared . The attendance at the WHAC meetings was sporadic especially on the part of the health board personnel. This made it particularly difficult to progress work on the preparation of the plans and did result in considerable delays. These delays became particularly acute when it came to agreeing and finalising the plans. It was noted in discussions with counterparts and Chairs alike that the attendance was greater the closer the WHACs came to discussions and decisions about budgets and expenditure.

Most of the WHACs worked as one committee to develop their plans. The work was conducted at the regular monthly meetings; occasionally day long planning meetings were held to prepare a work programme for the Committee. Some WHACs proceeded by assigning responsibility for particular topics/themes to members (MHB) whilst other WHACs set up Sub-Committees which brought in a wide of additional statutory and voluntary sector expertise. (SEHB)

All of the WHACs produced regional Plans for Women's Health. however, not all of them were published or easily accessible. A number of those health boards who had websites made their reports available on the Internet. One of the health boards publicly launched the report but also produced a brochure which introduced the Plan to a much broader audience.(SEHB) This brochure was widely dispersed amongst women's and community groups throughout the region.

All of the health boards had engaged in the consultation process prior to the publication of the Plan. However, the Plan envisaged that consultation should not just be a once-off exercise but rather an ongoing feature of the way in which health services for women are planned and delivered. However, despite this commitment only one health board formally addressed the issue of consultation again. (WHB) This health board engaged in a series of local consultations throughout the region (5 meetings in all). These meetings were planned and organised by the counterparts, the Health Co-Ordinator and the WHAC.

The other WHACs have acknowledged the need to re-engage with the consultation process in the light of changing needs and developments in the health services. The return to consultation was a priority for many of the WHACs for 2001.

The WHACs were not originally intended to have funds for distribution. However, there was considerable frustration amongst WHAC members that they did not have funds to permit piloting and innovation in health initiatives for women. Therefore, funds were made available from the Department of Health to the Committees. The amounts involved were £40,000.00 in the first year, 1999; and £80,000.00 in the second year. This money was made available to the seven health boards throughout the country with a larger sum being made available to the Eastern Health Board in recognition of the larger population in that region. The funding was intended to enable the WHACs to proceed with the implementation of their plans. The funds were spent on a variety of different initiatives:

- The launch and/or publication of the regional plans for women's health
- The development of a range of information materials for women
- Commissioning research e.g. the carer's research in the West
- Purchasing of equipment
- Supporting health promotion initiatives
- Supporting innovative projects for young mothers
- Providing a grants scheme to women's organisations and women's community groups

Having completed the process of preparing the regional plans for women's health the WHACs moved on to address the implementation of the proposals. The situation varied again from region to region. One health board set up a specific Implementation Committee, a smaller more focussed group; another retained the current WHAC but also established an Implementation Committee and others have continued working as WHACs on implementation issues.

APPENDIX 4: FUNCTIONS OF THE WOMEN'S HEALTH COUNCIL

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of women's health, either on its own initiative or at the request of the Minister and in particular on:

a) the implementation of the recommendations on women's health contained in policy reports commissioned by the Minister for Health;
measures to promote women's health

b) action, based on research, required to plan and develop services to improve women's health

c) methods of increasing co-ordination between public bodies at national and local level in the planning and provision of health services for women

d) means of encouraging greater partnership between statutory and voluntary bodies in providing health services for women
means by which the health services could assist the improvement of women's health in the developing world

1. To assist the development of national and regional policies and strategies designed to increase health gain and social gain for women by:

a) undertaking research on the health needs of women in Ireland

b) identifying and promoting good practice in the provision of health services for women

c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health and well being of women

d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional polices which have as their object health gain or social gain for women

3. To develop expertise on women's health within the health services.

4. To liaise with international bodies which have functions similar to the functions of the Council.

5. To advise other Ministers, at their request, on aspects of women's health which are within the functions of the Council. The work of the Women's Health Council is based on three principle