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Centred voices : A study of the lived experience of women's health centre coordinators

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CENTRED VOICES:
A STUDY OF THE LIVED EXPERIENCE OF WOMEN'S HEALTH CENTRE COORDINATORS

BY

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ABSTRACT

The purpose of this phenomenological study is to explore and describe the lived experience of women's health centre coordinators. In addition to the intrinsic value of telling these women's stories, this research provides data which can be used to strengthen the economic, political, organisational and social position of women's health centres and the women who work in them.

Four women managers from regional urban women's health centres in Australia were interviewed about their subjective experiences with respect to their current working roles. Interviews were audio taped, transcribed and coded to produce themes and to preserve anonymity. Data was analysed using Colaizzi's phenomenological method. Credibility and validity of data was enhanced by the use of multiple interviews, member checks, a pilot study and a clearly identifiable audit trail.

The findings of the study reveal that the main themes relating to the experience of women's health centre coordinators are: the importance of shared principles, passions and rewards; their feminist leadership role as managers of a specialist health service; working with the wider system; and the demanding nature of their job.

Theoretical sensitivity is demonstrated by re-analysing the emergent themes and descriptions obtained from the data against the backdrop of the current social, economic and political climate of women's health in Australia. This second order analysis reveals the processes and strategies employed by women's health centre coordinators in carrying out their work, and highlights the many factors that have influenced their development as feminist managers. Furthermore, the findings suggest that the experience of women's health centre coordinators in this study parallels those of feminist managers elsewhere, and as such, this thesis represents a significant contribution to the dearth of literature on women managers working in feminist, consumer-based organisations.

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DECLARATION

"I certify that this thesis does not, to the best of my knowledge and belief:

(i) incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;

(ii) contain any material previously published or written by another person except where due reference is made in the text; or

(iii) contain any defamatory material."

Signature..[redacted].....

Date.....2/3/99.....

ACKNOWLEDGMENTS

This thesis is dedicated to
Mr Daniel Lloyd

I dedicate this thesis to my partner in life and love, Daniel. I wish to express my deepest thanks for his total belief in me, his unconditional encouragement, love and support, and his patience with those things in our lives - big and small - that sometimes needed to be put on hold throughout the term of this project.

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CHAPTER ONE

Background To The Study

Introduction

This thesis describes a phenomenological study of the lived experience of coordinators of urban women's health centres in Australia. The research is a response to the dearth of literature on women's health centres and its workers, despite the existence of these services in Australia for more than twenty years. In addition to the value of telling the stories of these women, it is anticipated that the research will help to make these women more visible among health services providers, to academia and the wider community. This increased visibility may contribute to positive changes in the economic, social, political and organisational circumstances of women's health centres and the women who work in them.

Organisation of thesis

This thesis describes the background to the study, the methodological and theoretical frameworks, the process by which the research was conducted, and the findings that emerged. In Chapter One, the historical, social, economic and political context of the women's health movement and women's health centres is described. A brief review of previous studies of women's health centres and their workers illustrates the lack of research on women's health centre coordinators and supports the rationale for undertaking the current study. The chapter concludes with an outline of the significance and purpose of the research and each of the specific research objectives is clarified. Chapter Two introduces the interpretivist paradigm, this is followed by a detailed exploration of the qualitative, phenomenological approach employed in this

study, and its compatibility with feminist research principles. Chapter Three contains a step-by-step account of the sampling, data collection and data analysis processes, and evidence of appropriate methodological rigour. This chapter also discusses ethics, foreseeable limitations of the research and impact of the pilot study.

The four main themes arising from this study were: the importance of shared principles, passions and rewards; the role of women's health centre coordinators as feminist leaders; the challenges of working with the wider system; and the demanding nature of the job. Chapters Four to Seven describe the findings of the research, with each chapter focussing on one of the four main themes. Each theme is discussed in relation to the relevant literature, and the results, namely excerpts from each woman's story, are interwoven in the text to ensure that their voices prevail.

Chapter Eight concludes the thesis with a brief resume of the findings and their implications for future research. The appendices provide substantiating evidence for the rigour with which the study was conducted by providing original examples of each stage of the research procedure.

To fully appreciate the role of contemporary women's health workers in Australia, it is important to sketch the background from which they have emerged in order to contextualise the findings of this thesis. The following section outlines the history of the women's health movement and the role that women's health centres and their workers play in addressing women's health issues in the modern, western world.

Historical context of the women's health movement

The modern women's movement, which came to the fore in England in the early nineteenth century, was the precursor for the women's health movement of the last three decades of the twentieth century. What began in the work of prison reformer Elizabeth Fry and others, and extended into subsequent feminist reform and suffragette work in England, the US and Australia, established an understanding of the key concepts which underpin the oppression of women. The women's movements of the past two centuries have fought for equal rights in all spheres of women's lives and in so doing have exposed the central issues of patriarchy, racism, class, scientific rationality, bureaucracy, the state, and the medical model of health that ultimately impair women's access to quality health services. Economic processes such as capitalism, corporatism and the new economic rationalism have imposed additional restrictions on women's ability to receive appropriate, affordable and accessible health care.

The women's health movement has therefore arisen out of a need to challenge the "prevailing social, political and theoretical relations" which act against women's health interests (Gross, 1987). The feminist underpinnings of the women's health movement have created a way of thinking about women's health that promotes empowerment and equality as central themes of their crusade. Most importantly, the women's health movement is committed to exposing the gender and health inequities inherent in the patriarchal, economic and political structures that pervade the fabric of western society.

Diagram 1, below, illustrates the importance of these societal structures to the context of the women's health movement. The diagram shows the inter-relatedness of the core themes of patriarchy, capitalism, scientific rationality, bureaucratic processes, corporatism, the state and the medical model of health, and their influence on the context in which the women's health movement is anchored.

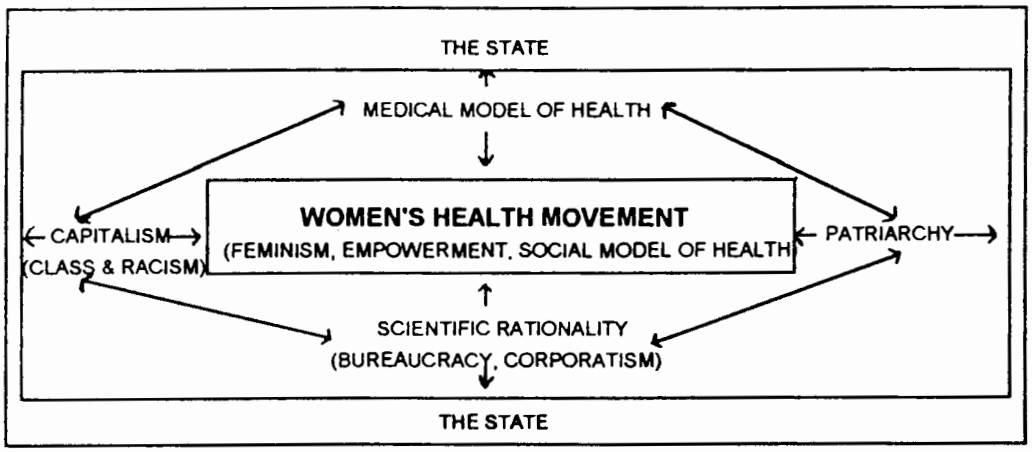


Diagram 1: Landscape of the women's health movement (Hunt, 1994, p.52).

According to Hunt's model, each feature of the landscape comprises the context within which the women's health movement has been shaped and continues to evolve. The double-headed arrows indicate the fluidity within the system, mediated by the more rigid parameters of the state. In order to understand the background to the women's health movement, Hunt maintains that the main components of patriarchy, capitalism, scientific rationality, the medical model of health, bureaucracy, corporatism and the state need to be defined in relation to their significance for women. The remainder of this section of the chapter explores each of these components, summarising the historical, social, political and economic context of the women's health movement which contextualise the women's health centres in this study.

Patriarchy, capitalism and scientific rationality

Patriarchy is a central concept to the history of the women's health movement. It describes the monopoly of male power in the Western world. The rise of capitalism in recent centuries has fuelled patriarchy, by reinforcing power inequities between men and women. For example, with the industrial revolution the financial centre of families shifted from home-based enterprise (for example, farming) to factories and offices, resulting in a reorganisation of male and female roles. Women were no longer partners in a family business, but relegated to passive home-carers, nurturers, or low status factory workers, while the men became the breadwinners (Robertson, 1990). This redefinition of male and female roles created a social and financial imbalance, in which women lacked economic independence and power.

Capitalism, and the resultant shift from rural to urban life, not only undermined women's position in society, it destroyed community and village life, leaving women isolated from sources of support. Traditional knowledge about women's health was lost, and women who continued to practice natural or herbal medicine were persecuted as witches (Ehrenreich & English, 1973, 1979; Kneipp, 1997). Women's traditional knowledge and social status was further eroded with the growth of technology, which brought with it an increasing reliance on scientific reason over spiritual or traditional awareness. Women's home-based knowledge became defined as unscientific and irrational, while men's technology or work-based expertise was seen as scientifically legitimate and afforded greater worth. In brief, the rise of capitalism and technology led to the greater authority and power of the rationality of science (Larson, 1977).

The dominance of scientific rationality is particularly relevant to the history of the women's health movement because of the way it undermined the traditional medical knowledge and expertise of women, creating a monopoly by men on all sanctioned medical practices. This shift in medical knowledge and power has been challenged by feminists in general, and by the women's health movement in particular. For example, prominent feminists (Harding, 1987; Stanley & Wise, 1983), have noted the exclusion of women's experience and knowledge from scientific thought and practice. The ascendancy of scientific rationality, which was sustained by a belief in its objectivity, has also been critiqued by Kuhn (1962) and Foucault (1979) who attributed its popularity to paradigmatic and political motivations.

In its application to the rise of the medical profession, reliance on a scientific rational approach had particular import for women's health, both in terms of defining science as inherently objective, and in securing the dominance of mainstream medicine (and therefore male doctors) over all health matters. The result was the de-gendering of health, via the assumption that women and men's health needs were homogenous, and that the medical model of health - through its scientific autonomy - provided the only reliable solutions to the health requirements of the community (Broom, 1998). This model of health care, and its implications for women, will now be described in more detail.

The medical model of health

Women have had a long history as community healers and nurturers. The rise of scientific rationalism, together with patriarchal power and traditional Christian views have denigrated women's traditional medical knowledge, labelling it as irrational and unscientific. In recent centuries women have been actively excluded from medical practices, as they were seen to be too fragile and at the mercy of their reproductive processes to make reliable practitioners (Miles, 1991). Furthermore, with the rise in status and power of medicine in the nineteenth century, women were considered beneath the task of such a complex and scientific profession.

The popular medical theory on women in the nineteenth century was that they were 'the weaker sex'. Men were the 'correct prototype' to which women were unfavourably compared; any biological differences were used to explain or justify women's perceived inadequacies and lower economic and social status (Ripper, 1994). Medical focus was on women's reproductive organs, as they distinguished her from her male counterpart, and it was this distinction which defined her medical needs (Gannon, 1998). As Kneipp (1997, p.3) states "women were thought to have embodied illness simply because it was the nature of their sex".

In modern times, the western approach to medicine has favoured male biology as the template for all health matters. In comparison, women's biological processes have been cast as 'other', with their differences often being conceptualised as illness. Overall, the framework of this model of health revolves around the diagnosis of disease, and medical terminology reflects this pathology-based approach. The focus of

this white, middle class, male approach is epitomised in its research history, which has typically concentrated on health trials pertaining to its own single class group, often without reference to other racial, sex, class or social cohorts (Broom, 1998; Fee & Krieger, 1994; Kneipp, 1997). Additionally, in many cases, the medical model of health has failed to recognise the influence of psychology, economics, politics, spirituality or social environment on disease, unlike the social model of health espoused by the women's health movement which considers all of these factors to be relevant to women's health (Broom, 1991; Doyal, 1995, Gannon, 1998). At the end of the 20th century, women are still perceived to be physically weaker than men, more prone to illness, and normal reproductive processes such as menstruation, pregnancy, and menopause are defined as health problems requiring medical intervention.

Bureaucracy, corporatism and the state

One of the key processes by which the ruling power of scientific rationality and the medical model of health has been installed into the fabric of western health (and other) systems is the bureaucratic organisation of modern medicine (Blackmore, 1992; Hunt, 1994). The dominance of the medical approach to health has infiltrated the state, with legislation and constitutional law guaranteeing its continued autonomy and power (Kneipp, 1997). As this power has increased, the male domination of medicine and the growth of the male, medical empire has moved the public health focus away from small, gendered community health approaches to large, male-dominated health enterprises such as surgeries and hospitals. Bureaucracies have been developed, typified by hierarchical structures with codified systems of rules (Weber, 1968). In the modern health system, bureaucratic structures such as hospitals represent the main

bastions of modern, commercial medicine, and contain infrastructures which keep knowledge and power with men at the top of the hierarchy, and women staff and patients at the bottom of the heap.

In particular, it is the 'top-down' hierarchical nature of bureaucracies and their subsequent reinforcement and reproduction of "relations of masculine dominance and feminine subordination" (Petersen, 1994, p.92), that has come under criticism from feminists (Blackmore, 1992; Smith, 1992, Weeks, 1994; Wilson Shaef, & Fassel, 1988). Of most concern is the 'new look' bureaucracy, that of corporate managerialism, which represents a new organisational culture that 'uses' the traditional female skills of empathy and effective interpersonal communications to achieve maximum organisational outcomes (Blackmore, 1992). Corporatism in the health care system poses a new threat to women's health through its strategy of incorporating "big business, big labour and big government" to streamline health service delivery and create what Gardner (1995, p.201) termed a "tripartite power bloc."

Another significant outcome of corporatism in the health sector is that bureaucratic controllers of organisations that provide health care (such as hospitals), and those organisations that fund these health services (such as government health departments) can combine their own professional and economic agendas to emphasise "rational long-term planning and cost effectiveness" at the expense of individual or specialised service delivery (Gardner, 1995, p.202). Robertson (1990) in her summary of the literature on corporatism, concurs, stating that corporatism is increasingly forging links with government bodies in order to most efficiently (and cost effectively) gain power

and influence over common goals. Similarly, Yeatman (1990, p.27) criticised the economic fixation of corporatism as trying to "do more with less" and sacrificing humanism and care in the process.

The recent shift to corporatism, and the inherent emphasis on cost and time efficiency, has serious ramifications for the women's health movement. This focus on corporate strategies "represents an attempt to introduce business ethics and systems of accountability into human service organisations" (Hunt, 1994, p.36). As a direct consequence, women's health centres are now required to adhere to strict corporate accountability procedures in order to continue to receive accreditation and funding. Such procedures focus on productivity measures, output and outcome targets, and time/cost effectiveness strategies. These corporate philosophies cut across those of the women who work in women's health centres, whose primary goals are woman-centred rather than economically driven. Furthermore, women's health centres are focussed on quality of service delivery, measuring their success by their ability to respond to the individual health needs of the women who access their services. In direct contrast, the economic rationalism that dominates corporate accountability strategies seeks to mainstream service delivery, thereby universalising its response to client/customer needs in order to produce more cost efficient, standardised services. As Hunt (1994, p.37) argues, this attempt to standardise services is "an important point in the context of the women's health movement for its *raison d'etre* is that women have distinctive and varied health care needs".

Bureaucracies, economic rationalism and corporatism are by nature based in a "thoroughly masculine financial cultural style" (Yeatman 1987, p.347). They are approaches which employ hierarchical, control-based and patriarchal methods in order to reduce management processes to linear, single unit models (Yeatman, 1990). For example, until recently, women's health centres were managed as individual units, with a degree of autonomy over daily service delivery issues. However, the infiltration of corporate accountability and the economic rationalist argument into government policy has resulted in a trend toward market oriented policies, such as de-regulation, privatisation, and reduced government spending (Belcher, 1988). The generalisation of state funded services to reduce public health costs has been one strategy implemented in the name of economic rationalism. This has had dire consequences for specialist services, such as women's health centres, which have been forced to amalgamate with larger, generalist services, such as major teaching hospitals and incorporated generic health services. Such a direction has taken corporatism to new heights, with an even more hierarchical structure, less independence, and each individual unit (eg women's health centre) being managed by a (hierarchical) line of managers. According to Weeks (1994, p.293),

> It is rare for this model to allow any real autonomy to the smaller unit. The pressures of corporate management make it all too likely that uniform arrangements and practices will be imposed.

As a consequence, the innovative and radical voice of women's health workers has become further diluted. For example, Yeatman (1990, p.172), states that as "claims and claimants are brokered much lower down the line... it becomes all the more difficult for their advocates to elaborate them into generalised and generally visible discursive practices". Broom's (1991) study of women's health centres demonstrates

the fragmentation and tension caused by the influence of bureaucratic structures and corporate accountability as a consequence of the marriage between the state and the principles of economic rationalism.

Thus corporatism has led to the ultimate cooptation of women's health centres, although this has always been a calculated risk (Auer, 1990; Broom, 1991; Burton, 1985; Freeman, 1979; Hunt, 1994). The women's health movement (as well as other feminist social movements) has typically sought funding from government departments, knowing, at least to some degree, that cooptation may result. This has been despite the patriarchal, capitalist and bureaucratic nature of the state that runs counter to the principles of equality and collegiality held by most women's movements. The rise in bureaucratic organisation and economic rationalisation that has provided the necessary fuel for the dominance of the state by corporatism has simply increased the risk. The challenge for the women's health movement is, and has been, to find ways to employ the funds of the state to carry out work which they see as appropriate for women, and yet maintain a degree of autonomy (Albury, 1994; Auer, 1990; Kaplan, 1992). The strategy is to become a part of the system in order to change it. As Kaplan (p.273) proposed, such activity keeps feminist wisdom alive and allows access to an otherwise unattainable "vital audience" consisting of "policy makers, politicians, and women and men at every level of activity".

The conflict in seeking funding from a source, such as the state, which is founded on principles antithetical to feminism, may provide other opportunities for feminist organisations that override the risk, ambivalence or tension involved in such a financial

union. For example, feminist organisations may be well-placed to gain more from their state-funded enterprise than the state co-opts from them (Freeman, 1979). In some circumstances, it may be possible to utilise the funding, and enjoy the greater economic freedom, security and stability without compromising one's own ideals and outcomes (Simon, 1982). Burton (1985) maintained that any opportunity is a potentially good one, and urged that feminists should work hard to identify the hidden agendas behind the funding dollars and use them to promote social reform. However, Broom (1991) states that the pressure to conform to mainstream health strategies has taken its toll. For example, the state supports and promotes the patriarchal, capitalist, scientifically based, medical model of health, in contrast to the alternative, holistic, social model adopted by the women's health movement. However, as long as women's health centres survive, at least an alternative model of quality health care for women is available to - an albeit limited - proportion of the female population.

Moreover, the rise of corporate bureaucracies, while providing infrastructures and systems to improve accountability, have proved inflexible and unresponsive to women's needs, and represent a hierarchical approach to health care management that is oppositional to the basic premises of empowerment and equality espoused by feminist organisations and movements. In short, corporatism, and its agents of bureaucracy and the state, has enforced an hierarchical structure on women's health centres, through amalgamation with hospitals and large generic health services, giving rise to particular difficulties for the coordinators of women's health centres whose everyday experience forms the focus of this study.

The women's health movement and the social model of health

The history of public action by women about health and health care has been a long and successful one. Prior to the so-called second wave of feminism in the 1970's which heralded the Australian women's health movement, women were working in the background to build better maternal and child health services. The role of the family planning movement was instrumental to this reform, as were associations such as those for 'nursing mothers' and 'mothercare' groups (Weeks, 1994). However, it was the feminist analysis and action of the 1970's which started to produce visible changes to the women's health landscape.

The women's health movement began as a response to the dissatisfaction which many women experienced in relation to the "huge, costly, powerful, mainstream health system" (Rogers-Clark, 1998, p.7). What began as a feminist groundswell of interest in reclaiming their bodies and taking control of their lives led to a more critical appraisal of the current health problems facing women (Auer, 1990; Broom, 1991). An alternative approach to women's health was developed, one which challenged the narrow, patriarchal, illness-based medical model of health. Instead, feminist analysis of the health system for women resulted in a women's health framework that acknowledged the influence of social, political, economic, cultural, environmental and spiritual factors on women's (and men's) health and health care. It also exposed the assumptions about the experience and health of women made by the male-centred medical approaches to women's health issues, and provided a context for women's individual heath needs which acknowledged their inherent diversity and character (Kenwood & Hanson, 1996).

This new and radical framework for thinking about women's health was all-encompassing. It took into account social health issues such as domestic violence as well as preventative health measures that medically oriented mainstream health strategies had not addressed. This social model of health not only recognised the complex interrelationships between the multiple factors which influence health, illness and general well-being, it rallied against the definition of women's health as purely 'reproductive health' and validated women's desire for an holistically-based response to their health needs. Furthermore, the women's health movement fuelled a double barrelled process of health reform, via "firstly, the development of alternative health services and, secondly, reform activities designed to impact directly on public services and the health system itself" (Dwyer, 1992, p.213).

The alternative health services which sprang up as a result of the first wave of reform were part of a host of feminist women's services that were being formed under the broader umbrella of the women's movement of the 1970s. Some of these feminist services were multi-purpose, such as women's information and telephone services, working women's centres, and women's domestic violence refuges and shelters. Some were more specific, and included rape crisis centres, centres against sexual assault, and specialist health services for women (Broom, 1991; Weeks, 1994). These specialist health services represented the first of their kind, and offered an holistic, social model of health care as an alternative to mainstream medical responses. It is these women's health centres and in particular, the women who now run them, that form the focus of this study.

Women's health centres

The first funded Australian women's community health centre opened in Sydney in 1974. Since then, women's health centres have been established around Australia, and continue to provide alternative, quality, specialist health care to women. The philosophical underpinnings of women's health centres reflect those of the broader feminist goals upon which the women's health movement was formed. These founding feminist principles primarily seek to achieve two goals: "to actively improve women's quality of life; and to remove those fundamental patriarchal ideologies within contemporary society which lead to the oppression of women" (Rogers-Clark, 1998, p.6). Moreover, women's health centres also incorporate the principle of diversity that acknowledges the differences between women, as well as the more traditional distinctions between male and female economics, social position and power.

In keeping with both traditional and contemporary feminist principles, women's health centres carry out the goals of feminism through the provision of direct health care services based on an holistic, woman-centred approach. In recognition of the diversity of women's lives, women's health centres have been established to respond to the individual health needs of women, rather than providing a standardised response. Consequently, women's health centres not only meet their desired targets of enhancing women's health and well-being, they also challenge the medicalised, mainstream health service response that homogenises women's health needs. As such, women's health centres have a clear social action brief, one which is endorsed by the State in Australia through the National Women's Health Policy.

Like other feminist services, women's health centres are run by and for women, and are community-based. They have a triple purpose of responding to women's unmet needs through educating women to increase their personal power and control in their lives, initiating social action to improve conditions for women via policy and law reform, and wider community education about a broad range of women's issues. According to Weeks (1994, p.36-39), such feminist women's services have several other common elements, in that they:

- address issues and problems facing women;
- are organised to respond specifically to women's needs;
- operate on an explicitly feminist philosophy about social change;
- understand that the issues facing women are grounded in the broader context of existing gender, power and economic arrangements in society;
- are staffed by women, who work in a paid or unpaid capacity;
- have attempted to create a safe space for women, founded on women's culture or way of doing things; and
- have organised their work practices according to collective or co-operative, rather than hierarchical, power relationships.

In particular, women's health centres have in common the uniting principles of giving women access to balanced, appropriate health information and encouraging them to take control of their bodies through collaborative decision making. Providing information and guiding women to take an active role in their health care does more than encourage greater autonomy and self-determination: it wrestles control away from

health professionals, drug companies, husbands and fathers, and places it back in the domain of the individual woman (Eisenstein, 1984; Rogers-Clark, 1998).

Women's health centres began as small, independent and autonomous agencies, often funded by government grants but maintaining a degree of control over their feminist ethos and participatory decision-making structures. However, prior to the development of a national policy on women's health in 1989, funding of women's health projects such as women's health centres was difficult to obtain, varied between states, and seemed somewhat ad hoc (Broom, 1991). Even having obtained funding, it was often difficult to hold on to, as evidenced by the rise and fall of some women's health centres over the 1970's and 1980's (Broom, 1991; Brown, 1988). The 1989 National Women's Health Policy (NWHP) not only identified key health issues for women and prioritised areas for action, it also formally acknowledged that inconsistencies of care to women existed and needed to be addressed (Bates & Linder-Pelz, 1990). Funding was made available through the National Women's Health Program for a variety of women's health initiatives, including continued financial support of women's health centres. Furthermore, the NWHP proposed to overcome the previously fragmented health system for women by outlining a clear structure for action that was well coordinated and nationally based (Commonwealth Department of Community Service and Health, 1989).

Since 1989, there have been some significant changes in the Australian women's health landscape. The vision of the NWHP has not been entirely upheld, due to the marginal success of implementing a social model of health. As Beaumont (1995)

argues, this has been due to the narrow focus of the NWHP on the health system, rather than a broader implementation plan targeting a range of social and economic settings. Despite the continuation of the NWHP initiatives beyond its original 1995 deadline, a motion which was carried by the Third National Women's Health Conference held the same year, many of the directives of the NWHP have not been extended. In fact, since the change in 1995 to "a new, conservative government...many of the recommendations of the Third National Women's Health Conference have not been adopted" (Rogers-Clark, 1998, p.9).

Furthermore, recent changes to government funding principles, the increase in corporatism and the dominance of economic rationalist doctrine by the state has challenged the continued autonomy and independent structure of women's health centres. The new introduction of the Funder-Purchaser-Provider Model of health care has resulted in an increase in competition for funding between health care providers including women's health centres. This model in particular, through its process of requiring health service providers such as women's health centres to tender for health service contracts, has placed enormous pressure on health services to justify their existence, and to do so using economically based accountability measures. The focus has thus been taken away from the quality *processes* favoured by women's health centres, and placed on quantifiable *outcomes* as proof of productivity.

Economically driven government policies of 'integration', 'mainstreaming' and 'amalgamation', have also meant that women's health centres are being incorporated into larger, mainstream health service providers, such as community hospitals (Dwyer,

1992). Consequently, women's health centres are being faced with the challenge of adapting to a larger, hierarchical management structure while still maintaining their feminist ideologies. According to Hunt (1998, p.293), the real danger in corporatising women's health is

> that the particular processes developed in the women's health movement would atrophy in inappropriate mainstream, organisational contexts. For example, the preservation of woman-space in clinical settings may be difficult to sustain, and free women's health services would disappear when 'user-pays' principles are applied.

The introduction of mainstreaming health services combined with the 'contract culture' of the Funder-Purchaser-Provider Model of health servicing has meant that women's health centres, as providers of services, are now not only in direct competition with other women's health service providers, but are contractually answerable to the purchasers (larger generic health services, such as those with whom they have amalgamated), and, ultimately, the funders (the government). This combination of imposed changes to the structure and function of health servicing in western countries directly threatens the survival of women's health centres (Egan & Hoatson, 1998). In addition, amalgamation with larger health services has overlaid the relatively flat structure of women's health centres with an administrative hierarchy of line managers to whom women's health centre coordinators now report. As a consequence, both amalgamation and tendering processes place the financial as well as philosophical foundations of women's health centres at risk.

These as well as other economic considerations, such as the shrinking health dollar, have meant that women's health centres are becoming even more marginalised than

before. Initiatives to counter this trend are unlikely given that all of "the time and energy of women's health workers are consumed by frantic efforts to maintain existing services and programs" (Rogers-Clark, 1998, p.9). This sentiment is echoed by Hunt (1998, p.294), who states that "under-resourced women's health centres have little time to do anything more than deliver services". Ruzek (1978), maintains that any alternative form of service delivery in itself performs a necessary social reform function by promoting the notion of choice as well as competition in otherwise homogenous health care systems. Furthermore, claims Hunt, the "very existence [of women's health centres] challenges medical centres of all types to improve their service to women" in addition to continuing to provide a necessary alternative health response to mainstream medical services. The social reform function of women's health centres is endorsed by a number of authors as being a critical and defining component of these unique, specialist health services for women (Broom, 1991, 1998; Hunt, 1994, 1998; Rogers-Clarke, 1998; Weeks, 1994). The following section explores the nature and scope of previous research on women's health centres and their workers and identifies the gaps in existing literature.

Previous studies of women's health centres and their workers

Although there has been much written on the women's health movement, much less has been documented about women's health centres. Those studies that have focussed on the latter have discussed the political, economic, social, cultural and organisational aspects to the exclusion of the individual. No research to date has considered what it is (or has been) like for the women who run these centres, pointing to the significance and uniqueness of this thesis.

A review of the relevant literature is necessary to focus this study, and to find out how others have approached this topic. Yet, reviewing the literature presents a dilemma in qualitative inquiry because it may influence the outcomes of the study, resulting in premature closure and a narrowing of receptivity to whatever emerges in the field (Brink & Wood, 1994; Bryman, 1988; Glaser, 1978; Patton, 1990). The purpose of this review, therefore, is simply to provide evidence that the present study is necessary in order to supply information that is missing from current literature.

There has been little research focussing on women's health centres in particular. In the United States of America, Ruzek (1978) contrasted the women's health movement with mainstream health care. In Australia, Smith (1978) looked at the role of specialist health centres for women, and more recently, Broom (1991) completed a social history of women's health centres. Stevens (1995) followed on from Broom's research by focussing on the history and politics associated with one particular Australian women's health centre - Leichhardt Women's Community Health Centre in NSW. Smith (1992) compiled and edited a series of academic and clinical nurse practitioners' writings on women's health in Australia covering a wide range of women's health issues, but did not focus on the role of women's health centre managers. Brown's (1992) study entitled *Women Organising,* explored non-hierarchical organisations, women's centres and women's ways of organising, but did not focus on women's health services or the experiences of the women who run them. Hunt (1994) conducted an institutional ethnography of women's health praxis, exploring the relationship between the thought and action of women's health care workers from an international and sociological

perspective. Hunt's study, however, concentrated on work-related issues for women's health workers, not managers in particular.

Weeks' (1994) writing on women working in feminist services looked at the experience of women managers of generalist services as well as women's services, but did not specifically focus on coordinators of women's health centres. Her study was also guided by the theme of leadership rather than a more general approach of unstructured exploration into the experiences of these women.

A few articles have appeared in newspapers and magazines. Some have focussed on the demise of women's health centres, such as Hindmarsh Women's Community Health Centre in S.A. (Coles, 1980; Hindmarsh Women's Community Health Centre, 1980). All have commented on political and social aspects, but not on the experiences of women managers themselves. Similarly, Creagh (1992) and Jones (1995) have had much to say publicly about the role of women's health centres and the problems associated with them, but again, information on the experiences of the women who work in them has been totally lacking.

Significance and purpose of the study

This study seeks to redress the lack of attention by researchers to the experience of women managers working in women's health centres and similar organisations. The outcomes may be used to increase academic, political and community awareness of women's health centres in particular, and issues for the management of not-for-profit, community-based services in general. Of particular significance is the manner in which

corporate managerialism and purchaser-provider funding affect coal-face service delivery and management.

It is well documented that "women's health centres are generally under-resourced and marginalised from mainstream health care" (Hunt, 1994, p.227). Increased competition for funding, a history punctuated by battles for mere survival, an already marginalised position in society, shoestring budgets and a changes to government policies must all impact on the experience of women managers in women's health care settings. The fact that these women's experiences have not yet been documented is an indication of the invisibility of these individuals in the system. The embattled history of women's health centres in Australia is proof that their voices have not been heard.

The purpose of this study is to "turn up the volume" on these women's voices by producing an exhaustive, accurate description of their experiences as women's health centre coordinators. However, there is the potential that more than this may be achieved as "the documentation of the unique initiatives of women health workers has a political importance which extends beyond the establishment of baseline data" (Hunt, 1994, p.25). Although telling women's stories is an important exercise in itself (Krieger, 1983; Hunt, 1994; Ruzek, 1978), it is anticipated that this research will produce data which can be used to strengthen the economic, political, social and organisational position of women's health centre and the women who work in them. Certainly it follows that the more visible they are, the better placed these women will be to attract the funding necessary for the continued existence of women's health centres. It is particularly timely that such research be conducted, given the increasing

pressures placed on all health services to compete for the ever-diminishing health dollar and the current climate of political uncertainty and change.

The aim of the research, therefore, is to explore and describe the lived experience of women's health centre coordinators working in Australia. 'Lived experience' is defined as the everyday feelings, attitudes, meanings and perceptions associated with respondents' roles as women's health centre coordinators. A phenomenological approach has been chosen in order to study the 'phenomenon' in question, that is, the essence or central meaning of the lived experience for this population. The 'phenomenon' is the synthesis of the main elements of their experience.

Therefore, the specific objectives of this study are:

- to describe the experience of women's health centre coordinators currently working in Australia;
- to gain an appreciation for the meanings of 'being a women's health centre coordinator' held by this group of people;
- to extrapolate the shared meanings of 'being a women's health centre coordinator';
- to consider the shared meanings of their experience against the backdrop of the current social, economic and political climate for women's health in Australia; and
- to explore the implications of their experience for broader health and community service sector management practice.

Summary

This chapter has provided an introductory analysis of the context of the women's health movement, describing how it has been shaped by the powerful influences of patriarchy, capitalism, scientific rationality, the medical model of health, bureaucratic processes, corporatism and the state. The implications of this are that the women's health movement has evolved - and continues to do so - as a direct challenge to the oppressive nature of the social landscape in which it is positioned. A crucial aspect of this response has been the development of a unique set of guiding principles and ideologies which have been instrumental in forging a visionary path for women working in and around the women's health movement.

The survey of the literature in this first chapter revealed that little research has been conducted on women's health centres and their workers, and in particular, on the women who manage them. The current study, therefore, has been instigated to address the gap in the literature, by exploring and describing individual and shared meanings of 'being a women's health centre coordinator'. This description of their experience is considered within the historical and current context of the women's health movement described in this opening chapter.

To conclude, the significance of the research is in the telling of these women's stories because they have never been told. The most appropriate method for placing women's stories at the centre of analysis is phenomenology, an approach to social research which is described in the next chapter.

CHAPTER TWO

Phenomenology: A Frame Of Reference

Introduction

Many texts on qualitative research clearly state that phenomenological inquiry is the approach of choice to answer questions about the structure and essence of the experience of a particular phenomenon for a particular group of people (Colaizzi, 1973, 1978; Crotty, 1996; Guba & Lincoln, 1981; Morse & Field, 1995; Oiler, 1986; Spiegelberg, 1975). This chapter begins with a broad brush survey of the literature relating to research conducted on the lived experience of individuals in working roles generally in order to justify the choice of a phenomenological approach for the study of women's health centre coordinators. This method of inquiry places the study within an interpretivist rather than positivist paradigm. Following a description of the interpretivist paradigm, Chapter Two concludes with a critical appraisal of the qualitative, phenomenological philosophy and methodology, and its compatibility with feminist research theory and method.

Phenomenological studies: A review of the relevant literature

An extensive search revealed that little research has explored the lived experience of individuals in their working roles, least of all the experience of women working as managers in a health setting. Several studies have used a phenomenological approach to investigate aspects of the lived experiences of individuals in the general health area (Beck, 1992; Haggestrom et al, 1994; Jablonski, 1994; Jarrett & Lethbridge, 1994; Kennedy, 1995; Macleod, 1994; Rather, 1994; Rutman, 1996; Sella & Macleod, 1995; Sheilds, 1995). Of these, only four studies were found to focus on the lived experience

of individuals with respect to everyday working roles (Macleod, 1994; Rather, 1994; Rutman, 1996; Sella & Macleod, 1995). These studies were broadly related to the current research because they all used a qualitative paradigm, a phenomenological approach, their samples were women working as health care providers (nurses and caregivers), and data collection involved the 'telling of their stories' either in writing (Sella & Macleod), or verbally (Macleod, Rather, Rutman). However, in all of these studies the focus of the research was more interpretive than purely explorative and descriptive. Hermeneutical analyses were employed to answer '*how*' these women experienced their working roles. In contrast, the purpose of this study is to explore and describe '*what*' women's health centre coordinators experience, therefore a phenomenological analysis was justified.

One study was found which used qualitative approach to answer specific questions relating to women's experience as coordinators working in a range of feminist services (Weeks, 1994). This study used a semi-structured interview format to elicit information pertaining to leadership issues, and was based "on the findings of research which demonstrates that women's experience of management differs from that of men" (Weeks, 1994, p.169). Weeks also drew comparisons between the experience of women coordinators working in feminist services and male and female managers working in large, bureaucratic organisations. Her conclusions highlighted issues of gender and sexuality, and stated that women managers are differentiated from men by their commitment to sharing and developing competence, leadership and team work among their staff.

Less related in content, but closely related in methodology, were four studies that yielded rich descriptions of the lived experience of individuals as health care consumers (Beck, 1992; Jablonski, 1994; Jarrett & Lethbridge, 1994; Kennedy, 1995). These studies were exploratory and descriptive in nature, focussing on the structure and essence of the lived experience of their particular participants. Three of these studies favoured Colaizzi's (1978) phenomenological method of data analysis, the fourth study by Jarrett & Lethbridge did not state which specific phenomenological method of analysis was used. These studies indicate the use of the chosen methodology for the research - a qualitative inquiry using phenomenological method and Colaizzi's five step process of data analysis.

The Paradigm

As the purpose of this research is to explore and describe the lived experiences of women's health centre coordinators, the aim is not to control variables, or to manipulate data to test hypotheses, or to satisfy presupposed truths, as in positivistic research. Instead, the nature of the research is to capture the essence of the experience of being a women's health centre coordinator. As such, a qualitative, naturalistic approach, based on an interpretive paradigm is well suited to achieving an holistic understanding of the everyday experience of the women who participated in the study.

The naturalistic approach was selected because the alternative paradigm, that of logical positivism, suggests that people and the world are organised in a preordained and 'lawlike' fashion, 'which can be identified, predicted, manipulated and controlled' (Munhall, 1994a, p.12). Quantitative and experimental methods are used to test

hypotheses from a specific theoretical framework, controlling for error and bias as much as possible by utilising a complex array of research design methods. The researcher's role is to remain scientifically detached while pursuing a line of inquiry based on 'knowing (in principle) what they don't know' (Guba & Lincoln, 1989, p.175). However, not all of life's variables can be controlled for, manipulated, measured or compartmentalised to fit a neat, scientific research model. In this study, positivist research methods were not used, as they do not adequately address all aspects of experience, and are less sensitive than interpretive approaches to seeking the essence and meaning of a particular phenomenon in question (Salsberry, 1989).

An interpretive approach is more appropriate to an exploratory or descriptive study such as this analysis of the lived experience of women's health centre coordinators. Interpretive studies, such as a phenomenology, involve the identification and analysis of both subjective and objective data in order to investigate the internal and external worlds of participants. The process involves the formation of naturalistic generalisations beginning with concrete "snap-shots" of each participant's experience and progressing to a more abstract conceptualisation of the shared meanings underlining their common experiences (Abdellah & Levine, 1994; Crotty, 1996; Morse, 1989; Polit & Hungler, 1995, Stake, 1978). This empirical or naturalistic inquiry involves the researcher in going "out into the world", in order to describe the experience in question from the insider's view (Kellehear, 1993).

While proponents of positivism assert that interpretivism is too subjective and unreliable, Guba and Lincoln (1989) see the two "opposing" paradigms as independent and complementary, and propose to "define science as existing on a continuum with discovery at one end and verification at the other" (p.113). They go on to suggest that differences between positivism and interpretivism are at the conceptual and "epistemological level", and are not significant at the more concrete level of how an inquiry is conducted, "because methods and paradigms are independent" (p.157). This notion is endorsed by Cook and Reichardt (1979) as well as Patton (1982) who contend that researchers can be flexible in their approach to selecting a paradigm, even shifting paradigms within a particular investigation if needed.

In this study, the interpretivist paradigm provides the framework for the inquiry, with women's health centre coordinators as the participants in the research process. The interpretivist paradigm was chosen because it allows for the meanings of the women respondents' everyday thoughts, feelings and behaviours with respect to their working lives to form the focus for the study. Additionally, the researcher is an integral part of the research process, unlike the positivist researcher, whose role is that of the detached observer. The interpretivist researcher acknowledges that complete objectivity is impossible. Moreover, the interpretivist paradigm complements, rather than contradicts, the feminist research principles which underpin this study by challenging the existence of scientific objectivity and recognising the role of subjectivity within the research process.

Interpretivist and feminist research approaches allow the researcher to place herself within the research process. The result is an interactive experience for both respondent

and researcher, facilitating a participatory, non-hierarchical alliance from which the data can emerge (Duelli Klein, 1983; Finch, 1984; Oakley, 1981; Reinharz, 1992; Stanley & Wise, 1993). This process is further enhanced by the researcher investing her own personal identity into the relationship by being open to answering questions posed by the respondent, sharing knowledge and experience and giving prompts when needed (Oakley, 1981).

Furthermore, this researcher's personal feminist theoretical orientations, her life experience as a white, middle class woman in her 30's, and her professional background as a psychologist and counsellor all support the choice of an interpretivist paradigm. The many years spent by the researcher interviewing women (and men) and developing skills of listening, encouraging and facilitating individual's accounts of their own life experiences, necessarily informs the research and the choice of an interpretivist paradigm.

As Lynch-Sauer (1985) states, "the goal [of phenomenological research] is to understand human beings not only to know how they 'are', but to understand them, in order to know how to act." Therefore, the aim of this interpretivist research is to achieve an in-depth understanding about the experience of women's health centre coordinators in an attempt to contribute to the body of knowledge about them, and others like them. Such a contribution may ultimately improve their visibility through the collation and dissemination of information about their everyday experience.

Phenomenology as Philosophy

Phenomenology was originally developed in the late 19th century by Edmund Husserl, a mathematician and philosopher who promoted phenomenology as a rigorous science that offered an alternative to the logical positivism paradigm. Hussel described phenomenology as a method through which researchers can explore and understand phenomena which people experience, as they experience them. He considered phenomenology to be not only a research method, but also a philosophical movement and an approach, as it is still considered by some today (Beck, 1992; Crotty, 1996; Field & Morse, 1985; Morse & Field, 1995; Patton, 1990; Pollio, Henley & Thompson, 1997).

Historically, a range of philosophers have been associated with phenomenology, including the hermeneutic phenomenologist, Martin Heidegger, and the existential phenomenologists, Merleau-Ponty, Sartre, Ortega y Gasset, Marcel and Ricoeur (Crotty, 1996). Not surprisingly, over the years multiple interpretations and modifications of phenomenology have emerged, mostly relating back to the differing perspectives of either Husserl or Heidegger. This evolutionary nature of phenomenology, particularly as a research method, is continuous as it is rooted in "a philosophical movement that is still in the process of being clarified" (Omery, 1983).

Michael Crotty, in his (1996) book, *Phenomenology and Nursing Research*, maintains that phenomenology as both a philosophy and a method is still evolving today. He points to two main streams of phenomenologists: the first, European phenomenologists (who Crotty refers to as 'mainstream phenomenologists') such as Husserl, Heidegger

and Merleau-Ponty; and the 'new' North American phenomenological movement, upon which many recent studies on the lived experience of individuals, especially by nursing researchers, are based. Influential American scholars such as Van Kaam (1969), Giorgi (1971), and Colaizzi (1973, 1978) are among these 'new' phenomenologists.

Mainstream phenomenologists, according to Crotty (1996), have in common their devotion to obtaining a description of human phenomena which is stripped bare of all preconceptions and presuppositions of everyday existence and the imposed meanings and values ascribed to such phenomena. They believe that such pre-ordained beliefs distort perceptions of human phenomena, contaminating the research process.

Husserl was first of the mainstream phenomenologists to attempt to describe the researchee's experience in a pre-reflective, primordial way, capturing the essence of their experience, as it is ***immediately*** (or first) experienced. Husserl achieved this by a concept he called phenomenological reduction or 'bracketing' which is based on the mathematical strategy of placing brackets around part of the equation that needs to be treated differently from the remaining equation. In this way, 'bracketing' refers to when the researcher makes all attempts to acknowledge the awareness of preconceived notions about the phenomena being studied, and to suspend that perspective when analysing data (Parse, Coyne & Smith, 1985). Husserlian phenomenologists describe the procedure of bracketing as 'epoche'. Epoche involves suspending any belief about the reality of an object so that the object itself, in itself, can be known (Cohen, 1987).

Beliefs in the reality of the natural world are suspended in order to permit other perspectives to emerge. In essence, one brackets one's very existence (Crotty, 1996).

In contrast, Heidegger maintained that the bracketing procedure as described by Husserl is not possible as humans are unable to deny the basic actuality that they always exist in the world. In Hermeneutical phenomenology, as developed by Heidegger, one brackets or separates oneself during research, but one can disclose or make explicit the presuppositions and beliefs that guide his/her interpretations (Mitchell & Cody, 1993; Crotty, 1996). Heidegger described bracketing as letting "that which shows itself be seen from itself in the very way in which it shows itself from itself" (Crotty, 1996, p.79).

The technique of bracketing prior knowledge and presuppositions of the participants of the study is a fundamental concept which underpins both the philosophical and methodological aspects of mainstream phenomenology. Husserl and Heidegger claimed that their approaches required researchers to 'get back to the things themselves.' Likewise, Merleau-Ponty described phenomenology as an attempt to recapture 'a direct and primitive contact with the world' (Crotty, 1996). Furthermore, mainstream phenomenologists espouse the notion that bracketing is much more than the suspension of values and assumptions, "the phenomenological reduction is a change of attitude that throws suspicion on everyday experiences" (Armstrong cited in Crotty, 1996, p.4).

According to Crotty, the concept of bracketing, and how it is carried out, forms one of the main points of difference between mainstream and new branches of phenomenology.

Mainstream phenomenology seeks to find the sense people make of a phenomenon, elucidating what people experience pre-reflectively, unadulterated by the researcher or researchee's values, giving a "pristine innocence of first seeing" (Spiegelberg, 1966). The new phenomenological movement has employed a 'bracketing shift' away from the researchee, bracketing the assumptions and preconceptions of only the researcher (Crotty, 1996). As Crotty correctly opines, this shift marks a significant departure from traditional phenomenology, where what is sought is a reflective (not pre-reflective) description of the phenomenon under study.

Munhall and Oiler (1986), propose that the new phenomenology represents a pragmatic, philosophical and methodological shift from the study of phenomena, to that of the *effect* of phenomena. They state that "lived experience is the focus of attention in phenomenology rather than the process of experiencing" (p.54). The philosophical emphasis of the new approach to phenomenological inquiry is on experience rather than purely on objects or subjects, and that such experiences cannot be dis-embodied, or separated out by vigorous bracketing of their reflections on those experiences. People's current experiences are therefore inevitably a consequence of their past experience of their world, and are embedded in contextual complexity. Munhall and Oiler thus maintain that people can only understand their experiences in terms of the over-arching context of their world as they have previously (and continuously) experience it. They argue that the new phenomenology has been formed out of a necessity to acknowledge the value of describing people's everyday experience of the world (or phenomenon), not

just as they *first* experience it (as in mainstream phenomenology), but as they continue to experience it.

Mainstream phenomenologists, are primarily concerned with the 'pure phenomenology' of the meaning of 'being in the world', seeking to capture and describe experiences as they are most primitively experienced. For example, Heidegger placed little or no value on everyday meanings about existence, as Crotty (1996, p.77) highlights:

> Looking at subjective everyday experience and discerning its visible meanings (or even its 'hidden' or 'implicit' meanings)...is not what Heidegger is about. Heidegger was after the meaning of being itself. He is not intent on divining the meanings of real life experiences.

It is precisely this type of traditional approach that may have heralded the divergence of the 'new' phenomenologists. Certainly, the burgeoning use of phenomenological methods by nurse researchers in recent years point to the desire within their profession to explore the 'everydayness' that traditionalists like Heidegger seek to avoid. As mainstream approaches reject the familiar, and 'throw suspicion' on the mundane, the new phenomenology actively seeks out knowledge pertaining to the everyday meanings which research participants make of their world. Thus, the new phenomenology is more focussed on what the researchee feels, perceives and understands as a result of their internal reflections upon the phenomenon in question. This approach continues to evolve as it gains popularity in the fields of nursing, feminist and social science research, where the study of people's everyday experience is not only given prominence, it is considered to be a primary strength of their approach.

Despite the fluid nature of phenomenology as both philosophy and method, several key philosophical concepts have remained relatively unchanged. Merleau-Ponty (1962) postulated five core elements to philosophical phenomenology, namely consciousness, embodiment, natural attitude, experiences and perception. Consciousness provides a framework with which one determines what reality is operative at any given time. It connects thoughts, feelings and actions and gives a sense of immediacy in the world. Embodiment is the relationship between body and mind, subject and object, and receptiveness to knowledge fed via one's consciousness (Munhall & Boyd, 1993). Attitude is the recognition and interpretation of knowledge thus gained. An immediate experience is noted by our consciousness, stored and altered by previously noted experiences, and together form the natural attitude of each individual (Merleau-Ponty, 1962). Experience is transformed or interpreted in the mind of the individual, acknowledged by them at some point in time, and ultimately forms the perception of reality of that person. Phenomenology seeks to understand perception, and thus gain insight into respondents' consciousness, embodiment, attitudes and experiences. Put simply, phenomenology is about experience and perception as it takes place through the body and the individual's consciousness. Perception of experience is what matters, not whether what is perceived is true or false. Interpretation by the individual, from his/her point of view is the critical issue, not what is happening, but what is perceived to be happening (Merleau-Ponty, 1964).

The essence of phenomenology's philosophical tradition is "intentionality", a concept which Crotty (1996, p.41), maintains is the foundation stone upon which all schools of

phenomenology rest. Intentionality was described by Husserl as "the general theme of 'objectively' oriented phenomenology", and, as Merleau-Ponty stated, is significant in linking human action and experience. Crotty argues that the use of the word "intentional, as used in phenomenology, does not mean 'purposive'...it is an epistemological concept...not a psychological one", it is about "the bringing together of objectivity and subjectivity"(p.42). Phenomenologists do not believe that subject and object are the same, rather that subject and object are inextricably bound to one another, rejecting positivist researcher's claims that subject and object are mutually exclusive. The role of the researcher in phenomenological inquiry is to "not divide or separate the knowing subject from the object of the study in order to concentrate on one or another" (Psathas cited in Crotty, p.42). What phenomenology seeks to achieve is a study of the whole individual, where the mental (subjective) life and the embodied (objective) life are understood in tandem (Munhall & Oiler, 1986).

Phenomenology, therefore, challenges the notion of truly objective research. It claims that no object can exist without its subjective counterpart. Thus, the purpose of this phenomenological study is to explore the subjective aspects of the phenomenon in question, that is, the structure and essence of the lived experience of women's health centre coordinators. To this end, the new phenomenological approach is best suited, as what is sought is a first person account of their subjective experience, as they relate to it, told from their point of view, and using their words. The method by which this is achieved will be outlined in the following section.

Phenomenology as Method

> Proceed with the greatest care. For the phenomenological method is not foolproof, and plenty of fools have rushed in where neither angels nor conscientious phenomenologists have set foot...There is no substitute for constant checking and re-checking (Spiegelberg, 1976, p.645).

The phenomenological method was selected for this study of women's health centre coordinators because of its fundamental assumption that the lived experience is valid. It maintains that meaning is contextually created as an intersubjective phenomenon; that is, meaning is constructed through human interaction. Phenomenological inquiry "accepts experience as it exists in the consciousness of the individual" (Patton, 1990, p.28). The adaptation of the mainstream 'pure phenomenological essences of lived experience' to a more pragmatic 'new' phenomenology which explores the researchee's feelings, perceptions and experience in a reflective rather than pre-reflective manner is more appropriate to this study of women's health centre coordinators. For the primary aim of this research is to grasp the essence of their everyday lived experience, to "touch on the essential core of their experiences", rather than attempt to unlock the deeper meanings behind them (Munhall, 1994b).

The essentially metaphysical approach of Heidegger and the almost transcendental flavour of Husserl's traditional phenomenology is beyond the scope of this research. While this researcher strives for a certain level of objectivity in her approach (that is, to limit personal researcher bias by bracketing her prior knowledge and presumptions about the study), the greater focus on subjectivity of the North American or new

phenomenology provides a better 'fit' with the researcher's personal, professional and epistemological history. As a woman, counsellor and feminist researcher, the focus in doing this study is to seek out the complexity of the subjectively described, woman experience. The traditional preoccupation by mainstream phenomenologists with the 'essence of being behind being' or 'transcendental consciousness' elicited from 'perfectly bracketed' participants appears to be counter to the purpose of conducting research into women's experience.

However, the aim of this research is also to be self-critical, as open as possible to gathering data that is rich in participant's subjective meanings, and to simultaneously strive to describe the phenomenon itself. In that sense, this research borrows from mainstream phenomenology, but without the dis-embodying process of bracketing participants' experiences. The focus of this research is explicitly subjective, with Spiegelberg's (1966, pp.142-143) words as a guide to balance the level of subjectivity in the process:

> There is no escape from subjectivity. The only cure for subjectivistic subjectivity is more and better subjectivity, more and discriminating subjectivity, and more self-critical subjectivity, which will show the very limits of subjectivity.

The ultimate goal of this study is to find the inner reality of each woman's description of the phenomenon (that of the lived experience of women's health centre coordinators), not, as Heidegger suggested, to apprehend 'being' (existence) beyond the phenomenon. This approach not only fits the research question, but is compatible with the feminist

perspectives, held not only by the researcher, but also the women's movement with which women's health centres are aligned.

While there is enormous diversity within various 'schools' of feminism, their common ground is the belief that women are economically, politically and socially subordinate (Kneipp, 1997). An important aspect of this study is that the explanation of what these women respondents think and feel in itself validates their experience and thus "renders visible a female world which has largely been ignored in academic discourse" (Hunt, 1994, p.24). Therefore a phenomenological method was appropriate to this study and its purpose because it represents a "kind of thinking which guides one back from theoretical abstraction to the reality of the lived experience" (Field & Morse, 1985, p.27). Moreover, the new breed of phenomenology respects the right of the participant to tell their story free from any attempts to bracket their experience, so that what unfolds is truly representative of how they perceive what they experience, in their own words, and in their unique descriptive style.

Phenomenology differs from qualitative descriptive and ethnographic methods in that phenomena are studied from the participants' unstructured descriptions of lived experiences (Salsberry, 1989). Participants do not therefore, answer questionnaires or a battery of pre-selected interview questions. As Keen (1975) explains:

> Phenomenological method does not attempt to predict or control behaviour, nor to discover causal relationships, but rather interpret and understands phenomena by describing, analysing and intuiting.

An assumption underlying this method is that the reality of the phenomenon being researched, in this case the experience of women's health centre coordinators, can be understood through the participants' rich, free-flowing descriptions of their everyday experiences. By encouraging such unconstrained accounts of their experience to emerge, the researcher is able to obtain data which reflects the participants' personal realities.

The goal of phenomenology is to capture as accurately as possible the experience of the phenomenon under scrutiny and to describe this experience as fully as possible. In order to achieve this goal researchers must rigorously identify their own presuppositions, beliefs and assumptions and put them aside so that the phenomenon can be seen as it is and not as it is reflected (or distorted) through the layers of their (the researcher's) interpretations (Ahern, 1997; Beck, 1992; Field & Morse, 1985; Morse & Field, 1995; Patton, 1990). Thus, phenomenology is as free as possible from preconceived notions, expectations and prejudices and does not involve theories about causes, or presuppositions about processes (Carpenter, 1995; Field and Morse, 1985; Morse & Field, 1995; Polit & Hungler, 1995; Pollio, Henley & Thompson, 1997; Spiegelberg, 1975).

While there may be considerable diversity regarding phenomenological traditions and approaches, there are some overlapping elements with regard to the phenomenological method (Parse, Coyne & Smith, 1985). Within these commonalities, Spiegelberg

(1975), found six foundational processes or 'types' of phenomenology which all have in common the aim of describing human phenomena as faithfully as possible:

- *Descriptive phenomenology* - A direct investigation, analysis, and description of phenomena aimed at maximum intuitive content. Aims to be as free as possible from preconceived expectations and presuppositions.

- *Essential (Eidetic) phenomenology* - Perception and probing of the phenomena for typical structures or essences. Seeks to explain these essences and their relationships.

- *Phenomenology of appearances* - Attends to the ways in which the phenomena appear in different perspectives or modes of clarity. Acts to distinguish that which is distinct from the haze surrounding it.

- *Constitutive phenomenology* - Explores the processes by which a phenomenon establishes itself, or takes shape in our consciousness.

- *Reductive phenomenology* - Suspending belief in the reality or validity of the phenomena. This process has been implicit since the inception of the method and now becomes explicit through the use of 'bracketing'.

- *Hermeneutic phenomenology* - Interpreting the concealed or hidden meanings in the phenomena not immediately revealed to direct investigation, analysis and description.

A descriptive as well as interpretive approach, exploring the structure of essences appeared to be the best 'fit' for the research question and the data. The process of bracketing was taken in its implicit context, and as discussed earlier in this chapter, this applied only to the researcher, not to participants. In this way the key features of the methodology , that is, the skills of intuiting or grasping, were able to be preserved, within the philosophical constraints of modern phenomenology. In particular, these features refer to the mode of awareness and of remaining faithful to the primary aim of attempting to describe the phenomenon from the viewpoint of the participants (Knaack, 1984; Rose, Beeby & Parker, 1995).

Three main strategies are required in order to understand human experience from the participant's point of view. These are complementary to Spiegelberg's six key elements and include phenomenological reduction, imaginative variation and interpretation (Ahern, 1997; Keen, 1975; Pollio, Henley & Thompson, 1997; Valle & King, 1978). Bracketing one's preconceptions and value systems by making them explicit in writing forms the first step of the phenomenological reduction process. Imaginative variation involves imagining what a particular phenomenon looks like against the backdrop of various meanings of experience. This process leads the researcher to an understanding of what the phenomenon means to participants. Finally, interpretation is the description of meanings as they emerge, such that they accurately reflect the true meaning of the phenomenon *as perceived by the participant* (Ahern, 1997; Keen, 1975).

Thus phenomenology is all about obtaining the individual's perspective or point of view, and targeting his/her experience as the individual sees it, using his/her *own* words. Phenomenology affirms subjective experience and is, therefore, the methodology chosen to suit the purpose of this study.

Feminist Research Methodology

This research is based on a feminist epistemology, which necessarily informs the process of inquiry. The connection between epistemology, theory and methodology has been well documented by a number of feminist researchers (Abbott & Wallace, 1990; Duelli Klein, 1983; Fonow & Cook, 1990; Harding, 1987; Kelly, Burton & Regan, 1994; Maynard, 1994; Smith & Noble-Spruell, 1986). Feminist researchers, unlike their mainstream counterparts, do not harbour notions of research as an objective exercise of collating a series of value free 'facts'. Rather, feminist research pivots on the argument

that a person's world view and theoretical orientations shape the questions they ask, the process or method they choose and the interpretations they make. Therefore, any real distinction between epistemology, theory and method is tenuous, and may not even exist. However, for the purpose of clarity, this section will outline feminist research principles and method, and their relationship to phenomenology.

Feminist theory and research is notably critical of the male bias inherent in positivist approaches to the construction of knowledge and research practice (May, 1997). Several feminist research theorists have highlighted the need to develop an alternative mode of inquiry which contributes to greater understanding of the research process itself (Abbott & Wallace, 1990; Baldock, 1990; Gunew, 1990; Lather, 1986; Weeks, 1994). Other feminist researchers have placed emphasis on the need for researchers to be suspicious of any 'pretence to objectivity' as espoused by traditional research approaches, and of the use of research methods that attempt to detach the researcher from the process of the study (Baldock, 1990; Kelly, Burton & Regan, 1994; May, 1997; Maynard, 1994; Oakley, 1981; Stanley & Wise, 1983; Wallace, 1990). In preference, they support research approaches that:

- acknowledge the overlap between theory and method;
- appreciate the value of women's knowledge;
- recognise the importance of the researcher actively situating themselves in the study; and
- seek to situate the researcher so they can engage in a dialogical and reflexive process with respondents of the study.

In this research into women's experiences as coordinators of women's health centres, any pretence to detached objectivity has been resisted per se, and approaches that emphasise control, detachment and distance and neglect the importance of complexity, integration, subjective experience and feelings have been rejected. Such a research decision is compatible with the philosophical underpinnings of the 'new' phenomenology, which similarly challenge notions that promote objectivity over subjective experience.

The phenomenological method, through its core assumptions that an individual's unique experience of the world is valid, is thus compatible with feminist research traditions. Feminist research methodology is by definition woman-centred, focussing on the particular perspective and 'lived realities' of women (Weeks, 1994). It values and respects women's experiences and the women's words used to relate those experiences (Wadsworth & Hargreaves, 1993). Emphasis is placed on exploring individual 'truths' that the women participants would recognise as their own, not those of the researcher.

Many authors on phenomenology imply that an assumption of theoretical naivete with regard to a target phenomenon be rigorously employed by qualitative researchers in order to preserve the validity of findings (Brink & Wood, 1994; Crotty, 1996; Glaser, 1978; Field & Morse, 1985; Patton, 1990). However, "it is naive to assume that any human project can ever be approached *naively* or atheoretically" (Sandelowski, 1993, p.215). If theory must be present, the question then becomes one of centrality versus peripherality of a theoretical framework in relation to the study.

The feminist approach to research likewise suggests that theory should be peripheral, so that the data - the voices of women - can prevail "over the authorial or theoretical voice of the researcher" (Sandelowski, 1993, p.215). Patai (1991) endorsed this point when she opposed turning interviews with women into "opportunities for imposing our own politically correct analyses [which] requires an arrogance incompatible with genuine respect for others" (p.148). In Sandelowski and Jones' (1986) research on infertile women's social interactions, social science conceptualisations merely provided a frame of reference, taking a back seat to the data itself. In Krieger's (1983) qualitative study of a women's community, again, the participants' views took precedence over the researcher's theoretical interpretations. According to Krieger (as discussed in Sandelowski, 1993), "pervasive and repetitive patterns are better represented through description rather than through abstract concepts" (p.215). In Krieger's work readers are "*shown* the data rather than *told* them". The data takes centre stage, the theory merely provides the backdrop.

Feminist research methodology not only respects women's experience and their accounts of it, but seeks to include women participants in the research process, rather than making them the passive 'objects' of the research. In practice, feminist research methods are collaborative, non-oppressive and participatory, involving participants as much as possible in the data collection, analysis and writing up stages of the research. In this study, participants were invited to comment on the data collection process, to edit and proof-read the transcripts of their interviews, and to give feedback on emerging themes and the final analysis and presentation of the data. Copies of this manuscript were provided to the participants for further comments and for their own records.

Thus, feminist research is 'process-focussed', where the process is as important as, and contributes to, the final outcome.

The feminist researcher also has a unique role in the process of the research. A primary component of the feminist research method requires the researcher to engage in both a reflexive and reflective manner, reflecting critically on all aspects of the research process and outcome. The researcher's role is to listen and reflect back what is of most interest and relevance to women (Wadsworth & Hargreaves, 1993). Every attempt is made to accurately "represent the richness, complexity and interconnectedness of women's experiences rather than representing women's experiences in categories that are not useful or distorts them" (Weeks, 1994; p.189). With regard to outcomes, the researcher has a responsibility to substantiate findings and to present conclusions in their context, thereby recognising the complexity of 'real' situations. To this end, the researcher demonstrates reflexivity, regard for context, and reflective skills by recording her impressions, interactions, potential biases, opinions, feelings and observations in a reflective journal throughout the period of conducting her study (see Appendix I).

Carol Erlich (quoted in Stanley & Wise, 1983) described feminist research as performing a number of functions. These included a corrective function, whereby the research fills gaps in knowledge about women; and a movement oriented function, in which the research furthers the interests of the women's movement. The present study is primarily corrective, as little so far has been documented on the experience of women health centre coordinators in their role as women managers. However, it can also be argued that the present research is also movement-oriented as it has been conducted in

order to support the position of women's health centres by helping to make the role of their coordinators more visible in the wider community.

Feminist research is not just concerned with validation of women's experiences but is also 'change-oriented' (Wadsworth & Hargreaves, 1993). It recognises the need for change to occur, and attempts to assist and allow for this change by providing information through the presentation and publication of research findings. One of the identifying characteristics of feminist research is its aim to contribute to women's understanding of their situation and to help them to identify new or better ways to change and improve their lives. In this study, it is anticipated that the findings will help to clarify and confirm women's health centre coordinators' experience of their work as well as enhance their profile outside of their immediate environments.

Summary

In summary, this chapter has provided a frame of reference for considering the key features and merits of the chosen qualitative approach of modern phenomenology. A review of the relevant literature highlighted the suitability of this approach, both in relation to the goals of the research and the feminist orientation of the researcher. Furthermore, the decision to employ a naturalist mode of inquiry, and to faithfully attempt to describe participants' experiences from their viewpoint was outlined and discussed. The process by which this was achieved is the focus of the next chapter.

CHAPTER THREE

The Research Process

Introduction

This chapter describes the procedural steps involved in obtaining rich, reliable, descriptive data relating to the lived experience of women's health centre coordinators. Each stage of the research process from the initial selection of participants, to the use of in-depth interviews and the analysis of the resulting transcripts is clarified. A detailed examination of issues pertaining to methodological rigour follows, with corresponding examples of how the research demonstrates appropriate levels of truth value, applicability, consistency and neutrality. Relevant ethical considerations and limitations of the study are also outlined and discussed, and finally, the pilot study is used to demonstrate the credibility and validity of the completed research investigation.

Sampling

The qualitative research method requires that only a small number of participants be used (Rissmiller, 1991). The strategy for sampling most commonly employed in phenomenological inquiry is obtaining a purposive sample, whereby the researcher selects participants according to the needs of the study (Bogdan & Biklen, 1982; Diers, 1979; Glaser & Strauss, 1967; Patton, 1990, Polit & Hungler, 1995). This method is used in order to gain access to selected cases and to obtain a rich descriptive data base (Streubert & Carpenter, 1995). The focus of purposive sampling is to target people who have experienced particular events, incidents and experiences, rather than seeking to satisfy a set numerical quota of people (Parse, Coyne & Smith, 1985; Sandelowski, 1993).

Furthermore, as the phenomenological method involves in-depth analysis of data, large amounts of research data are generated, which together with transcription, coding, analysis and journalling by the researcher, results in a time consuming and labour intensive process. This time demand, in itself, prohibits the practical use of larger numbers of participants.

The selection of participants who are likely to supply information-rich data for in-depth, phenomenological analysis is crucial to the logic and power of purposeful sampling (Patton, 1990). This was taken into account when considering participants for the present study by selecting those individuals who had at least six months experience working as women's health centre coordinators. Criteria for inclusion in the study were women who were working as coordinators in regional urban women's health centres in one Australian state. The study did not include rural centres or centres which have a single service function for women, such as sexual assault centres, family planning clinics or domestic violence refuges, as this was beyond the time and financial constraints of the study. The scope of this research was limited to those centres which fell under government guidelines of regional women's health centres and which served general clinical and/or information and referral health services to women. This particular group of people was chosen for their specific working roles and experience considered relevant to the research and who were, therefore, thought to be appropriate and adequate (Morse, 1986; Patton, 1990; Walker, 1985).

Once the sample population had been identified, the process of 'hand-picking' respondents who met the study criteria followed (Polit & Hungler, 1995). Since the

researcher did not have access to information about potential participants, it was decided that the snowball technique be used as an additional aid in the sampling process. In snowball sampling researchers begin with the relevant contacts available to them and ask these people to recommend potential respondents (Sarantakos, 1993). This technique is particularly useful when the researcher may be regarded as an 'outsider' or when interviews may elicit personal or sensitive material. As both these factors were present in the current research, the snowball method was considered a suitable option.

Three initial sources of contact across a broad geographical area were therefore used to begin the snowball sampling process. However, only one of these contacts eventually led to willing and appropriate respondents. The other two contacts independently stated that the uncertain political climate for women's health centres in their respective regions of Australia may reduce the ability of respondents to provide information freely about their experiences. Consequently, a total of four respondents from one contact yielded seven qualitative interviews.

While the small number of participants and the method of sampling may elicit information that is not evenly distributed amongst the total population of women's health centre coordinators in Australia, or women working in similar settings, it is important to note that this is not the primary aim of phenomenological research (Diers, 1979; Polit & Hungler, 1995). The researcher was also aware of the limitations and criticisms of using such sampling techniques. It could be argued that the sample is

biased by virtue of the selection process, however the aim is to use the bias "positively as a tool to facilitate the research' (Morse, 1991, p.138).

The four women who met the criteria were invited via written and telephone contact to participate in the study. Due to the significant geographical distances between the researcher and study sample, a letter of introduction formed the initial mode of contact, and provided information about the research in order to assist prospective participants to make an informed choice about whether to participate (see Appendix A). This letter was followed by telephone contact to ascertain verbal expressions of interest by participants. Consent forms outlining the purpose of the research, the research questions and the level of involvement required by the participants were then posted to potential participants (see Appendix B). This process was designed to allow participants time to consider all the information prior to the researcher phoning them to answer any questions they may have had and to establish verbal consent. Interview times and venues were then negotiated between the participants and the researcher, and these were confirmed in writing by the latter.

All of the women who met the criteria agreed to participate in the research, resulting in a sample size of four. Each coordinator had been employed in their jobs for a minimum of 12 months, with three of the four coordinators having been in their current positions for three years or more. Two of the women had previous management experience, the others had come directly from women's health centre or project worker positions.

Data Collection

Data collection was primarily achieved via the use of in-depth interviews, supplemented by the use of verbal, open-ended prompts, and entries from the researcher's journal. Data collection, phenomenological analysis and validation of the data were conducted concurrently.

Phenomenology demands a mode of data collection that "will present the participant's experience precisely from their particular perspective, i.e. in terms of the significance it has for them personally. What is sought is a first person description that stays in the first person." (Crotty, 1996, p.19). No interview guide or questionnaires were used, the main instrument for data collection in pure phenomenological research being the interviewer herself. As Oiler (1982), Drew (1986), and Morse (1991) suggest, the interviewer becomes the primary research 'tool', whose "task is to facilitate the subject's recall of experience, record the data and then allow it to speak for itself" (Oiler, p.179). Thus, one-to-one, unstructured and open-ended interviews were conducted in order to ensure that participants' accounts were accurately and fully obtained, and to protect the subjective character of the data from researcher bias. The overall method of interviewing was one which encouraged a narrative, helping participants to describe situations and events, telling their stories and anecdotes, and describing their feelings and attitudes in as rich detail as possible.

Data collection was not commenced until a sense of rapport had been established with participants. This initial stage of the research interview consisted of the researcher introducing herself, outlining her reasons for carrying out the research and answering

any questions about the study and data collection process. Participants were given time to re-read the consent form, reassured of confidentiality and reminded that they would be kept informed and involved in the transcription and analysis of the interview material. Participants were shown how the tape recorder operated and encouraged to exert their right to stop recording at any time, if desired. Not until participants were fully informed and written consent was obtained, did tape-recording and interviewing begin.

Interviews were permitted to develop naturally and spontaneously, and, in true phenomenological style, were initiated by only one question. This initial question was open-ended and very general in order to encourage women to speak about what they know to be important about their experience (Crotty, 1996; Oiler, 1986; Swanson-Kauffman, 1986). This question was: *"What is it like, on an everyday level, to be a women's health centre coordinator?"* Thereafter, circular dialogues with participants were encouraged rather than a linear, question/answer approach. Use of reflective silences, paraphrasing and active listening responses, both verbal and non-verbal, were used by the researcher to develop rapport and to facilitate comfort and involvement of participants.

Two interviews of up to one hour duration each were conducted, with concurrent analysis, for all but one participant (with whom only one interview was possible) in order to determine saturation. Evidence that saturation had been achieved was indicated not only by obvious repetition of content, but also by participants' uses of phrases such as *"I may have said before..."* and *"I think I talked about that last*

or *"I think we've covered that (topic) in this one (2nd interview) and the last one (1st interview)."*

Participants were interviewed at a venue of their choice, where the level of privacy and comfort was decided by them. General questions were used to facilitate clarification of information. A concurrent analysis of data was conducted so that participants were given the opportunity to expand on, or extend any developing themes from previous interviews. General prompts regarding specific topic areas were used during the second interviews in order to gain clarification on these emerging themes. Focus was given to both implicit and explicit meanings in descriptions and explanations given by participants.

The researcher's biases, presuppositions, theoretical and experiential knowledge was identified and acknowledged prior to each interview and set aside during the data collection and analysis stages (see Appendix C). Great care was taken to avoid leading responses or influencing participants' descriptions, so that each individual's stories clearly and accurately reflected their unique perspective of the phenomenon in question. Strict attention was paid to the phenomenon under investigation as it was being described, allowing it to emerge freely and without restriction. The researcher constantly monitored her own reactions, avoiding all evaluation, criticism or personal opinion. This was assisted by the use of a reflective journal, where personal opinions and reactions were recorded (see excerpt provided in Appendix I). In this way the researcher sought to maximise the likelihood of capturing the empirical reality described by the participants, with minimum interference or contamination by the

researcher's views (Ahern, 1997; Beck, 1992; Swanson-Kauffman & Schonwald, 1988).

The data collection stage involved the tape recording of all interviews, so that the researcher was free to attend to non-verbal cues and to give participants her undivided attention. Tape recording allows the researcher to obtain a complete record of the verbal interaction between participant and researcher, enabling greater analytical depth. Data is thus preserved in tact, increasing the accuracy of the data collection process and enhancing validity (Munhall, 1994a; Schwartz & Jacobs, 1979). As audio-taped interviews do not capture non-verbal data, these were recorded in the researcher's methodology journal, where personal reflections and comments regarding the interview process, interactions with participants and, later, memos relating to the analysis of data were noted. Regular journalling was also used to control for potential researcher bias, and provided another source for the triangulation of data (Kimchi, Polivka & Stevenson, 1991; Marshall & Rossman, 1989).

Data Analysis

Four women's health centre coordinators participated in the study. Data was obtained via research interviews, stored on tape, and transcribed ready for analysis. Each participants' interview(s) were transcribed and each transcript of the participants' descriptions of their experiences were analysed using Colaizzi's (1978) phenomenological method.

The transcription of the audio-tapes were carried out by an experienced transcriber who reproduced the nuances of verbal expression such as the idiosyncratic use of voice, inflections and tone of each participant by the use of inverted commas, dashes, exclamation marks, dots and brackets. Laughter, whispers, expletives, and side-comments were also typed into the transcripts. A thorough check was conducted by the researcher of all transcripts and any mistakes or gaps were corrected in the final version of the transcripts. Repeated exposure to the original transcripts in the checking and re-checking of them facilitated subsequent data analysis through familiarisation with the material.

The transcripts were entered into the Q.S.R. Nud.ist program, a computerised package designed to aid in the analysis of non-numerical and unstructured data in qualitative research. The Nud.ist computer software package was chosen for its suitability to the task and the researcher's knowledge of the program's scope. This software is particularly useful for large amounts of detailed data requiring thematic analysis.

Organisational and storage properties are the primary strengths of the Nud.ist package, despite its capacity to perform other data analysis functions. In this study, the data was manually analysed into codes, categories of meanings and theme clusters, and concurrently stored, indexed and cross-referenced. Each line of text in the transcripts was numbered by the Nud.ist program for easy cross-referencing and organisation. Significant statements were extracted which pertained directly to the phenomenon of interest. Meanings were formulated from approximately 430 significant statements and compiled into 17 thematic categories. These categories were then organised into

four clusters of themes. Finally, these themes were synthesised into an exhaustive, descriptive statement about the essence of the lived experience of women's health centre coordinators.

The specific steps used to conduct the thematic analysis are derived from Colaizzi's method of phenomenological analysis (Beck, 1992; Colaizzi, 1978; Crotty, 1996). Each step of this method is outlined below:

- each of the transcripts were read several times in order to get a sense of them;
- significant statements and phrases were extracted as they directly relate to women's health centre coordinators' experiences;
- from these significant statements, meanings were formulated;
- these formulated meanings were then organised into clusters of themes;
- saturation of the themes was ensured such that no new data could be found;
- the results of the data analysis were synthesised by exhaustively describing the experience of being a women's health centre coordinator; and
- these exhaustive descriptions were validated using member checks, ie. these descriptions were then sent back to the respondents to verify their content.

To begin discovering the meaning of the lived experience for each participant, and to obtain an overview of the data each tape was replayed several times while reading the corresponding transcripts. This process allows the researcher to fully immerse herself in the research material, becoming "extraordinarily familiar with the data" (Field & Morse, 1985, p.97).

Subsequently, the researcher combined her experience of the interviews, tapes and transcripts with the technique of imaginative variation in order to examine the relationships between the component essences of the phenomenon under investigation (Spiegelberg, 1976). This combination is described by Oiler (cited in Munhall & Oiler, 1986, pp.78-79) as highly desirable, as it uses "experience and intuitive procedures in conjunction, to synthesise knowledge about a phenomenon". This interpretive process was achieved by exercising reflexivity, attending to each aspect of the data and by the researcher reflecting on her own thoughts about the phenomenon as details emerged into view. This process was essentially an iterative one, necessitating the researcher to repeatedly switch between her own reflections on the data and immersion in the data itself. The researcher used memos to track her 'voice' in this process, as distinct from the voices of the participants. According to Ahern (1997), the role of the researcher during this stage of analysis is to keep an open mind in order to avoid premature closure.

Content analysis was used to extract significant statements and phrases relating to each participant's lived experience. Field and Morse (1985) give an example of this process:

> Passages or paragraphs are reviewed within the context of the entire interview in order to identify and code the major thrust or intent of the section and the significant meanings within the passage. This permits the overt intent of the information to be coded, in addition to the analysis of the underlying meanings in the communication (p.103).

This method is not without its risks, as reliability may be reduced due to the possibility of the coding becoming too subjective (Field & Morse, 1985). However, the use of multiple interviews in the present study served to enhance reliability, enabling cross-

checking of information between interviews for each respondent, and increasing the depth of investigation and thoroughness of data collection.

Meanings were formulated from the 430 significant statements resulting in 70 in vivo codes. This was achieved by reflecting on each significant statement in the context of the original transcript (Munhall & Oiler, 1986). Examples of these statements and their corresponding codes are provided in Appendix D.

These codes were analysed for similarities and differences, then collated into 17 categories using the line referenced transcripts generated by the Nud.ist program. Appendix E gives an example of how the Nud.ist program numbered each line of each transcript to enable easy cross-referencing into categories. Appendix F contains an example of the decision trail for one of these categories, using the line numbered transcripts as reference points back to original statements and their corresponding in vivo codes. A partial audit trail for this process of analysis was created using a simple tree diagram (see Table 2, Chapter 8).

The four main theme clusters that finally emerged from the data represented a comprehensive collation of the original significant statements made by each respondent as they related to each theme. Memos made by the researcher about each of the themes were recorded in her data analysis journal (see Appendix H). The analysis using the line numbered transcripts generated via Nud.ist, together with the significant statements relating to each category within each major theme, as well as each theme's accompanying memo, all provide evidence of the decision trail used to

arrive at the final four theme clusters. Description and discussion of these themes are provided in Chapters Four to Seven.

Methodological Rigour

Many authors over the past 15 years or so have discussed and described in depth the issues relating to methodological rigour in qualitative research (Guba & Lincoln, 1981; Leininger, 1985; Lincoln & Guba, 1985; Miles & Huberman, 1984 & 1994; Morse, 1991; Munhall, 1994a; Sandelowski, 1986 & 1993; Yin, 1984). The four main factors necessary to satisfy tests of rigour in both quantitative and qualitative research are, according to Guba and Lincoln (1981), truth value, applicability, consistency, and neutrality. In qualitative research these factors are termed as creditability, fittingness, auditability and confirmability respectively. In the following section, each of these factors will be defined, followed by examples of how the researcher demonstrated rigour with respect to each factor.

Creditability

In quantitative studies, truth value relates to the internal validity of the research, while in qualitative research the truth value lies in the creditability of the findings (Guba & Lincoln 1981, Lincoln & Guba, 1985). Creditability is the degree to which the study presents descriptions of a phenomenon or experience such that participants, researchers or other people would "recognise the experience when confronted with it after having only read about it in a study" (Sandelowski, 1986, p30).

Creditability was enhanced by the use of a co-coder as an independent judge for the phenomenological analysis. Credibility and validity of data was further strengthened by the use of member checks, whereby participants' opinions were sought at various stages of the data analysis process. Validation of the data was thus conducted concurrently with the data collection and analysis. This was achieved by inviting each participant to edit their transcript from the first interview, noting any omissions, additions or other desired changes. This process was repeated following the second round of interviews. Following the end of the data collection period, and at various stages of the data analysis process, participants were asked to comment on the formulated categories and themes and to verify that the final exhaustive description of the lived experience of women's health centre coordinators accurately captured the essence of their experience (Lincoln & Guba, 1985).

Extensive inclusion of direct quotes from participants' transcripts are included in the findings of this study in order to increase the authenticity of the data. In this way the transition to theme clusters from the original data was made clearly visible. This also increases the replicability and auditability of the research (Beck, 1992; Crotty, 1996; Guba and Lincoln, 1985; Rodger & Cowles, 1993).

Potential bias in both the data collection and analysis stages of the study were limited by the identification of the researcher's preconceptions and careful bracketing of these (Beck, 1992; Cohen, 1987; Crotty, 1996; Mitchell & Cody, 1993; Patton, 1990). In practice, bracketing involves the researcher having the primary prerequisites of self-awareness, time to analyse and identify personal preconceptions, and the ability to

articulate these and put them to one side (Ahern, 1997, Cohen, 1987; Crotty, 1996; Oiler, 1980; Pollio, Henley & Thompson, 1997; Schultz, 1994).

Bracketing, according to modern (or 'new') interpretations of phenomenological method helps to ensure that the researcher's views do not contaminate or influence the collection or analysis of data. It acts to enhance methodological rigour, and facilitates the process by which the data reflects the experience of the participants, not the researcher (Ahern, 1997). However, bracketing does not remove the influence of the reciprocal relationship that exists between the researcher and participant. As Ahern (1997) explains:

> The dialogue between researcher and researched should be acknowledged for any possible influence it has on the process of interpreting the text [of the research interview] because the interviewer shapes the interview, but is also shaped by the process.

Bracketing involves the researcher in a reflexive process whereby the researcher views "their own beliefs in the same fashion as they view those held by their subjects" (Ahern, 1997, p.2). The researcher in the present study attempted to be faithful to the reflexive process by employing the same amount of analysis and commitment to honesty about her own preconceptions as she did to the rich data provided by the participants. For example, her status as a white, feminist, middle-class, well-educated, employed female in her 30's was taken into consideration. Her previous work experience in non-government welfare agencies delivering services to a majority of female clients also needed to be identified and bracketed. Any previous readings on the history and status of women's health workers in Australia, including political and sociological aspects of health provision to women were similarly identified and noted.

Potential areas of conflict between the researcher's perceptions of possible findings of the research and those themes that emerged - as they emerged - were noted throughout the period of the research. These musings were recorded in a reflective journal which the researcher carried with her at all times (see Appendix I). Even 'favourite' key words idiosyncratic to the researcher which were used to initially describe emergent themes were carefully noted, checked with her supervisor and, where appropriate, more neutral alternatives were substituted.

The reflexivity needed to ensure successful bracketing and to thus increase the creditability of the research was achieved by the researcher's commitment to ongoing self-evaluation not just before and during the period of data collection and analysis, but was continuous throughout the writing up of the study. Decisions about how to present the findings were analysed and checked with the researcher's supervisor. Ahern (1997) considers this 'post analysis' to be a valuable component in the maintenance and demonstration of rigour within the research. Even so, it is impossible to remove all sources of potential investigator bias from qualitative research, as it is not humanly possible to bracket one's own experience of the world. Even if this were possible, it would not be desirable, because a certain degree of interpretation is necessary in the data analysis process. As Porter (1993) asserts, the key to rigorous qualitative investigation lies not in the seeking of scientific objectivity by removing the effects of the researcher, but in understanding them as fully as possible.

Fittingness

Applicability in quantitative studies is proportional to the external validity of the research, whereas in qualitative studies Guba and Lincoln (1981) recommend that applicability be determined by how well the study can be applied to other situations or contexts outside the original study setting. Applicability not only relates to how well the study 'fits' other comparable situations, but also how closely the findings of the research 'fit' the original data obtained in the study. Thus, in qualitative studies, applicability is commonly measured by the degree of 'fittingness' of the study.

At each stage of the analysis significant statements, categories and theme clusters were related back to the original transcripts of each interview in order to validate them. This process established whether any information in the original transcripts had been overlooked in the clusters of themes, and whether these theme clusters suggested anything that was not implicit in the original transcripts. Throughout the data analysis procedure, emerging categories and themes were scrutinised for any ambiguous, contradictory or seemingly unrelated elements. Where there was ambiguity, further interviews sought to target this, using clarifying questions in order to further explore these aspects. No contradictory or totally unrelated categories or themes were found, thereby suggesting that the findings closely matched the original data, thus demonstrating a significant degree of 'internal' fittingness of the study.

The preliminary findings of the study were presented at two national conferences where some members of the audience identified themselves as women working in either women's health centres or regional community health centres. These women thus

represented work situations similar but not identical to the participants of the current study. Unsolicited, informal feedback from these members of the audience after both of the conference presentations confirmed that the findings were consistent with their experiences of working in women's health centres. Comments included statements such as *"I can't believe someone's doing research on my experiences!"*, or *"I just wish 'So-and-so' (her coordinator's name) was here today to hear your talk, it's exactly what she's been going through too!"* This feedback strongly supports the fittingness of the study, whereby the results obtained by researching one group of participants also fits another context or group of participants. Obtaining data from different sources is particularly useful in order corroborate, elaborate or illuminate the research in question.

Auditability

Consistency in qualitative studies relates to how well another researcher can follow the decisions and analysis of data made within a particular study in order to independently achieve identical or similar findings of the original researcher (Guba & Lincoln, 1981; Sandelowski, 1986). In quantitative studies, consistency is often measured by the reliability and stability of testing procedures. In qualitative studies this is assessed by how well the researcher audits her work and provides a clear 'decision trail' or 'audit trail' so that others can follow each step of the research process.

Auditability was enhanced by the creation of a clear decision trail for the analysis (as in Appendices D-G). This was achieved in a number of ways by providing the following:

- an example of how the Nud.ist computer program numbered each line of each transcript to enable easy cross-referencing of original statements during each stage of data analysis;
- an example of significant statements and corresponding formulated meanings and their link back to the raw data source;
- an example of a category with its component codes (formulated meanings); and
- a diagram showing how themes were derived from categories.

Each of these steps help to clarify the transition from the raw data to the formulated meanings to the final theme clusters (Crotty, 1996; Lincoln & Guba, 1985; Hyner, 1985).

Other features of this study conferring auditability include: the transcription of interviews from audio-tape recordings (Brink, 1991); clarification of the purpose of the study; detailed descriptions of the data collection process; and clear information about how the analysis of data was conducted (Sandelowski, 1986).

Confirmability

Guba and Lincoln (1981) emphasise the importance of neutrality and confirmability to the demonstration of rigour in research. Sandelowski (1986) describes neutrality as "the freedom from bias in the research process and product" (p33). In quantitative research, neutrality is synonymous with objectivity. In qualitative research, objectivity is not the primary goal, so neutrality is more about the confirmability of the research process and findings. Put simply, confirmability 'asks that the inquirer report his data in such a way that it can be confirmed from other sources if necessary' (Guba &

Lincoln, 1981, p.126). In practice, confirmability relates to how well the criteria of creditability (truth value), fittingness (applicability) and auditability (consistency) have been met. As each of these aspects of rigour have been addressed in detail with respect to the current study, it follows that confirmability of the study has been demonstrated.

In conclusion, the words of Sandelowski (1993, p.2) perhaps best sum up the notion of rigour in qualitative research: "rigour is less about adherence to the letter of rules and procedures than it is to the spirit of qualitative work." Sandelowski goes on to say that the best test of rigour is the "creation of true-to-life, and meaningful portraits...of human experience' (p.2). The positive member checks and unsolicited feedback from other women working in similar settings who have seen the findings of this research and identify them as representative of their experiences seem to confirm that the present study has demonstrated appropriate methodological rigour.

Ethical Considerations

Prior to embarking on this research, permission was obtained from the Edith Cowan University Committee for the Conduct of Ethical Research. At all times during the study, the researcher was aware of the vital importance of maintaining a commitment to "describing the experiences of others as faithfully as possible" (Munhall, 1994a). Overall, the researcher's ethical position was one of recognition that people are never obliged to assist with research, and this was appropriately conveyed to all participants. All individuals were recognised as having the right to self-determination and free choice.

One of the most important ethical considerations for this study was that of obtaining informed consent. All the relevant information respondents required to make a decision to participate was provided in the letter of introduction, consent form and telephone contact with the researcher prior to beginning data collection. Furthermore, the researcher remained as neutral as possible about prospective participants' involvement in the study, that is, no personal investment was made by the researcher in the participant's choice to participate. In this way, coercion of participants was avoided, and reassurances were given that no prejudice or penalty would be incurred should they decide to decline involvement *at any stage* of the study. It was pointed out to respondents that the researcher had no formal association with any Women's Health Centre, health department or funding body in Australia, and was not a member of staff, committee member or direct colleague of any participant. The researcher had no professional association of any kind with any of the participants.

All participants were treated with respect, confidentiality and in a non-judgemental manner. A participant's right to privacy was upheld at all times, ensuring a private room for conducting interviews, as well as keeping all tapes and transcripts anonymously coded and locked away in a safe place. Only the researcher had access to identifying material; co-coders knew participants only by pseudonyms and code numbers. All records have been and will continue to be kept secure for a maximum period of five years, after which time the data will be destroyed.

Confidentiality was assured and specific details about how this would be maintained was given on the consent form and verbally. All respondents were informed that confidentiality would be upheld except in the following two unlikely scenarios:

- if the research data was subpoenaed for use in court;
- if the respondents disclosed information about persons under 18 years who were being abused.

Consequently, this final report contains no identifying information about any participants or their centres.

Furthermore the researcher was aware of the full range of possible responses by individuals to interviews which may have uncovered sensitive or personal information. The researcher was prepared to make appropriate referral should the data collection process have triggered an unwanted or unpleasant reaction. While this was not necessary in practice, the researcher had educated herself regarding referral resources local to all participants, should this have been required.

Limitations of the study

Phenomenological studies are unique in that any potential limitations which usually apply to quantitative research methods are not relevant. Phenomenology is not concerned with satisfying sample size quotas, nor does it seek to provide results which prove themselves to be widely generalisable. Furthermore, in phenomenological research, any possible sources of error or bias in sampling, data collection and analysis are countered by strict adherence to the criteria governing methodological rigour.

Given that the current study has provided clear evidence regarding each aspect of rigour, any possible limitations relating to the research have been addressed.

Above all, the focus of this project has been to access the *essence* of the *experience* of women's health centre coordinators who participated in the research, and as such, the study is necessarily bound only by the natural parameters of their individual and shared experiences.

The Pilot Study

A pilot study was conducted prior the commencement of the data collection in order to discover possible weaknesses, inadequacies and problems in the research method. The primary function of the pilot study was to obtain any information for improving the project, for testing data analysis software and for assessing the study's feasibility (Polit & Hungler, 1995). Additionally, the pilot study provided an opportunity to practice qualitative research interviewing skills in a real situation, and to test the response of participants to the method of data collection. In this context, the pilot study proved a valuable tool for enhancing the reliability and validity of the research project (Morse, 1991; Sarantakos, 1993).

Pilot procedure

One women's health centre coordinator was interviewed by the researcher for the pilot study. Data gathered from the pilot study was not included in data gathered for the major study. The participant was contacted by telephone and a convenient time arranged for an interview. The nature and purpose of the study was explained to the participant, and a letter of introduction and a consent form (see Appendices A & B)

were sent prior to the interview. Issues of confidentiality and anonymity were discussed and ample time was allowed for any questions to be answered prior to taping the interview. The interview took place at the participant's workplace, and took approximately an hour and a half.

The interview was conducted according to the phenomenological process pertaining to the research, which included the use of one open-ended question to start each respondent telling her story about her experience as a women's health centre coordinator. Each woman's initial surprise at being asked only one question was soon replaced by a fluid account of her experiences, only interrupted by brief pauses and comments like *"are you sure this is what you want, just my ordinary, everyday experiences?"*

This pilot study interview reinforced the researcher's interviewing skills, particularly with regard to interviewing solely for research purposes. For example, the skills demonstrated throughout the data collection process are listed below.

- The establishment of *rapport* during the time spent with the respondent prior to taping the research interview. This process also enabled the researcher to ensure that truly informed consent was obtained, and also allowed good rapport between herself and the respondent to develop.
- An *open-ended* style of interviewing was employed, as can be seen from the use of an initial opening question, allowing the respondent to tell her story in her own way and in her own time.
- *Appropriate probes* were used for clarification and to encourage the respondent to expand on previously mentioned themes. Most of the time only very minimal cues

such as "mm, mm" were required in order to facilitate the elicitation of data from the respondent.

- *Active listening* was demonstrated by the use of paraphrased summaries of the respondent's statements when needed to reassure her of the researcher's interest and to encourage the respondent to continue.
- *Flexibility* of approach was shown by encouraging the respondent to spend as much time with the researcher as required in order to feel comfortable prior to taping the interview; by supporting the respondent in her right to interrupt the research interview, by switching off the tape recorder whenever she indicated a need to take a break or receive reassurance from the researcher; and by remaining open to wherever the respondent wanted her story to go, and creatively working with her to elicit rich data.

The researcher also learnt the value of recording her own personal observations from the pilot interview. These observations were written in a journal immediately after leaving the interview.

Pilot data analysis

As the pilot study involved only one respondent, thematic comparisons of the full participant group could not be conducted. However, non-comparative themes were derived, and the Nud.ist software package was trialed. Colaizzi's (1978) procedural steps were followed, in vivo codes were generated, significant statements extracted, meanings formulated and themes emerged.

The pilot study was particularly useful in the critical analysis of the Nud.ist program as a tool for analysing data according to a phenomenological method. It was found that the tree diagram generated by the Nud.ist program was unhelpful and confusing, and the number of codes able to be stored as 'nodes' in the program was too limited. Consequently, this researcher decided to use the Nud.ist program simply as a filing system and to generate line numbered hard copies of transcripts to aid in the manual cross-checking, indexing and organisation of codes, significant statements and themes.

Since the primary focus of the pilot study was to test data gathering procedures, techniques and analytical processes, the final step of critically reviewing the findings was omitted. It was also considered that any literature review in order to complete the analysis of data obtained in the pilot interview could bias the collection of data in the main study, and was also contraindicated on the basis of the phenomenological tradition of conducting literature reviews *after* data analysis.

Results of the pilot study

Over 150 in vivo codes were manually extracted from significant statements made by the respondent during the pilot interview. These codes were analysed manually, then collated into categories, then into the main theme clusters using the Nud.ist program. Appendix G, give an examples of statements, codes and categories derived from the pilot study.

The results gained from the pilot study suggest that overall, the techniques and procedures initiated were successful in gathering rich, descriptive and relevant data

from the pilot study participant. Audiotaping the interview, spending time developing rapport with the respondent, using a single open-ended question, writing out a verbatim transcript and then analysing the data by extrapolating significant statements and meanings, proved to be useful steps in gaining insight into the everyday experience of a woman's health centre coordinator. The richness of the data, the willingness of the respondent to talk about her experience, and her enthusiasm and support for the goals of the research confirmed the feasibility of the study.

Discussion of pilot study

The use of a tape recorder during the interview proved to be extremely valuable and useful in gathering and analysing the data. When the tape was replayed, much of the information was beyond the recall of the researcher. Taping the interview also provided a means to document the participant's vocal inflections and range of emotions. The audio tape and transcripts combined to provide an extremely effective means for the researcher to immerse herself in the data prior to analysis.

The position of the tape recorder was also found to be important, both in terms of best sound resolution and least distraction to the respondent. As a result of the pilot study, equipment better suited to the purposes of data collection was used for the research, namely the voice activated microphone of the pilot study was replaced by a multi-directional, sensitive mode microphone for better sound reproduction. This latter device reduced transcription time and cost due to the better sound quality of the taped interviews.

The format of the interview procedure was also modified in minor ways as a result of the pilot study. For example, the introduction of the tape recorder in the main study was changed to increase participant comfort, by encouraging participants to play with the controls, do 'dummy runs' if they wished, play back small samples of our preliminary conversation, and to reinforce the option of turning the tape recorder on and off at any time during the interview according to their wishes. This appeared to enhance rapport and trust, and assisted the respondents to feel more in control of the data collection process.

Another important outcome of the pilot study was the necessity to bracket out personal attitudes and opinions and to focus on the primary research question which concerned the respondent's thoughts, feelings, world view and experiences. While bracketing is a variation of the techniques used by the researcher in her profession as a counsellor, the pilot study helped her to practice this skill in relation to a research interview.

Overall, the pilot study was enormously successful in aiding the interviewer to feel more confident about her skills and the pattern that future interviews might take. This greater comfort and confidence is likely to have enhanced the establishment of trust and rapport with respondents in subsequent interviews, increasing the likelihood of obtaining rich, descriptive data in the main study. Thus, the pilot study proved to be a valuable inclusion in the larger research process, not only as a means of testing and evaluating the research structure of the main study, but also as a process of personal evaluation of the researcher's data collection and analysis skills. Both the technical

and personal evaluations contained in the pilot study are therefore used to make a claim for credibility and validity of the completed thesis.

Summary

In this chapter the selection of participants, methods of data collection and analysis were presented. The process of conducting un-structured interviews to facilitate the natural unfolding of each woman's story about their experience was outlined, and the importance of methods to protect the subjective character of their accounts from researcher bias was emphasised. The thematic analysis procedure outlined by Colaizzi (1978), and its application to the analysis of each woman's interview data was defined. The themes which emerged from this analysis are presented in the following Chapters Four to Seven. Each chapter contains a detailed description of one of the four emergent themes, using verbatim exerpts of participants' stories to highlight each aspect of each theme (each participants' direct quotes are presented in italics, and their given names are pseudonyms). In this way, the common and shared meanings of the experience of women's health centre coordinators can be best appreciated, giving full value to their words and their unique style of communicating their experiences.

CHAPTER FOUR

Shared Principles, Passions and Rewards

Introduction

> *"This is the commonality that we've got. I don't need to struggle any more about whether we are far enough feminist or radical or anything, because these are the principles. It was clearly something that was clear...we actually defined some key things in women's health that we wanted to maintain. And so I think by doing that we actually created a strength, and as I say, for me, it then became a positive."* (Mary)

In these words Mary describes one of the strongest themes to emerge from the analysis of the interviews of women's health centre coordinators: their sense of having shared beliefs, goals and principles. All coordinators identified the importance of working with a team of co-workers and belonging to a network of women's health centres where their shared principles are recognised as a vital component of their work. They spoke in terms of the ideologies of feminism, empowerment and a social perspective of health which help to maintain their energy levels and provide them with the necessary rewards to keep working in the ever-marginalised, under-resourced setting of women's community health centres. In particular, their core feminist principles, shared by all the coordinators interviewed, provides them with the guiding framework for their work, and a powerful source of passion, commitment and personal satisfaction in their everyday working lives.

A key finding of this study is that the coordinators of women's health centres have a clear vision of why they are doing what they are doing. It is not unusual for the management of large or small corporations to have a vision of their work (Martin, 1990; Weeks, 1994). Indeed, this is commonly expressed in mission statements and

strategic plans. What is unique in women's health centres is the nature of the vision, and the notion of a shared approach and understanding of that vision:

> *"We all have a much more shared understanding [of what we do], and the organisation has as its values in its role document that feminism is part of the underlying principles, or values of this organisation."* (Karen)

> *"We've got something special to offer from women's health. It is a feminist perspective..."* (Sue)

What emerged from the experience of the women in this study is that feminism, and how that relates to the management of their centres, is a core value. This raises some interesting questions. What are the common values shared by women coordinators? How do they keep these values alive as economic rationalism and privatisation threaten the very existence of their specialist, alternative health services? What are the practical management difficulties of negotiating alternative visions of health care in a context espousing rather different principles and practice? Furthermore, how do women managers working in marginalised and under-resourced alternative health services maintain their motivation, and what role does personal commitment and job satisfaction play in this? In this chapter, each question will be explored in turn to demonstrate the importance of shared principles, passions and rewards.

The importance of shared principles

A significant aspect of women's health centre coordinators' everyday experience of their working lives was the importance of having clearly stated principles for practice. These principles provided a common understanding of the goals of women's health centres, and were shared by all coordinators interviewed. Their belief that these principles are shared by their staff means that they do not have to fight within their

own organisations for common understanding. In fact, the converse was found to be true. It emerged from this study that the existence of a common ideology was crucial to their work as managers in clarifying their purpose and practice. Sharing these principles - having *"a joint purpose together to help make things different for women,"* was an important essence of their experience as coordinators of women's health centres.

These findings are substantiated by the many authors who have pointed to the significance of the core ideologies of feminism, empowerment and the social model of health to the principles and practice in the women's health movement (Kenwood & Hanson, 1996; Hunt, 1994; Kneipp, 1997; Shaw & Tilden, 1990; Weeks, 1994). As Hunt (1994, p.57) observes:

> In combination, these ideologies have facilitated a new approach to women's health which is now enshrined in daily practice at women's health centres and in the constitutions of women's health organisations.

The notion of a shared philosophy was the over-riding theme that emerged from the coordinators' descriptions of their experiences. *"Clearly explicated baseline principles and assumptions"* were stated as essential in guiding women's health centre coordinators in their work. They talked about their struggles at times to define and publicly state these baselines and to negotiate around them. For one coordinator, Mary, a formal document was developed that gave her and her Centre *"the framework to continue the discussions and to resolve issues."*. For others, the principles have been just as important, although not necessarily transcribed into a formal document or mission statement.

The coordinators' statements reflect not only the importance of the guiding principles, but also the diversity of response of such managers to the existing demands of working in the women's health field. For example, each coordinator stated that they needed to work on their own version of each of the guiding principles of the women's health movement in order to convert them into a practical, working mission statement. Table 1, below, provides a specific example of one women's health centre's summary of the core principles governing its operation.

1. The health of women is integrally linked to their position in society.
2. Women's position in society does not give them equal access to economic, social and political resources and that this inequity creates a significant health disadvantage.
3. Women have a right to the control of decisions over their health.
4. Women have a right to information which will enable them to make decisions appropriate to their needs
5. Women have the right to the resources required to achieve and maintain good health and to prevent ill health.
6. The full and informed participation of women in all aspects of decision making about health and health care is one of the principal means by which their health will be improved and maintained.

Table 1: An example of one women's health centre's guiding principles.

While the above document is largely representative of all women's health centres' principles, some differences were evident. To illustrate this, a more general statement of the guiding principles of women's community health centres is provided in Appendix J. Information in this Appendix has been summarised from the NWHP, the

work of Shaw and Tilden (1990), and the Manual of Standards which is used to evaluate all community health centres in Australia (CHASP, 1993).

What is clear from the current study is that the key ideologies of feminism, empowerment and the social model of health form an important backdrop to the everyday experience of women's health centre coordinators. These ideologies help them to shape the common, guiding principles which constitute the focus of their centres, and their own roles as managers. It is, therefore, pertinent to explore each of these core ideologies in relation to their experience as managers of women's health centres. What follows is an exploration of the core ideologies that have influenced women's health workers' views about women's health, and in particular how women's health centre coordinators view these ideologies as a significant, guiding feature of their work.

Feminism

The women in this study emphasised the importance of shared feminist principles, and in so doing, did not specifically identify any one version of feminism. Instead, they spoke of feminism in a collective sense:

> *"...this is the commonality that we've got. I don't need to struggle any more about whether we are far enough feminist or radical or anything, because these are the principles. It was clearly something that was clear. And it is that stuff about what is a feminist and what is feminism, stuff. Now I don't think that we defined feminism by those principles but we actually defined some key things in Women's Health that we wanted to maintain. And so I think by doing that we actually created a strength, and as I say, for me, it then became a positive."*
>
> (Sue)

Another coordinator, Clare, spoke of the shared ideology of feminism as a given, almost unquestionable premise upon which their work rests, however, much discussion occurs amongst staff regarding different views within a feminist framework.

> *"I don't have to battle with men or women around feminism. We have discussions that are different, and we have different views, but it's a discussion, and it's not a closed book, and I don't have to argue a case for feminism like I would in another workplace."*

In fact, one coordinator revealed the difficulty in identifying a particular feminist stance in relation to service provision:

> *"But the struggle I have had, and others have had, is how do we articulate what feminist service means? And so I have often felt lost in which version of feminism we are we talking about..."* (Mary)

Such confusion is not surprising given that the feminist ideology upon which the women's health movement is based is diverse, representing many different perspectives within the overarching embrace of an ideology against the oppression of women. Tong (1989), in her exploration of the diversity of contemporary feminist traditions, identified seven main types of feminism: radical; liberal; Marxist; socialist; existentialist; psychoanalytical; and post-modern. At the end of the 20th Century, one of the most popular of these is the postmodernist perspective (Cixoux 1981; Irigaray, 1985; Kristeva, 1982). This is due, in part, to the way postmodernism has revealed the pervasiveness of gender-related power imbalances in society, across all social, economic and physical boundaries (Eagleton, 1991). Of particular relevance to the women's health movement is the work of Foucault (1974), who explored the manner in which power is exercised through medicine. Also popular, particularly with regard

to social action and reform, has been a combination of the Marxist, liberal and radical schools of feminist thought.

To illustrate the diversity of feminist interpretations amongst women's health workers - including coordinators - one of the women's health centres in the current study spontaneously generated a list of definitions of feminism (Appendix K). Perhaps the acceptance of such diversity explains why the coordinators interviewed in this study did not seek to identify with any one type of feminism.

The experience of the women managers in the current study is supported by feminist writers. For example, Stanley and Wise (1983) claim that any attempts to classify separate strands of feminism is largely an academic exercise, as most feminists individualise their points of view, resulting in a unique synthesis of different aspects of each type of feminist thought. Similarly, Hunt (1994, p.65), in her study of women's health movement workers in Australia, found that her respondents "actually opposed any doctrinaire approach to feminist ideology". The focus instead, was on maximising women's choices and acknowledging that all women have the right to choose what they believe and how they wish to express their beliefs. Weeks, (1994, p.133) summed up the apparent irrelevance to women's service managers of publicly aligning with any one strand of feminism by stating that, "feminist analysis is about understanding, naming and defining issues for practice and service delivery from the perspective of women's experience".

While, there may be diversity regarding some aspects of their philosophical base, all coordinators expressed the importance of *"core feminist principles"* to their approach to their work in women's health. These principles are based on a sound understanding of women's experience, women's points of view, the position of women in society, gender analysis, feminist theory and women-based, democratic organisational practices. Their focus is on the need to listen to what women are saying, to learn from them and each other, and to share their knowledge in a respectful and empowering way.

> *"There's definitely respect for each other's view, and acceptance of that. I mean, you know, we'll work through different views and people sometimes have to give up things, and that happens."* (Clare)

This statement has crucial implications for the everyday management of any service, although it is particularly relevant for organisations such as women's health centres based on feminist principles. For example, women's health centres acknowledge the importance of shared, collaborative decision making and the empowerment of women - both as clients and staff - as part of that process (Broom, 1991; Martin, 1990; Weeks, 1994). In the current study, the coordinators identified that a significant issue for them in their management of their services is the ability to respect each others' views, while still being able to facilitate the making of a final decision. Their abilities to effectively 'manage' this process is a key component of their work. A fair and collaborative approach to management sets them apart from many forms of mainstream management, where more hierarchal or authoritarian approaches to decision making are likely to be encountered (Brewer, 1994; Gilbert & Nelson, 1991; Weeks, 1994).

All of the women in this study identified themselves as 'feminist managers'. As Karen put it, the setting up of the service along *"feminist lines"* has influenced her to manage along *"the right lines of management practice"*. Clare expressed it thus:

> *"Yeah, it's actually really important for me to be able to work in a feminist organisation, be a feminist manager, and that means valuing the work and trusting the work that workers do."*

The collaborative relationships, favoured by the feminist coordinators in the current study, focus on "shared purpose, values and strategies amongst managers and employees that lead to joint decision making processes and commitment" (Brewer, 1995, p.44). They are distinguished from other employment relationships by their philosophy of putting collective goals ahead of self-interest, and are located in a culture based on active participation and equality.

The identification with the title of 'feminist manager', mentioned by all the women in the current study, provides evidence of the importance of background ideology. Their belief that such management approaches represent 'best practice' was also mentioned, as Karen stated earlier. This finding is supported by Broom (1991, 1998), who states that women's health centres have always focussed on a collaborative approach, not just in terms of organisational structure but with regard to all aspects of team work and communication. The shared philosophies of feminism, empowerment and the social model of health, and feminist principles of organisational practice have also ensured that "collaborative and participatory-democratic" processes predominate in women's health centres, as well as other feminist services (Weeks, 1994). That a collaborative approach has endured over the entire history of women's health centres points to the

value of participative working strategies as good management practice, not just an ideological imperative (Broom, 1991; Egan & Hoatson, 1998; Martin, 1990).

Furthermore, collaboration and participation in feminist services represent a deliberate and political strategy to resist the hierarchy of patriarchal working relationships (Broom, 1991). As Weeks (1994, p.134) summarises, the range of implications of democratic and collaborative processes for feminist women's services are:

- total organisational form, as in collectives;
- decision-making structures;
- division of labour;
- shared authority and leadership; and
- participatory models of service delivery.

While the women managers in this study did not pause in the spontaneous recounting of their experiences to list the above strategies as part of their practice as feminist managers, they did emphasise the critical value of having a shared social and political purpose, common principles of practice and favouring a facilitative approach to staff and service delivery. For example, as Karen articulated:

> *"I mean, I often end up having to make the final, final decision, but the process of facilitating that outcome with staff, and which takes ages sometimes, is important, and that's a big part of my job..."*

Weeks' (1994), in her analysis of the differences between coordinators of feminist services and women managers in more traditional organisations, supports the comments of the women managers in the current study. She concluded that feminist managers operate from a group-centred model of leadership, concerned with joint

political and social purpose, context and principles of practice; a model of management which she labelled as "woman-centred democratic coordination". This model focuses on working within a team to develop an overall vision and joint goals, developing the team by valuing each individual's contributions, keeping centred on the purpose as well as the process involved in maintaining an effective and useful service. She also stated that often the final decision-making component of these processes were left to the managers to negotiate, however, co-workers were consulted fully.

The centrality of feminist philosophy to the work of women coordinators in this study is clear, and yet their reported management styles reflect a departure from the radical, collective style of management of women's health centres in the 1970's and 1980's. As Mary put it, *"we all know that collectivity wasn't really that, was it?"*, suggesting that the notion of feminist collectivity as a management strategy did not always work, and was often difficult to implement in its purest form. Partly, the divergence from collectivism has been forced on women's health centres by amalgamations and hierarchal funding structures, but also partly because collectivism has ultimately been found to be impractical (Egan and Hoatson, 1998). The women managers in this study identify key components of their practice as being informed by a core feminist philosophy, as well as by pragmatics. They also did not employ labels for the type of feminism that guides them.

Feminist principles are at the core of women's health centre coordinators' belief systems, and clearly underpin the women's health movement and the network of women's health centres. Most of all, the sense that their beliefs are shared by co-

workers and other coordinators is a source of strength and confidence to them in their jobs. As one coordinator, Mary, expressed it, *"...this is my strength, being able to hold on to those feminist principles."*

This section has explored the range and diversity of feminist perspectives and highlighted that, in practice, distinctions between these perspectives are essentially theoretical. The immediacy of everyday experience appears to render such distinctions secondary to the more pragmatic concerns of facilitating choice and empowerment for women. Furthermore, the findings presented here reveal that the key ideology of feminism has influenced the working identity and methods employed by coordinators, leading to a feminist management philosophy.

Empowerment

> *"I just want women to get something that is useful and empowering, that they can have control over. I want them to get that in their lives somewhere, and I think this is one place where you can get it".* (Clare)

As Clare notes, a key ideology underpinning the work of women's health centre coordinators is the notion of empowerment, specifically of women, whether they are co-workers, clients or women in the general community. That this finding emerged from the current study is perhaps not surprising, given that feminism and empowerment are closely interconnected. Feminist ideologies are concerned with the empowerment of women, however it is worth considering the notion of empowerment separately because it is a general concept, not exclusively feminist. Many organisations work to empower individuals, not just women, as in women's health centres, and not necessarily from a feminist perspective (Martin, 1993).

Many definitions of the word empowerment exist, especially with the increasing popularity of the term over the past 15 years or so (Alpander, 1991; Gilbert & Nelson, 1991; Shaw & Tilden, 1990; CHASP, 1993). Some may argue that it has been over-used, and thereby its meanings have become so broad as to render the whole concept 'murky' (Labonte, 1990b). In attempting to seek clarity on this issue, Labonte (1990b), distinguished between the transitive and intransitive forms of the verb empower. Used transitively, the word means to 'bestow' power on others, suggesting that one is giving power to another, an act which in itself could be experienced as dis-empowering. The intransitive form of the word empowerment refers to the gaining or assuming of power, which, according to Labonte (p.73), can occur at three levels: intrapersonally; interpersonally; and within communities.

The present study revealed that empowerment is central to women's health centre coordinators' ideas of the principles that guide them in their everyday work. According to their accounts of their managerial practice, the whole concept of empowerment seems to extend to all levels: intrapersonal; interpersonal; and community. For example, at the interpersonal level, one coordinator talked about the issue of empowerment in relation to the recruitment of a new coordinator, a position which she eventually filled:

> *"So I think there was a fairly strong concern amongst other workers and myself, that we wanted someone who would respect our values and the things that we'd built up and fight to maintain them."* (Karen)

This women's health centre coordinator was also referring to the use of the term empowerment in not just an interpersonal sense, as in recruiting staff who will interact

using the same principles and action as other workers, but also in the wider social action sense of community empowerment. As an example of empowerment at the community level, one of the initiatives of women's health centre policy is the promotion of health in the community, which can also be seen as an exercise in empowerment, particularly in an action-oriented, community sense (Shaw & Tilden, 1990). What women's health centres achieve by health promotion strategies is to empower women to have more control over their bodies and their lives, and thereby "have more opportunity to make healthy lifestyle choices and to control a fairer share of the resources that are linked with better health" (Shaw & Tilden, p.15). This in itself performs a political and economic function, taking the term empowerment beyond the individual and interpersonal levels, into the social reform arena.

The social reform aspect of their work was mentioned by all coordinators in this study as an important, if difficult, aspect of their role. As one coordinator expressed it, the difficulty, from a management perspective, lies in finding ways to meaningfully implement the ideology:

> *"We talk about community participation and women having some say in what we do and that, but I don't think we do that really well. We try to think of ways of doing that, but - it's hard not to be tokenistic...so that is one of my focuses, in which we try to improve that community input; seriously do something about it."* (Clare)

The adoption by women's health centres of an empowerment philosophy, together with a feminist organisational ideology, inevitably leads to a management style that promotes community participation in decision-making. An empowerment approach also leads to an expectation that women's health centre coordinators will actively facilitate involvement of the community at all levels of health care provision.

It is well documented that one of the primary principles of women's health centres is to assist women to make well-informed decisions about their health, and that such decision-making capacity is linked to empowerment (Broom, 1991, 1998; Saltman, 1991; Shaw & Tilden, 1990; Weeks, 1994). For example, in an Australia-wide consultation process to produce a set of guiding principles for practice in women's health centres, one of the main directives was that "there should be community/consumer involvement in making decisions about provision of health care at community, State/Territory and national levels" (Shaw & Tilden, 1990, p.14). Gustavesen's (1988) study supports this rationale, showing that increased decision-making capacity by workers in the workplace is a significant factor in determining health. This is a point which is clearly not lost on the women who run women's health centres and who are charged with making community participation in the decision-making process of their centres actually happen. This is all the more important given the centrality of the ideology of empowerment and its established link to improved health and well-being. However, the process of implementation of such community-based empowerment strategies is not always easy, and requires managers to continue to promote their services in the community. This is especially difficult in marginalised and under-resourced services such as women's health centres, where community perceptions are often not well informed or entirely supportive.

While encouraging community participation in decision-making about local health concerns for women represents a form of empowerment at the community level, women's health centres are also equally focussed on facilitating empowerment at the individual level. This is achieved by providing women with a range of health-related

information so that the empowering process of making individual decisions about one's own health and life is achieved through creating maximum choice. In the current study, providing women with choices was seen as intrinsically empowering, respectful of the individual needs of women, and central to the goals and principles of women's health centres. For example, as one coordinator expressed it:

> *"I think that being part of the women's health movement does offer people real choices, that that's what our service is about, is offering them real choice...and celebrating the diversity of our lives...being involved in a women's health service is to work with that diversity and that respect for diversity in [the] community."* (Sue)

The findings in this study are supported by Weeks' (1994) research. She found that issues of empowerment were crucial to all aspects of feminist service organisation, particularly with respect to involving women in the decision making processes at all levels of service delivery. The managers in Weeks' study also identified facilitation of community participation strategies as important to their role as managers, but did not further elaborate on this aspect of their work, as have the women in this study.

Social model of health

> *"We've got something really special to offer from women's health. It is a feminist perspective, it is something that treats women as whole women, and that's the thing that we convey through our pamphlets."* (Sue)

This quote was typical of the views expressed by the women's health centre coordinators in this study. They saw their role as managers as coordinating the implementation of health services to women that recognised women as *'whole women'*, not just a cluster of reproductive body parts. It was also clear that the women interviewed were proud of their role within women's health centres, and were

themselves committed to the 'holistic' approach to health which recognises the social, political, cultural, economic, physical and psychological aspects of a woman's environment and its impact on her health and well-being.

All coordinators spoke of the importance of the social model of health to their centres, and that their role was to continue to keep the service alive so that women would have a viable alternative to mainstream medical health responses. For example, one women's health centre coordinator in the current study described her experience of the everyday reality of the social model of health as it is operationalised within her health centre, as follows:

> *"I know that women [who] come here, they are going to come in for a nursing or a medical appointment, and it is not just going to be that we [just] take a blood pressure or say: 'You really need to take a pill', you know...If the doctor's appointment is an hour, they are going to look at the whole person. They are not just going to come in and say... 'I can't sleep at night so I've got headaches', and then: 'Yes, well, you take two panadol.' I mean, [there will be] some exploring: 'When do you get the headaches?' and 'What else is happening in your life?'* (Clare)

What isn't apparent here, is the proud tone of voice used by Clare to describe what 'her' service does. This theme was echoed by the other women in the study, who clearly shared the philosophy of a social model of health. It is what their service provides, not a purely medical approach to women's health needs. They encourage an integrated perspective on the issues affecting the health of women, unlike the fragmented nature of contemporary medical health care organisations (Auer, 1990; Broom, 1991; Dwyer, 1992; Stevens, 1995). As Labonte (1990a, p.1) asserts:

> Health is not a biomedically defined state so much as a cybernetically (information-interaction) defined process...It exists in social interaction, and so isolated persons suffer two to three times the risk of mortality independent of

> all other known risks...It encompasses intrapersonal, interpersonal, and environmental (social/physical) factors.

According to Hunt (1994, p.70), the women's health movement, through its other key ideologies of feminism and empowerment, has helped to broaden traditional, bio-medical conceptions of health into a construct which considers the health implications of the social context of women's lives. Certainly, the women's health movement, and women's health centres, as the movement's practical, visible agent of change, have heightened public awareness of the social model of health and provided evidence of its practical and theoretical viability.

Working to facilitate the implementation of the social model of health at the service delivery end of their centre is not the only concern of the women interviewed in this study. Their shared view of the importance of seeing their staff, not just their clients as whole women was also mentioned. For example, as one coordinator said:

> *"It is important to consider how the women who work here feel [in their jobs]. Sometimes making rosters fit their lives, fitting in around child care...are all important considerations."* (Karen)

For another coordinator, the social model of health influences the way she thinks about her role in that it provides her with broader view of her centre, and the role of both alternative and mainstream health services in the entire context of women's lives.

> *"If you look at the statistics of women's health centres, of course we can only service this mini-mini percentage of the women in this state, and that most women their interaction with the health system is with their GPs and with the hospital system, particularly during the reproductive years and when caring for young children."* (Clare)

Her point was that her centre, through its focus on the social model of health, recognises that women's roles are often marginalised, especially if their children are the focus of their lives and their experience of mainstream health systems. In recognising the role of women as workers, consumers, wives and mothers, Sue and Karen shared with other coordinators the central philosophy of a social model of health. This was implemented not just in terms of service delivery, but also with regard to their workers' welfare and broader issues for women in their community.

The social model of health is complementary to the ideologies of feminism and empowerment, because it recognises women as unique and integrated persons, as individuals with lives that reflect the diversity of their environments, and the multiplicity of roles they assume within those environments. As managers, this has implications for the way in which the coordinators in this study view their workers, organise rosters, furnish their centres, and support each other. As Clare and Sue mentioned, their centres need to be *"a nice place to come into"*, where women - workers and clients - can feel comfortable and safe. As managers, the social model of health affects how they view the broader context of their work. That they have a contextual view, is in itself, a notable departure from mainstream health service management.

The social model of health is embedded in the NWHP in Australia. This endorsement helps to sustain management principle and practice in women's health centres (Fatin, 1991). For example, in an Australia-wide consultation process to produce a set of

guiding principles for practice in women's health centres (Shaw & Tilden, 1990), the key missions of their social health policy are as follows:

- to impact on women's lives in a social and economic context as well as on their physical well-being;
- to require that health care systems focus on health development as well as responding to illness; and
- to identify maintenance of health and well-being as a community and public responsibility, not just that of individuals.

The women managers in this study were able to presume agreement on these principles. As a consequence they could use them to fortify their positions as managers.

> *"...that has been my absolute guiding thing, negotiating the amalgamation of the hospital, and now in the way that I continue to work with the hospital I have those bottom lines and principles as my springboard."* (Sue)

> *"So what we did was, we struggled, really valiantly in my opinion in our centre, with what are the bottom line assumptions that we are looking to work with. And so I became more confident that I understood the bottom line principles that we were going to negotiate with at the government and the local amalgamation level."* (Mary)

In summary, women's health centres provide a good example of the social model of health in action in the community. In its implementation, women's health centres necessarily have facilitated a partial re-orientation of the health system towards health promotion and prevention of illness, while still recognising the need for acute care and specialist medical services (Broom, 1991; Dwyer, 1992). As the women who run these

centres, coordinators are charged with the responsibility of overseeing the maintenance of the key ideologies of feminism, empowerment and the social health perspective, in the everyday running of their service. The following section in this chapter highlights the influence that these key ideologies have had on their experience as coordinators.

Implementing the shared principles - practical implications for coordinators

The impact of having a core feminist and social perspective of women's health cannot be underestimated, both in terms of its positive, supportive influence on coordinators, and with regard to its drawbacks. Their philosophies enable them to offer something special for women, and to challenge the dominance of patriarchal attitudes toward women's health and well-being. However, it is inevitably a source of discord in their everyday dealings with what some women's health centre coordinators termed the *"outside world"*. The external pressure placed on them by mainstream attitudes to women's health, and to traditional, male-oriented organisational processes was reported to be considerable. It created conflict between women's health coordinators and their 'line managers', politicians, and other main players in the funding hierarchy.

While tension has always existed regarding traditional versus alternative health services for women (Broom, 1991; Dwyer, 1992; Stevens, 1995) and for feminist services generally (Burton, 1985; Freeman, 1979; Simon, 1982; Smith, 1992; Weeks, 1994), the recent trend toward mainstreaming health services, and other 'amalgamations' has increased the conflict. Mainstreaming increased the necessity for women's health services to communicate with traditional health services about issues central to their identity and purpose such as how their service will operate, and which

programs will be funded or axed. A particular source of difficulty stems from the fact that mainstream health services function with guidelines and policies that were not developed with women and women's issues in mind.

The coordinators of women's health centres are increasingly required to negotiate with the world that exists beyond the shared ideologies of women's health, where feminist values, as one coordinator phrased it, are *"questioned, marginalised, and labelled in derogative ways"*. This holds the potential for women, coordinators and women's services to be scrutinised inappropriately.

Coping with marginalisation and the resulting mis-perceptions by the community and external agencies was a common theme in the experience of the women's health centre managers in this study. Homophobia, for example, was quoted by one coordinator as illustrating the degree to which she and her service was ostracised and minimised by some members of the community:

> *"There are men out in our communities who support women's health strongly. However, I do feel that it's also very threatening for other men, and one of the ways that they deal with that is by calling us a group of Lesbians because they think that's going to hurt us and hurt our reputation."* (Clare)

Weeks (1994), documented similar experiences of marginalisation (including homophobia) by the managers of feminist services whom she interviewed. She also found that the same sort of difficulties were experienced by feminist services generally, with community misconceptions and fears about women's services reported to be prevalent. For example, Weeks discovered that the managers in her study perceived that some people in the community, mainstream services or departments felt threatened

by feminism, or assumed that feminism and lesbianism are synonymous. The implications of such attitudes for managers is that these misconceptions may inhibit positive negotiations between women's services and other stakeholders.

At the very best, negative perceptions or misconceptions about women's health centres occur through lack of knowledge about what they offer. This was articulated by all coordinators. Karen described a general ignorance about women's health generally, whereas Sue discussed specific lack of knowledge about the coordination of alternative women's health services:

> *"There are a lot of women who don't know about women's health centres and what we do...and there are some politicians who would think, not just politicians, but bureaucrats as well, 'Why do we need them? Why are they there? Why do we need specialist women's services?...and that's why we go out and do community liaisons and community groups"* (Karen)

> *"I think that if you talk about how politicians and the bureaucracy in general perceive the [women's health centre coordinator's] position, I think it's with a lot of cynicism, scepticism and you know, downright disregard at times...I think we're still learning about how you work with a government that does not necessarily automatically accept the things that you're talking about."* (Sue)

Karen's comments particularly highlight one of the strategies used by women's health centre managers to educate community and funding bodies about the services and functions of their centres. Community liaison is a crucial component in these educative or public relations processes, and are part of a deliberate strategy by coordinators to combat negative or ignorant attitudes about women's health and the role of feminist services in responding to women's health needs.

Given the often hostile, external environment, coordinators described the need to focus on feminist values, visions and priorities as an important, yet difficult aspect of their

role. Maintaining their ideological integrity amidst negotiations with other agencies, funding bodies and government departments was a high priority for them, as well as a source of internal (intrapersonal) and external (interpersonal) conflict. As Sue observed, the tension results because *"it is about how far you toe the line and maintain the philosophy and things, and how much you can play that and still maintain the service without losing it in the process."*

The coordinators in this study underlined the importance of developing negotiation and advocacy skills as part of their roles as managers, especially in their dealings with an often hostile external environment. The necessity for clarity in their dealings with funding bodies and other agencies, and the central nature of the ideological underpinnings of their centres, resulted in the development of *"clearly explicated principles"* underpinning their advocacy role. For example, Mary stated:

> *"What we really ended up with was a formal document that spelt out the bottom line principles that...would give us the framework to continue the discussions [with funding bodies] and to resolve issues."*

These bottom line principles explicated how far coordinators were prepared to go down the mainstream path in negotiation without significantly compromising the core ideologies of women's health centres. These principles essentially helped each coordinator to feel confident that she was sufficiently upholding the philosophy shared by women's health centres and the women who work in them, while not remaining too radical and inflexible as to risk total alienation and subsequent de-funding. This was clearly a complex issue for the women interviewed in the current study, and most went to considerable pains to describe their struggles to maintain this tricky balance. The following quote highlights the practical, everyday value of these principles to the

confidence of coordinators in carrying out the public relations component of their job. The length of the quote gives some indication of the importance of this issue:

> *"...having those clearly explicated principles, have been the really important things for me. Because it sort of gives me a strength when I go out. But I know that when I am saying something, that this is something that my staff would agree with. And if I am thrown something I've got this framework within which I was formed. And so that is a strength which as an organisation we have developed, and given, I believe, to me, in order to be able to manage things better, whereas in the past I might have floundered and thought 'My God, how do I deal with this one? And what would my staff think, and what would they say?' I don't feel so concerned about that now. I feel I can deal with that stuff."* (Sue)

The struggle by the coordinators to *"maintain the philosophy"* of their centres, while negotiating with mainstream funding bodies is also described in Egan and Hoatson's (1998) work on government funded feminist organisations. They argued that "conflict is an inevitable part of human services, including feminist services", and that the neo-conservative contracting policies being broadly implemented by state governments in Australia are escalating the conflict (Egan & Hoatson, p.3). That women's health centre coordinators experience difficulties with the practical implementation of fundamental philosophical principles in their centres is validated by Egan and Hoatson's critique of the current government trend toward the centralisation and institutionalisation of previously autonomous community services.

The external pressure placed by funding bodies on the philosophical foundations of their centres, as described by all the women managers interviewed in this study, have serious ramifications for the continuation of their work. This pressure represents a different risk to that posited by Riger (1984) who argued in the 1980's that "feminist

organisations were more likely to die from internal bleeding than external pressure" (p.14). Riger was referring to the internal conflicts and tensions within feminist services that Egan and Hoatson (1998) regard as a normal ingredient of any human service organisation. However, in the 1990's, the external pressures exerted by an economic climate that is hostile to feminist philosophies presents government funded feminist organisations with "some rather bleak prospects" (Egan & Hoatson, 1998, p.14). Thus Riger's prediction for the 1980's is more likely to be the reverse in the late 1990's and beyond. Egan and Hoatson (p.14-15) see the future options for feminist services in their negotiations with the external, hostile, funding environment as follows:

- competitive policies are embraced fully with the risk that feminist services are dominated by outcomes and lose sight of their social change role;
- in order to survive, feminist services partially collaborate with current government requirements but risk endemic tension around how much political critique or action they can maintain; or alternatively
- feminist services make a conscious choice to no longer rely on government funding but risk that service provision, as we know it, may not be sustainable.

Broom (1991), suggested that those services most likely to survive will be those able to live with the tensions and contradictions inherent in any attempts by feminist services to implement alternative visions for women's health in a context espousing antithetical principles and practices. According to the women managers in the current study, the shared philosophies of women's health centres are crucial to the work of women's health centre coordinators, and yet presents them with a double bind: keep those

principles in tact and weather the storm of conflict from traditional health services and funding bodies; or sell out, 'go soft' on those principles and become even more vulnerable to developing the very structures, processes and attitudes to women's health that women's health centres and the women's health movement have fought to avoid. What the current study reveals is that the second option does not exist for the coordinators who were interviewed, and their reasons for this are the focus of the remainder of the chapter.

Passionate about their work

> *"I had - and I have - a passionate belief, that we [women's health centres] needed to maintain a willingness to exist. That was the bottom line...I also believed for myself, that I had to put into practice my own value-base..."*
>
> (Mary)

> *"I don't believe that it is just for us people who are coordinators. I think that if you are committed to women's health and if you have a political view of life, you actually then can get to act out your passion within your work..."*
>
> (Sue)

These words are reflective of the level of commitment, belief and passion expressed by all coordinators with regard to their everyday working life as managers of women's health centres. These statements are supported by the work of Weeks (1994) who found that a central component in the work culture of successful feminist women's services, and arguably any organisation, is the level of commitment amongst workers. Weeks noted the importance of a shared vision and clearly stated goals within women's organisations, and stated that one of the essential ingredients identified by women working in an 'effective collective' was the strong sense of commitment and responsibility for "managing the service and making it work well" (p.140). Jaffe and Scott (1988, p.71), conceptualised worker commitment as a link between vision and

passion, concluding that "defining your mission acts as an emotional touchstone that unleashes a powerful feeling."

In her documentation of the natural histories of women's health centres in Australia, Broom (1991, p.84), observed that the kind of commitment to women's health that prompts women to build a health service from the ground up, "may seem to the participants to be unique personal experiences, like falling in love, and so in some ways they are." This statement implies an intensity of belief or feeling for the 'cause', the cause being the revolutionising of the way women's health is monopolised by medicine, and challenging the patriarchal responses of society to all aspects of women's lives.

Certainly, in the early days of "setting up shop", the shared vision was crucial, and high levels of personal commitment mandatory among staff who, in some instances, even made their own furniture for their centres, in addition to working long shifts for little or no pay (Broom, 1991). Today, the challenges are different, with the emphasis less on collective structures, less focus on building centres from scratch, with instead, most energy going into the survival and maintenance of existing services to women (Kenwood & Hanson, 1996).

Despite the changes in women's health focus, and in the size and structure of women's health services, the current study suggests that the shared vision is still just as important, and the passion and commitment to the work of women's health centres is alive and well. All the women in this study mentioned the role of passion in their

work, some seeing the challenges in their roles as requiring the kind of drive and belief that world revolutionaries motivate people to experience. When it came to sharing their feelings for their work, their stories were about helping to contribute to large scale change for women, not just going to work and doing an ordinary job.

> *"I am really passionate about home-based work and what happens to women in those areas, and so we got a grant to do that. And so, you see, I'm not just passionate about women's health issues. To me it's [her vision] is much broader than that."*

Their passion for their work arises from a strong commitment to helping to change the status quo for women in society. In particular, this commitment appears to be linked to supporting women's rights, and carrying out this goal through their work as coordinators of women's health centres. As Karen put it, her role in a women's health centre represents an opportunity to challenge the oppression of women, *"where I can still kind of create revolution in some ways, exposing justice and fighting exploitation."*

All coordinators spoke about the passion they feel about their work, about working with women, for women. For them, it's a way of life that extends into every part of their existence. It's a mission or a vision, a way of thinking about women, women's health, and the world. Their passion also provides the energy and the motivation for the, at times, very demanding nature of the work. As Mary explained, the motivation to keep going, and to keep fighting the battles for survival against funding bodies and other bureaucratic hurdles necessitated a kind of harnessing of her passion. She described the process as needing to *"keep a fervour"* in order to remain focussed on the tasks ahead. Mary also 'used' the passion which existed amongst the other women

within her service to help get her message across to her other (mainstream service) managers and her management committee:

> *"I would just sit back, and they [the other services managers] would have to deal with stroppy women who had passion and fire in their guts...and they would have to actually interact with the women for whom our service existed. And that was a joy for me...because it broke down the sanitised conversations"*

Karen described a similar process, also linked to *"a passionate commitment"* to the principles of the women's health movement, which in turn manifested as having a *"very strong belief in what the service does."* Other coordinators described using feminist ideologies to carve out a vision for their service and their role as managers that was rooted in pragmatics, that was real, not just theoretical or idealistic. One coordinator quoted using role models like Nelson Mandela to remind her that anything was possible, to continue to believe in the existence of women's health services and to help keep her belief, her vision, her passion for the service alive within her.

Finally, all women in the current study spoke about their work as being a privilege, a job where *"you can get to act out your passion within your work"* and where their belief systems are supported in their immediate working environment. For one woman, Sue, the passion for her work is what keeps her going in the job, despite the difficult and hard times, *"If I still didn't get excited by things and if I still didn't feel passionate about it, I'd go."*

Rewards

> *"I could just go on and on about why I like this place [her women's health centre], and why it's really important to me and how much I get out of doing it [her job]."* (Karen)

The notion of what makes a job satisfying and therefore rewarding is a complex one. Many models have been developed in an attempt to understand job satisfaction (Beaumont & Partridge, 1983; Brewer, 1994; Hays & Kearney, 1988; Herzberg, 1987; Kable, 1988; Robinson, 1980; Tompkins, 1995). However, most of them fail because they measure either the person or the job in a linear, mutually exclusive fashion, rather than acknowledge the interrelatedness of the key concepts underlying job satisfaction and personal reward (Tompkins, 1995).

According to Kable (1988), job satisfaction results from intrinsic rewards derived from the work itself. These rewards include, a sense of achievement, recognition for achievement, the nature of the work, and personal growth. Other factors which may influence how rewarding individuals perceive their job to be include the level of participation in decision-making, collaborative team work, a supportive work environment, level of self esteem in the job, and a sense of affiliation with organisational goals and values (Brewer, 1995; Brockner, 1988; Gilbert & Nelson, 1991; Morton, 1990; Tompkins, 1995).

As the following section reveals, the women's health centre coordinators in this study identified each aspect of job satisfaction as very relevant to their sense of personal reward as managers of a feminist health service. Feminist organisations such as the

women's health centres in this study aim to improve their staff and client's self esteem and to employ collaborative approaches to carry out their work objectives (Martin, 1990). The women who manage such feminist services are similarly committed to employing strategies to enhance team work, self-esteem and joint decision-making (Weeks, 1994).

While components of job satisfaction, such as good working relationships, participation in decision-making processes and feeling included in the organisation are self explanatory, a number require further elaboration. Self esteem in the work place, for example, "is present when people feel good about themselves; that is, capable, successful and worthy." (Brewer, 1994). Employees bring to their work settings different levels of self esteem, which, in turn, relate to how they act, feel, and think while on the job. Self esteem in the workplace is difficult to measure and its correlations to other occupational factors such as role strain, job perception, role ambiguity, performance quality, job satisfaction and dissatisfaction, and peer support are complex and non-linear (Brockner, 1988). Nevertheless, self esteem has been positively linked to work commitment, and to the degree to which workers are valued and acknowledged by managers and other staff (Tompkins, 1995).

In the current study, while self esteem was not specifically mentioned, the level of commitment amongst staff and the degree of mutual respect and acknowledgment within their team was identified as a primary source of job satisfaction. All coordinators had the shared experience in their jobs of the rewards of working alongside committed and skilled co-workers. The sense of their beliefs being valued

by each other, and by the community of women who accessed their services, were highlighted in particular. In addition, they all commented on how satisfying their jobs were made by the knowledge that their co-workers support and accept them as individuals:

> *"So that's what keeps you going I think...working with a bunch of women who are really committed and very diverse, very diverse. You know, I sometimes look around my staff room, you know, when we're having morning tea together, and I think, isn't it amazing that this bunch of women are working together?"* (Sue)

> *"What's been in it for me is believing that the service we provide is very much valued by women, that's been one of the real pluses."* (Clare)

> *"...I've got great coworkers. They've been a terrific bunch of women who are incredibly skilled, incredibly committed feminists and who accepted me totally for who I was and who I am...Just really good coworkers."* (Karen)

A collaborative approach to team work, shared organisational goals, a high level of participation in decision-making and a supportive work environment are all positively linked to job reward and satisfaction (Morgan, 1989; Morton, 1990; Robinson, 1980; Tompkins, 1995). Nevertheless, what is most clear from the literature on worker perceptions of personal reward in the workplace, is the critical value of collaborative versus authoritarian, self-interest or purely social relationships between managers and staff (Brewer, 1994; Gilbert & Nelson, 1991).

The benefits to workers of being able to share in the authority, leadership, and decision-making of their workplace has been documented as facilitating greater personal autonomy, increased commitment, greater responsiveness to change, as well as more positive and rewarding work experiences (Considine, 1992; Fairbrother, 1994;

Gilbert & Nelson, 1991; Gummer, 1991; Lebonte, 1990b; Morgan, 1989; Resnick & Patti, 1980). Other advantages of participatory or collective employment relationships, such as those favoured by feminist organisations are: greater involvement and energy; a clearer rationale for decisions; increased sense of a shared vision or purpose for the organisation; preservation and facilitation of individual responsibility and commitment to the goals of the organisation; and increased opportunities for self development, acquisition of new skills, and personal achievement (Gilbert & Nelson, 1991; Tompkins, 1995).

It is not surprising, therefore, that a common thread to reported job satisfaction amongst the coordinators in this study was working in organisations where collaborative decision-making is part of the philosophy of their centres, as well as being compatible with their own beliefs. In particular, all coordinators emphasised the rewards of working with other women who share their same basic feminist principles. In addition to feeling professionally and personally accepted by their co-workers, they felt they were being challenged intellectually and emotionally from a common base of understanding, "*a comfort zone, a base level that we all agree on.*". Two coordinators also described this aspect of reward as:

> *"Well, I suppose the thing for me, that always keeps me going, is actually looking back at the principles of our work and saying 'Well, they may be marginalised but I believe they are really important'"* (Sue)

> *"One of the things that keeps me here is, I think the shared values, and people working together sharing the same political framework. It's really important."* (Karen)

The political, social action component of the rewards in their job, as Karen mentioned, was echoed by the other coordinators, too.

> *"I suppose that [the reward] is part of recognising that I am some sort of political being and that in other jobs that I've had I've always had to bite my tongue, I've had to shut up. I haven't been able to be a full person. So this job enables me to be that full, well rounded person. And so I think that's what keeps you in it, is that if you're passionate about it [the job] and political, it enables you to fulfil all those things."* (Sue)

> *"There's always been a strong tendency here for people to take a political or structural view about the world and therefore our work and who we are. And I like that."* (Mary)

Another highly rewarding aspect of their job with which all coordinators agreed to varying degrees, was the belief that they are part of a process of improving the social and health conditions for women.

> *"There's a lot of satisfaction and there's a great deal of learning to be done by all of us that work in women's health, so it's watching women move and change, and it's [watching] workers move and change along with those women...I desperately want things to change...I want systems to change, I want the best for women. And to be part of that for me is the most rewarding thing."* (Clare)

All coordinators stressed the relevance of the political and social action goals of the women's health movement which have, in turn, informed the mission statements and objectives of women's health centres. As coordinators of these services, an important part of their role is to help implement changes at a broader level, not just with clients, but with women who work in their own service and in the community, too.

> *"So I think that it's that satisfaction of knowing that you're doing things for women at a personal level...but this service enables you to do it at the political level [too]..."* (Mary)

This sense of achievement, both in terms of helping to change the broader social landscape for women, and in relation to their own professional and personal development was highlighted by several of the coordinators. The link between these factors and job reward, as reported by the women in the current study, is consistent with the literature on job satisfaction (Beaumont & Partridge, 1983; Brewer, 1995; Morton, 1990; Robinson, 1980; Tompkins, 1995).

Trusting their staff and identifying with a feminist approach to management were recurrent sub-themes mentioned by respondents in relation to the enjoyment and personal reward they derived from their jobs as coordinators of women' s health centres.

> *"I've a very strong connection to my co-workers and in terms of this service that it's been set up along feminist lines, and it's developed in the right way, or the way that I think is right. And so it's really the kind of place that I want to be in, in terms of how it operates, and in terms of its internal workings, and the way it looks at the broader world."* (Karen)

Support for these findings is provided by Weeks (1994), who maintained that feminist managers value and facilitate supportive team building, using mutual learning processes, giving and receiving balanced feedback, and prioritising self-care strategies in order to build trust and to keep the team functioning positively and productively.

Trust in the workplace is a crucial component in any organisation, and provides the foundation for a range of relationships both inside and outside work environments (Brewer, 1994). As Simmel (1978, p.179) states:

> Without the general trust that people have in each other, society itself would disintegrate, for very few relationships are based entirely upon what is known with certainty about another person, and very few relationships would endure if

> trust were not as strong as or stronger that rational proof or personal observation.

Risk taking is part of developing trust in relationships, and in work settings - as elsewhere in society - being able to take risks requires one to feel safe and supported by one's colleagues (Brewer, 1994; Schill, Tovis & Ramanarah, 1980). Open communication processes, cohesive team dynamics, collaborative work relationships, commonality of purpose and faith in the ability of management and co-workers also contribute to the development of trust in an organisation (Alpander, 1991; Brewer, 1993, 1994; Fox, 1974; Simmel, 1978). According to Brewer (1994, p.31), managers in the 1990's are increasingly having to

> move their employees away from 'low trust work', where the discretionary power of the employee is low, towards 'high trust work' where the employee is responsible for a range of decisions about making a product or delivering a service. New work structures require responsible employees who can be trusted by managers and co-workers and who can, in turn, trust them.

Feminist management by definition involves 'high trust' involvement by all members of the team. For example, the emphasis on participation in decision-making in woman-centred democratic management necessitates greater worker responsibility and co-worker trust (Weeks, 1994). In addition to the rewarding nature of increased participation in decision-making, collaboration, and feeling valued and supported in their work environments, worker job satisfaction is also related to the degree of trust amongst staff (Brewer, 1993, 1994).

The women interviewed for this study highlighted a link between feeling acknowledged, trusted and accepted by their co-workers and experiencing their

working environments as *"extremely supportive"*. A number of coordinators emphasised the enormous value and *"privilege"* of working in such a supportive environment, where they feel safe, and are *"allowed"* to be themselves in every way.

> *"I felt really privileged to do this job, and I, you know it upsets me that I think that I'll probably never get a job that enables me to be more myself than I've ever been able to be...but the important thing is to know that they [the other staff] are there behind you."* (Sue)

> *"Seeing your work in action, feeling like there's a really trusting group of women here..ah! I could just go on and on about why I like this place and why it's really important to me."* (Karen)

> *"I can trust their [the other workers'] judgements about things. And if there are problems, we work through them in a pretty safe way."* (Clare)

While a high level of participation, collaboration and commitment are important components to the amount of personal reward they experience in their jobs, financial reward was also seen to be significant. However, this was not a universal statement, with only two coordinators even mentioning money. For example, while Mary said the money was important, Sue felt that it certainly was not the main source of reward in the job for her.

> *"The money! I loved the money...having lived in poverty most of my life, I had to actually own up to the fact that this job gave me access to income that was beyond my comprehension...so somewhere money ended up being the real thing...and the reward that came to me every fortnight was a healthy pay package."* (Mary)

> *"Choosing to work in an area like this that is marginalised in lots of ways, shows a certain thinking, a consideration, a taking of choices to be here, and I think they're pretty strong things, you know, it's not about just being here for the money a lot of the time."* (Sue)

These findings are consistent with the literature on job satisfaction, which focuses more on intrinsic sources of reward such as work relationships, self-esteem and personal development, than external factors such as income. It is interesting, then, how much emphasis is placed by organisations and industrial award initiatives on the role of wages, hours and fringe benefits, given that these factors seem to have most significance in relation to mitigation of job dissatisfaction (Tompkins, 1995).

Summary and analysis

The findings presented in this chapter reveal that the women in this study identified themselves as feminist managers, a finding that is consistent with the work of Weeks (1994). This chapter identified the central role that shared belief systems play with regard to women's health centre coordinators' feelings about their jobs and how their shared feminist philosophies influence what they do and how they do it. Furthermore, women's health centre coordinators' commitment to feminist principles and the relationship of ideology to their practice of valuing their co-workers and striving to empower women, supports the work of Hunt (1994) who demonstrated that what women's health workers think affects what they do. The findings presented in the current study also revealed that the impact of having shared, core feminist and social perspectives of women's health adds both a positive focus for coordinators as well as presenting some practical difficulties.

Important components of their shared experience as women's health centre coordinators were their passion and commitment to work. Common sub-themes of *"having a very strong belief in what the service does"*, and being able to *"act out your*

passion with your work", emerged from the research. This belief in the value of their work and *"sharing the same political framework"* as their co-workers was found to be linked to reported job satisfaction. A sense of personal achievement was also mentioned in relation to personal reward in the job, a finding supported by the literature.

In this chapter, women's health centre coordinators identified the vital role that *"clearly explicated baseline assumptions and principles"* play in guiding their work and providing them with the confidence to defend the philosophy of their centres during negotiations with the *"external world"*. The need to have a clearly articulated 'party line', and an attitude of 'defence' was shown to be supported by the work of other feminist writers such as Broom (1991, 1998), Egan and Hoatson (1998), and Weeks (1994). These authors confirmed the existence of an economic climate that is oppositional in nature to the feminist foundations of women's health centres and other alternative feminist services for women.

Furthermore, this chapter revealed some of the strategies employed by the women managers in this study in their attempts to combat the practical management difficulties inherent in negotiating with agencies and funding bodies who espouse rather different principles and practices. Apart from the central strategy of developing clear statements about founding principles, other strategies included:

- using community liaison opportunities as a deliberate marketing strategy to educate the general public about the value of the work they do, and thereby dispel myths and misconceptions about their work;

- applying feminist management principles, such as collaborative decision-making processes, to enhance the self-esteem of workers and clients and thus fortify the internal resources of their centres;
- harnessing the *"passion"* and high level of commitment to their work that exists within themselves and their staff as a potent resource to help *"get the message across"* during otherwise *"sanitised conversations"* with bureaucrats and funding committees; and
- utilising their job satisfaction and their sense of *"privilege"* of being in management positions where they can *"make a difference to women"* as a necessary survival skill to keep going in difficult times.

This chapter has indicated that coordinators' experiences of their managerial roles are supported and sustained by their passion and commitment to the core ideologies of the women's health movement as indicated in Diagram 2 on page 121. The diagram shows how the coordinators' experiences of shared principles, passions and rewards can be conceptualised as interconnected. The double headed arrows indicate the way each component of the theme presented in this chapter feeds back and forth into the others. For example, the women in this study described how their feminist ideologies informed the working principles of their centres, and vice versa, a fact that has been borne out by previous research (Hunt, 1994). Diagram 2 also illustrates how these principles have provided a framework for their passion, and how in turn each coordinator's *"passionate commitment"* to their vision has, in different ways, provided the necessary rewards *"that kept me going"*. That these coordinators have been in their jobs for some time (at the time of interviewing, length of employment in their

position as coordinator ranged from 18 months to seven years), suggests that being a part of successful changes for women in the community (reward) may reinforce the appropriateness and validity of the shared principles and purpose of their work, which, in turn, is likely to 'feed' their personal belief in -and commitment to - their work (passion). The resulting increased belief in the value of what they do, and the continued viability of their work, continues to provide the rewards in the job, and repeatedly reinforces each aspect of their experience.

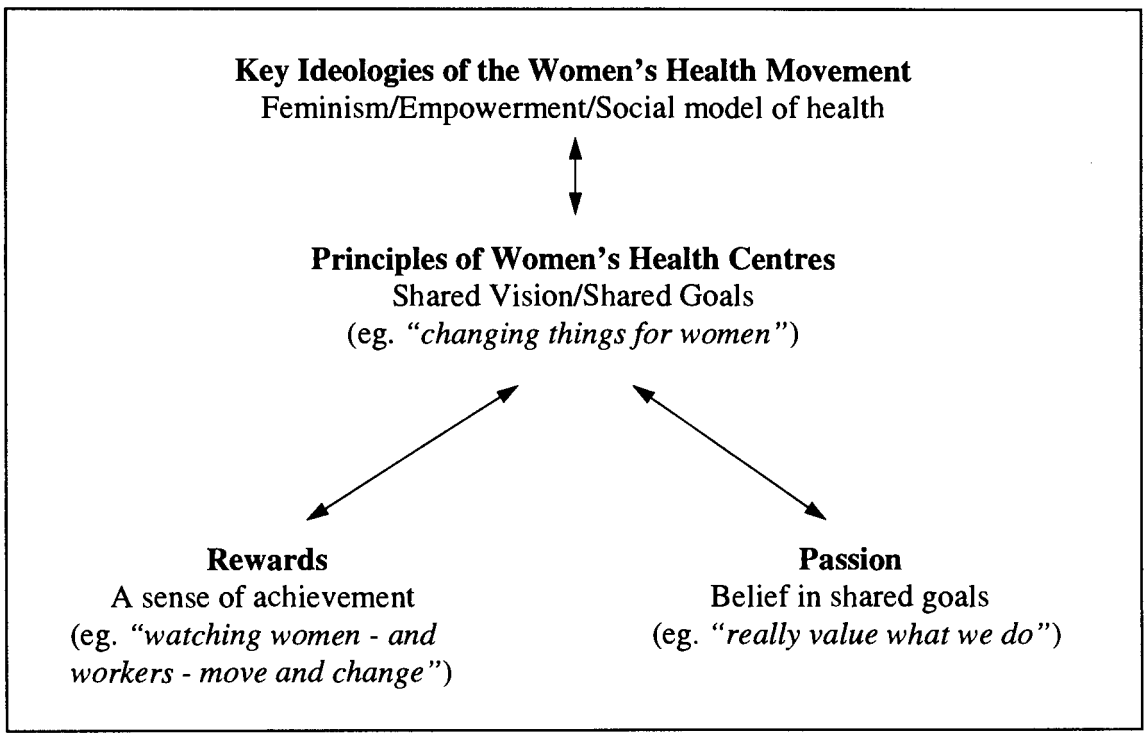


Diagram 2: The proposed relationship between shared principles, passion and reward in the everyday experience of women's health centre coordinators.

Diagram 2 represents a visual summary of the reported interconnectedness between the components of the theme presented in this chapter, and proposes a circular and recursive relationship between these factors. Further research into these relationships

may be useful to more precisely determine the parameters of those relationships and more deeply explore this aspect of women's health centre coordinator's experience.

All the women in this study spoke of the *"privilege"* of being in a job which enabled them to make a difference to women's lives. As one coordinator, Sue, articulated it, she has felt so privileged in her job that *"it upsets me to think that I'll probably never get [another] job that enables me to be more myself than I've ever been able to be."* Similar sentiments were expressed by the other women in this study, and clearly, they all perceived their role as coordinators as much more special than just a 9am to 5pm existence.

Broom (1991), noted similar responses from the women she interviewed in her study of the history of women's health centres in Australia. She summarised one aspect of their experience thus: "several women told me that the work was the best job they had ever had, full of learning, proud accomplishments and personal achievements" (p.84). One of the 'proud accomplishments' achieved by the women in the current study has been regarding their role not just as feminist managers but as leaders in the women's health arena, as well as taking a leadership role within their own organisations. The next chapter explores the central role of feminist leadership which emerged as a key theme in the everyday experience of the women's health centre coordinators who participated in the study.

CHAPTER FIVE

Feminist Leadership

Introduction

> *"...the 'grown-up' stuff...that is when you go out and you face the people in the suits."* (Sue)

> *"...I hadn't ever really aspired to be a 'manager' - you know, I was quite content. I never wanted to go up the ladder or be one of the 'big girls'..."* (Karen)

All women agreed that part of their everyday experience of being a women's health centre manager involves having to do the *''grown-up''* or *''big girl''* stuff. This aspect of their work commonly comprises several main elements: re-negotiating their roles from 'coordinator' to 'manager'; having to make sure that clear boundaries around staff working roles and decision-making processes are adequately defined and maintained; being the *"up front"* person who goes out into the wider system and advocates for women's health issues; sharing a strong personal commitment to the care and support of staff; shouldering the final responsibility and accountability for most events and decisions; and sometimes feeling lonely or isolated from other staff by their unique positions as managers. Throughout these elements ran a theme of duality of roles that incorporated the visible aspects of their work, such as their public role, with the invisible aspect, such as *"holding the service together."*

As a consequence of amalgamation of women's health centres with larger, generic health services, all coordinators spoke of the significance of the re-definition of their title from 'coordinator' to 'manager' and the implications this has had on their identity and their working roles. While the *"grown up stuff"* has always been a part of their

traditional role as coordinator, the transition to manager has necessitated an even more public role and the acquisition of more mainstream management terminology. However, they have all resisted the authoritative leadership style of traditional business management, and incorporated their own versions of participatory, feminist leadership principles under the umbrella of their new title of 'manager'.

The emergence of leadership as a central theme in this study is perhaps not surprising given the role each of the respondents has played in the development and continued survival of women's health centres in their regions. The ability of managers (male or female) to cope in times of great organisational turbulence and change, such as that experienced within the women's health arena, requires an unusual degree of tenacity, personal flexibility, and strong leadership skills (Ralston & Hulbert, 1995). This chapter explores aspects of feminist leadership as described by respondents, revealing the common and differing facets within each sub-theme. The chapter concludes with a model of feminist leadership described by the women managers in this study, and summarises the strategies used by them to define and implement their version of feminist leadership.

The transition from 'coordinator' to 'manager'

Most coordinators mentioned that they have had to make a personal transition to the role of a manager. For two coordinators, this was because they came from non-managerial backgrounds. For the others, it was more related to a change of attitude about the position, that is, a re-definition of their role from 'coordinating' a team to 'managing' a centre.

"We weren't coordinating a team any more. We were managing in a system, and that's been a big head-shift to me, that I do manage a centre now. I don't coordinate it...So that's been a big change...Quite a fundamental one. Because it has meant a separation from the notion of collectivity." (Mary)

"...there wasn't a big transition for me to make in terms of values or learning about the place. There was certainly a transition for me to make in terms of going from being a worker, community health worker, to being in a management role." (Karen)

The described transition, was seen as a significant change. The previously flat structure of women's health centres has been replaced with a more openly hierarchical one, which, together with recent amalgamations with other generic health services, has placed coordinators in a middle management position. Moreover, the loss of the title 'coordinator' has been particularly relevant, especially given the culture of organisational change and the need to fight to hold on to their feminist principles amidst those changes. Part of the struggle to re-define their roles within their centres has been to examine carefully the implications of the change in title from coordinator to manager. This battle has been partly a function of not having any clear precedence for this process in feminist organisations: the women in this study have been pioneers in their centres for the maintenance of feminist principles within a large-scale, bureaucratic re-structure of their services.

The common message, however, from all the women interviewed, was that the process of re-defining their roles within an imposed new corporate structure has been largely successful. While it has been a stressful transition, fraught with conflict, uncertainty and ambiguity, they have re-worked the imposed title of manager and transformed it into *"feminist manager"*. The transition process has forced them to explore their new

roles within a mainstream bureaucratic culture and to create a distinctively feminist leadership niche.

The challenges inherent in bureaucratic re-structuring of feminist services, such as the transition from coordinator to manager experienced by the women in this study, and the implications for the structure and function of feminist services such as women's health centres are acknowledged by a number of feminist authors (Egan & Hoatson, 1997; Hoatson & Dixon, 1998; Martin, 1990; Weeks, 1994). For example, Weeks' (1994) study of women managers in feminist organisations found that her respondents had actively resisted changes in title from 'coordinator' to 'director' because they felt the former gave a better "picture of feminist leadership" (p.157). Furthermore, claimed Weeks, the title of coordinator was significant because it suggested a co-operative mode of operation, whereas corporate management titles such as director,

> put(s) one person out ahead (of the rest of the staff) and in front, and in a position to direct (which is) a 'patriarchal' conception of leadership embodying the historic 'rule of the father' (p.157).

This quote highlights the way in which language frames action, and the hierarchical nature of bureaucratic terms such as 'manager' vs 'coordinator', and 'provider' vs 'service', leaves no doubt about the "one-directional" nature of this type of language (Hummel, 1987). One-directional language "offers no scope for talking back or inquiry", whereas two-directional terms, such as coordinator, suggest freedom to cooperate, communicate, negotiate and to inquire (Petersen, 1994, pp.100-101). Thus language implies a mode of behaviour, which can be either constricting and disempowering or liberating and inclusive.

However, one of the core differences between the women in this study and the women in Weeks' (1994) study is the element of choice. The re-definition of roles from coordinator to manager for the women in the current study, have been imposed upon them by the rigid re-structuring processes of the economic rationalist policies of the residing government. For example, these policies require that services, such as women's health centres, need to specifically consist of a 'manager', 'child care worker', 'reception staff' and so on, in order to receive funding (Hanson & Kenwood, 1996). It is through the mechanism of budgets and salaries, as stipulated on application forms for renewed funding, that these positions, through which their titles inform action, have been imposed on services.

Consequently, for the women's health centre coordinators in this study, their only choice has been to re-shape the assumed position of manager into a feminist rather than traditional, authoritative style of management. Acting on this choice is described by Martin (1993, p.287) as "striving for feminist transformational outcomes" which can have a powerful effect on not only individual managers, but on co-workers and entire corporations. Martin's analysis of the role of women managers who struggle to incorporate feminist principles into otherwise mainstream management structures endorses the experience of the women in this study and provides a compelling argument for the potential benefits of meeting these organisational challenges.

The impact of amalgamations of specialist feminist services, such as women's health centres, with larger, generic health services has also created a shift from coordination of an independent service, to management of a service within part of a larger

organisational structure. This has meant that women managers of women's health centres are now answerable not just to a management committee, but a line of managers horizontally and vertically within the larger generic health system with which they have amalgamated. Essentially, this has put them in 'middle management' positions, sandwiched between their staff (with whom they still strive to maintain collaborative, if not collective, working relationships), and their 'line' managers.

One of the difficulties associated with this structural change was mentioned by Karen and Mary in terms of not only *"having to manage 'up' as well as 'down'"*, but also being under scrutiny from all sides: upper management; staff; funding bodies; and the community. Some talked about this issue in relation to the Funder-Purchaser-Provider Model of health servicing. The mainstay of this model of health servicing, brought into effect by the increasing focus on cost reduction and government policies based on principles of economic rationalism, is the process of competitive tendering, or contracting, designed to encourage competition among providers. Women's health centres, as providers of services, are now not only in direct competition with other women's health service providers, but are contractually answerable to the purchasers (larger generic health services, such as those with whom they have amalgamated) and, ultimately, the funders (the government). These changes have been incredibly demanding and significant, requiring them to manage expanding upper management requests as well as continue to respond to community needs.

> *"It wasn't just the service that was looking at what we were doing. We had a whole bureaucracy and a whole government and we had a sector [looking at us]."* (Mary)

The difficulties of middle management experienced by the women in this study are supported by the health services management literature. For example, Kovner and Neuhauser (1994) state that health services managers, particularly those working in small, specialist services sponsored, funded and/or attached to larger, generalist service organisations face tremendous pressures from all sides: the parent or funding body; the health purchaser, their community group(s) and from key staff within their own service. This juggling act of considering everyone's interests can be extraordinarily time and energy consuming, as Kovner and Neuhauser (1994, p.5) observe:

> If the health services manager can never meet all the expectations of key participants in her organisation, she can at least be perceived by them as taking their interests into account in policy formulation and implementation. Unfortunately, this involves regular communication with numerous participants, the time for which is not always available.

This is likely to be even more challenging when managers are operating within a feminist management framework, as they are more concerned with processes not just outcomes, and are committed to exploring each stakeholder's agenda in a cooperative, democratic, inclusive and participatory style (Martin, 1994). This confirms the experience of the women managers in the current study, who clearly identified the transition from autonomous and collective coordination to middle management as a difficult, emotionally demanding and significant change.

Furthermore, for the women interviewed in this study, the new organisational demands resulting from amalgamation and the contract culture have required far more than a re-definition of their title, their identity as feminist managers, and their placement in middle management within the larger health system. There have been other, numerous

changes to their roles, as Hughes (1996, p.39) observed for all community managers affected by the "new contract culture",

> The new funding mechanisms require new organisational management skills, many of which have not been needed in the past. These include tendering skills, costing of services, managing business units, business planning, contract management, performance measurement, contract monitoring, managing change and design of services...Many of the new demands are about learning a new language and embracing terminology that for many symbolises a conceptual barrier.

The pressure to conform to the increased focus of funding bodies on managerialism and professionalism has indeed symbolised a 'conceptual barrier' to the women in the current study. As Mary stated, the transition from coordinator to manager involved *"a big head-shift"*, not only away from the notion of collectivity, but also a move toward hierarchical relationships and the kind of exclusivity that new terminology, managerialism and the jargon of professionalism engenders. For the women in the current study, these changes represent the very concepts that the women's health movement has fought against for decades. Hanson & Kenwood (1996, p.3) support the experience of the women in this study, and describe the dilemmas posed by the new contract culture in the health system of the 1990s as,

> When women's health service providers embrace professionalism it sets up a contradiction that must be addressed and that is - what is required of us if we become professionals? Do we have to trade anything off? If so, what concessions are worth making and what is simply not negotiable? These are issues that have confronted women's health services and continue to confront them.

An important part of being able to continue to confront these issues without losing sight of the basic premises of the women's health movement has been the use of their centres' *"clearly explicated baseline principles"* to guide the women managers in this

study through the tangled web of contradictions between feminist ideology and the practical implications of amalgamation with mainstream, traditional health services.

Another management difficulty encountered by all women in this study was the inability to delegate or manage effectively due to the small size of the organisation and the lack of resources. While amalgamation has meant that they are connected to larger health service organisations, they are still responsible for the relatively small team that makes up the staff of their women's health centres. For most managers it was an *"eye-opener"*, and *"an incredible revelation"* for them to realise that it is more difficult to manage a small team than to manage a larger organisation. The lack of administrative support and infrastructure in their centres were cited as contributing reasons: they are *"it"*, they have to pick up the *"loose ends"* and do the jobs that no-one else is paid to do.

> *"There is not the level of administrative support for this position in a place like this that there are at bigger places. So, a lot of the things I do, in other places there would be other people to do a lot - photocopying for the management, community, and you now, there are lots of little things that there is no-one for me to delegate it to."* (Sue)

Furthermore, increasing budgetary restrictions have made it even more difficult for small organisations like women's health centres to survive, let alone have enough money for adequate administrative support. The experience of the respondents in this study is echoed by the literature on the challenges of working in community-based organisations in the 1990s (Broom, 1991; Hughes, 1996; Egan & Hoatson, 1998; Hoatson & Dixon, 1997; Iles, 1997; Neuhauser, 1994; Weeks, 1994). For example, as Egan and Hoatson (1998) state, as core funding shrinks, and with increased competition for tenders, small, community-based services are struggling to fight for the

ever-diminishing health dollar. As community organisations are having to provide more services to more consumers on smaller budgets, as well as fulfil the complex contractual arrangements with funder/purchasers (Hughes, 1996; Egan & Hoatson, 1998), it is little wonder that the women who manage these centres are finding the transition difficult.

Clarification of roles

In addition to clarifying their own roles as feminist managers, all of the women interviewed for this study emphasised the importance of having well-defined working boundaries and parameters for their staff and the service itself. They were quick to emphasise the need to have clear lines of communication and that delegation is a vital part of their work. Just as important is the concept of democracy and team work in developing these working parameters, and this participative approach was mentioned by all as a given principle of their everyday practice as feminist managers.

> *"...as a staff member and as a coordinator there are very clear roles and parameters under which I act, and those parameters have been developed democratically in a participative manner by staff and management."*
>
> (Sue)

> *"... I was very clear about the way I wanted to work in the job, and clear about the delegations, you know, what decisions were made where, and very much in agreement with the centre's philosophy about participative stuff."*
>
> (Karen)

To be defined as managers, has meant a change from the previous one tier design of coordination of the service in cooperation with the other women who work in that service. While the collective approach may *"not have truly existed"* in the purest sense of the word, the imposition of a management hierarchy represented a significant

departure from the collective structure that previously guided the negotiations about everyday service delivery in women's health centres. Consequently, each manager has needed to re-consider her role in relation to her staff, and to clarify not only her role, but staff roles, the decision making process and the way in which their centres can best fit the notion of managerialism into the core principles of feminism and empowerment. As Radoslovich (1994, p.76) writes in the herstory of women's health centres in one state of Australia, "the management was [no longer] to be on a collective basis, the challenge was to incorporate feminist principles into the management structure imposed by the government." One woman in her study reflected the concerns of many by saying:

> The first fear is now that we have an institutionalised two tier hierarchy we will drift toward a fully fledged model. To have no hierarchy at all is an impossible dream but nevertheless I think it is an issue which should be foremost in our minds. It is certainly one of the foundation stones of the women's movement. I believe that the means determine the ends and that we cannot work against a patriarchal and authoritarian health system...from a micro-structure which reflects the very things which we are trying to overcome (p.76).

For all the women in this study, therefore, the goal has been to work as feminist managers attached to a mainstream health management structure, while preserving the essence of participation, cooperation and joint decision-making processes so valued by them and their women co-workers. Hence their comments have commonly focussed on the importance of democratic processes, the need to clarify the boundaries and *"parameters"* for each person's role, and the need to decide *"as a team"* about the degree of involvement each staff member should have in the early, middle and final stages of making decisions about each aspect of their centre's activities and operation. Delegation was also emphasised as an important part of this process, and while women

in the current study reported some difficulties associated with delegation, these were primarily concerned with the extra administrative tasks, rather than major delegations relating to individual areas of expertise and knowledge.

The transition from a one-tier administrative structure to a two-tier, has also meant that where staff had previously been involved in all aspects of decision-making, delegation and clarification of their roles under the new management structure needed to be handled cooperatively and using approaches consistent with women's health principles. The need for *"genuine"* feedback and communication was stressed as an important step in this process, and is supported by the literature on feminist leadership (Ely, 1994; Fagenson, 1993; Jacobson, 1985; Joyner & Preston, 1994; Marshall, 1993; Martin, 1990; Pearce, 1995; Radoslovich, 1994; Weeks, 1994).

While communication is a central component to the participatory model of feminist management and leadership, the conflict inherent in jointly making decisions as a team and the mainstream health management model of line management responsibility needed to be clarified. A key strategy to resolve this issue has been one of clear communication about the need for consensus by all staff in view of the overall decision-making power of the management structure. This has only been able to be resolved through *"the basic level of cooperativeness, open-mindedness and goodwill among staff."* Thus effective communication processes have been an essential ingredient in the renegotiation and clarification of roles, a point which is supported by

both Radoslovich's (1994) herstory of women's health centres and Weeks' (1994) descriptive analysis of managers working in feminist organisations.

From a broader perspective, all coordinators commonly shared the everyday tension of needing to juggle a number of different roles both personally and professionally as working women, as well as being mindful of the many roles that all women - both clients and staff - cope with on an everyday basis. Sue and Clare, in particular, underscored the importance of creating an environment for their staff and clients which is based on *"an ideal place (both work place and client space) for women"*. This has involved careful consideration *"of the many roles that women play"*, which translates to providing as flexible as possible working hours, being mindful of changing child-care needs and resources - for clients as well as staff - and trying to accommodate the full range of choices available to women.

As managers, acknowledging the many and varied roles that women generally play has been an important part of their job, and advocating for the adequate provision of organisational structures that support women - themselves, clients and staff - in their diversity is a central component of providing a feminist style of leadership in an organisation based on women's health principles. Several coordinators spoke of the challenge of providing a flexible work environment, as Sue's quote below illustrates:

> *"...we have always tried to, in your work environment, model what is an ideal workplace for women and therefore being considerate of the many roles the women play. And so that can be quite challenging as well, because you want to be as flexible as possible because women have got sick children or they want to work part-time for various reasons or they want to come in late or early or all those sorts of things because of those multiple roles in their lives..."*

The adoption by the women in this study of a more flexible style of management, one that permits choice and diversity in the workplace, is well supported by the literature on women's management styles (Antal & Krebsbach-Gnath, 1993; Davidson & Cooper, 1983, 1984; Ferrario, 1994; Martin, 1988, 1993; Rosener, 1990). For example, Martin (1993, p.286) summarises the flexibility of women managers, especially those working from a feminist framework as:

> feminist managers affirm the multiple obligations and demands that employees have on their affections, energy, and time. They support the provision of benefits and policies to help them with child care and family obligations, such as day care on site, benefit packages to cover day-care costs, leave policies that take children's activities into account, adequate health insurance and so on.

Most importantly, women managers, especially those committed to facilitatory, team-based and inclusive processes of leadership such as feminist managers, are able to be more empathetic and create a more respectful and productive work environment for themselves and their co-workers than their male or more traditional business management counterparts (Ferrario, 1994; Pearce, 1995; Rosener, 1990; Stevenson & Pinn, 1995). For managers working in community-based organisations, these skills are essential, and the ability to recognise the diverse needs of a community and work with them in a cooperative and permissive approach is a key skill for managers in these organisations (Iles, 1997; Weeks, 1994).

The women's health centre managers in this study specified the need for clarity about their leadership roles. This aspect of their job was as much about modelling an ideal workplace for women as fulfilling a leadership role to staff, the community and to women's health in general. This was a constant pressure to some coordinators, who

spoke of the need to be always aware that people were looking to them to show them the way it "*should*" be done. As two of the women managers articulated it:

> *"We have actually re-analysed our role, and I see part of my role as that leadership stuff."* (Karen)

> *"One of the challenging things in women's health and in feminism, is about the whole role of leadership and power, and that is something that we have certainly struggled with, but I think that we in [women's health] have got better with lately, that we see our role as a central service as being a leadership position."* (Sue)

This was particularly true for Sue who divides her time into two main parts, "*as manager of this service and [as] an advocate for women's health broadly.*" The other coordinators saw their leadership roles similarly, if not so distinctly divided. However, all agreed that their positions as managers have required them to provide a public leadership role, advocating for women's health issues in the broader community. This public role, and each woman's response to it, is the focus of the following section.

Public profile

All coordinators shared a common experience in their jobs of having to be the public face of their women's health centre. That is, they are the ones who negotiate with staff, community and funding bodies. In the latter-most case, it is their job to go out to *'fight'* the bigger battles for continued funding, or simply to maintain the service's existence.

> *"It's about going out where that community isn't so accepting, where the values aren't explicit, where the values are, you know, are challenged."* (Sue)

They all talked about the constant challenge of having to respond to repeated questioning from people in the community, politicians, bureaucrats, funding bodies, even other women sometimes, about the role and purpose of women's health centres. Each coordinator described very similar experiences of having to deal with people who do not believe in what they (women's health centres) are doing, and who actively undermine the value of their work and principles. The constant pressure to fight for what they believe, to fight for the right for women to have safe, specialised health services is, as Karen remarked, *"all about trying to hang on by the skin of your teeth to the things that are important about why this place is such a good place."*

Apart from the sheer energy and tenacity required to keep presenting the public profile of women's health in what they all described as a rather hostile *"outside world"*, for at least one coordinator, Clare, the role of being the spokesperson for her centre has also meant fighting against the *"extreme introvert"* inside of her.

> *"...Oh this being 'up front' stuff, yeah. That's been a real challenge for me because I am an extreme introvert and I have to get up and speak and fight quite opening about things which has been hard because I am a real thinking, a reflector type person...that's been hard because I've had to be very public, so I actually feel I wear a mask and I put on a different face for that, and people would never know that about me. I'm actually a very shy person."*

While none of the other women mentioned their own personality type as an issue, they all spoke of the pressures of being the *"up-front person"*. Some, like Mary and Sue, saw it as the *''grown-up''* stuff; having to be the one who is paid to face the harsh realities of the real world, away from the supportive environment of the shared values and beliefs of a women's health centre. For Karen, it was more about having to spend

so much time away from her centre, *"putting energy into somewhere outside of this place. Trying to make the bigger organisation work".*

One of the unexpected benefits of having to spend so much of their valuable time arguing publicly for the continuation of their services, is that they have become even more aware of what is so special about their respective work places. As Sue put it:

> *"I think the critical thing is the recognition of what is that environment that we have that's so protected. Like, we would rarely have to worry about a thing like sexual harassment, equal opportunity, you know they're given within our services. But you go out and deal with other agencies where those things aren't taken for granted, where you have to explain what you do..."*

Another common experience for coordinators was the sense of being supported by their staff when they went out to negotiate with the 'outside world':

> *"...I feel that I've got a fair amount of trust from the majority of staff about handling that stuff. Like, that's been really important, and in terms of dealing with the political stuff is, being able to go out and say things and knowing that your staff would agree or back you up on them."* (Sue)

> *"So in any forum that I went into I would feel that there would be these constituents here behind me, if you like, even though they weren't there. But there would be good discussions between staff and management about what line we'd take and what strategies we used, so I was just kind of implementing."* (Mary)

The comments shared by the women in this study about their public leadership role, and the pressures and rewards of this aspect of their jobs is supported by a number of authors (Ralston & Hulbert, 1995; Loden, 1985; Marshall, 1993; Weeks 1994; White, Hodgson & Crainer, 1996). Feminist leadership, by definition, relies on the companion concept of feminist teamwork, of 'leading from behind', and taking to the

public forum the team's opinions, attitudes and decisions, not just those of the leader. The supportive function of the team in this public role is crucial, as the women in the current study articulated, and their sentiments are supported by the work of Broom (1991), Hunt (1994), Radoslovich (1994), and Weeks (1994).

Perhaps the reason for the discomfort expressed by the women in the current study regarding their need to be the *"up front"* person may be suggestive of the conflict inherent in managing from a teamwork perspective and resisting any notion of superiority or inequality, and yet being required to stand up (and therefore stand out from the rest of the team) and be the *"public face"* of the organisation. In an ideal, equal world, perhaps it would be possible to share with every worker such public leadership roles (for example, take turns at being the *"up front"* person), but for practical reasons this is not viable in today's management structure (White, Hodgson & Crainer, 1996). At least, the women in this study seem to take comfort that feminist leadership ultimately relies on the team effort, and that their public role is merely a channel for their team's work to become known in a wider context. That they are the people charged with the task of broadcasting the views of their organisation, by virtue of their roles as managers, is also a practical necessity, as one person carrying out this role can give continuity to the way the message is conveyed, and to a lesser extent, the way in which it might best be received.

Visibility vs invisibility

It is this *"up front"* role in their working day that coordinators referred to as being *"visible"* in the wider system. Standing up and being seen so that women's health centres would not and could not be so easily ignored, sidelined or forgotten by funding bodies, bureaucrats and politicians has been a vital component of their working role. This role has been made even more essential by the many ways in which they feel that funding bodies and government agendas are seeking to further marginalise women's health centres, by amalgamations with generic health services that renders specialist health services to women invisible, if not obsolete.

For the women in this study, increased visibility has meant attending negotiation meetings, lobbying publicly for greater awareness of "Why women's health?", presenting as a *"unified front"* to politicians and bureaucrats, and continuing to successfully manage and deliver a wide range of health services to women despite being under constant threat of non-existence.

> *"We need to be in there. We need to be in there, being visible, being part of all these negotiations, because the ground can get shifted before you even know it. So people understand and want, strategically, for us to be involved, which generally means me, or it does now."* (Karen)

Most coordinators commented on the dual aspects of their everyday experience of visibility and invisibility.

> *"I certainly see myself as someone who pulls things together a lot, and I do think that a lot of it's invisible. My line manager said, 80% of team leader work is just done behind the scenes and people don't know about it, and I thought, 'oh that's a bit rich', but actually on reflection I think that's absolutely true."* (Clare)

> *"I don't feel that that people don't think that I work hard, but they haven't really got a sense of what it is that you're doing all the time."* (Sue)

They all spoke of needing to make their roles more visible to their own staff as well as the wider system outside their centres. One of the strategies employed by Sue in order to make herself more visible in her work place has been to install a whiteboard in the front office area, where staff can see where she is and what she is doing on any given day. This whiteboard is a public version of her work diary, and it has been successful in helping staff to appreciate the range of duties and tasks she is involved in on a day by day basis.

A number of studies on women in leadership positions support the experience of the women in the current study with regard to their perceptions about the invisibility of some aspects of their roles (Davidson & Cooper, 1983, 1986, 1988; Loden, 1985; Marshall, 1993; Sheppard, 1989; Weeks, 1994). For example, Weeks (1994) found that her respondents felt that some of their work as coordinators was *"taken for granted"* by co-workers, partly because their managerial tasks were expected of them, and partly because a lot of their work was done *"behind the scenes"*. Davidson and Cooper (1988) revealed that a source of stress among women managers was the perception that their efforts were not appreciated by superiors and colleagues alike, and that much of their work was invisible to the organisation.

In the context of current economic rationalist, performance measures, like team-building, caring for staff, maintaining good staff relationships and *"pulling things together a lot"*, are hard to quantify and difficult to acknowledge. Indeed, much of what distinguishes feminist leadership from traditional management strategies is qualitative, interpersonal and invisible in performance appraisal processes which focus

on the economic indicators of success. Consequently, essential ingredients to good feminist leadership such as empowerment of staff, creation of a culture that enables colleagues to initiate projects and take ownership of them, and the caring monitoring and maintenance of supportive and respectful working relationships are overlooked. Small wonder then that the women in the current study commented on the contrast between the intense visibility of some aspects of their jobs and the almost total invisibility of some of their other tasks.

Perhaps, as more women enter management positions and define their roles as feminist leaders, these *"invisible"*, yet valuable attributes will gain a greater profile, wrestling the focus away from more quantitative, traditional forms of management toward a more qualitative, person-oriented style of feminist leadership. This process may thus render visible those feminist managerial tasks and skills which are currently buried beneath the patriarchal management culture of observable, measurable outcomes, and create a presence and reality for women's management styles that has previously gone unrecognised. The following section highlights one such invisible aspect of feminist leadership that was commonly mentioned by the women managers in the current study.

Staff support

The leadership role of these women came through clearly when they were talking about management issues in relation to dealing with staff. They all saw it as their role to *"look after"* their staff members, particularly during times of chaos, turmoil or difficulty. They all saw it as their role to be the one to *"hold it all together"*, by putting on a *"calm face"* regardless of what they were feeling or thinking themselves.

> *"...when I'm feeling very busy and when I've got my list that long that I'm trying to work through and deadlines to meet, and someone comes and asks me something that I think, "Oh God, can't you find that out? I told you that three times." But I have to put on my calm face."* (Karen)

A common strategy used by them to cope in such times was giving themselves the space, time and permission to *"think things through"*, not bowing in to pressure to come up with solutions or responses immediately. This has been a particularly vital strategy during the tense negotiations with funding bodies and purchasers when the immediate future of their centres has seemed most bleak, and when sharing all the detail with co-workers about these negotiations would have been counterproductive to staff morale.

> *"So there was that stuff about giving myself some time to think and to let me process it, so that I could help other people, you know, facilitate other people's processes. Otherwise you were just throwing things at people all the time...it was recognising that, OK, my role is the manager. My role is to deal with these things. And so what I need to do is keep people informed about this, but also not sort of throw it at people so that they fall apart and say, 'Oh my God, that is the end of us!'".* (Sue)

Sue, Mary and Karen mentioned the value in standing back, reassuring staff of their calming presence, while facilitating a participative model of problem solving. Clare spoke of a similar process, but stated that she had to fight with her own sense of feeling over-responsible for the outcome and *"having to give all the answers"*. This was improving, as she developed the ability to delegate and *"let go"* of needing to be so responsible. While two coordinators described the temptation to always be there for staff as a type of *"mothering"*, this term was rejected by the others, who were concerned by its suggestion of dependency. Nevertheless, all agreed that creating a

dependency amongst staff was to be avoided, and emphasised the concept of empowerment as a primary consideration in their supervisory role as managers.

However, they all expressed a strong commitment to protecting and supporting staff in order to keep the team working, and based many of their actions on this concept. For example, they spoke of recognising the need to keep their immediate responses to themselves, not sharing their anxieties or uncertainties with staff. If they needed to "*de-brief*", this was usually sought from family and friends or persons not in their immediate workplace. All agreed that often their first responses to some crisis at work were not helpful to staff, instead consciously deciding to keep a *"calm exterior"* in order to take the pressure off workers or off the situation.

> *"I think there's an onus on this position, and I feel it at times to be there for other people and that has meant perhaps doing my 'panics' elsewhere...I've never felt that sense of being alone in it, but I have felt that sense of needing to show leadership by being steady in myself, and thinking through things."*
>
> (Karen)

> *"I think it takes the pressure off workers, or the pressure off the situation or off clients. It's that sense of somebody's got to be able to take control of this situation, and I'm the one that's paid to do it."* (Clare)

Most of all, they see a major role as women managers to be there to reassure, support and guide staff. This may be formalised, such as providing regular supervision sessions, or more of an informal process, such as being available to debrief staff when needed. Much of the literature on how women managers 'lead' reinforces the focus on staff support described by the women in this study (Grimwood & Popplestone, 1993; Jacobson, 1985; Marshall, 1993). A number of studies have shown that women managers have a more 'team' management style, and a greater attention to the

supporting dimensions of leadership (Davidson & Cooper, 1983, 1984; Ferrario, 1994; Marshall, 1994;).

Comparative studies which have examined the unique differences between women and men managers highlight the strengths that women bring to management positions by their ability to establish and maintain good, supportive working relationships between themselves and their staff (Ely, 1994; Ferrario, 1994). For example, Davidson and Cooper (1983, 1984, 1988, 1992) in their studies on women managers observed that women have a 'relations oriented' style of management which focuses on quality of relationships and manager-employee relationship processes. By comparison, male managers more often rely on outcome-oriented approaches and favour more authoritative, hierarchal management styles. Like the women in the current study, women managers have generally been found to have "a distinctive style of management which display(s) more understanding and sympathy for others" (Ferrario, 1994, p.116).

The literature on feminist leadership styles supports the statements of the women managers interviewed in this study, especially in relation to their commitment to supporting, protecting and supervising staff (Ely, 1994; Fagenson 1993; Ferrario, 1994; Martin, 1990, 1993; Pearce, 1995; Stevenson & Pinn, 1995; Weeks, 1994). For example, Martin (1993) sees feminist practice in itself as an exercise in nurturing, and this is extended to the workplace through the provision of adequate supervision and support of all staff by managers and co-workers alike. Weeks (1994) observed the role that feminist managers play in their support of co-workers as an extension of the

traditional leadership roles adopted by women for centuries in the community and in their own families as nurturers, caregivers, efficient organisers and service providers.

Weeks' (1994) study of women managers also revealed similar concerns to those raised by the women in the current study. For example, her respondents reported a concern for the well-being of their staff, not only in relation to wanting to protect them from stressful aspects of their work, but also being worried about overloading staff and the possible effects of stress on them. Furthermore, Weeks' respondents similarly stressed the importance of staff support and supervision, and also saw themselves in their role as coordinators to be the primary source of this "supervisory feedback", leadership and support to staff (p.166).

The burden of responsibility

"The buck stops with me" was a phrase used by a number of coordinators when describing this component of the leadership theme. As Clare put it:

> *"...it's hectic and it's responsible and you're the person who cops the crap if it goes wrong, and you're the person who can enjoy the delights when it all goes well."* (Clare)

Part of feeling that responsibility is about having to do the hard things, make the hard decisions, be fully accountable, to *"stand up and do the things that "no-one else wants to do"*. These *"hard things"* were most commonly identified as: dealing with staff and work role conflict; general staff problems such as unreliability or unprofessionalism; staff shortages; work overload (*"having to do everything"*); dealing with organisational restrictions, conflicts and the general mainstream organisational culture; and having to make decisions which may be unpopular, time pressured and/or about

situations over which they have little or no control. The following quotes illustrate some of the key issues that were perceived as carrying a lot of responsibility and difficulty:

> *"...I would be having to address issues like perceptions of unprofessionalism, duty-of-care issues, approaches to work, lesbian issues, homophobia, and even I think that I would have to describe it as class issues around the actual style of dress that the workers had."* (Mary)

> *"...quite a number of staff have no interest in doing the management stuff because they see it as hard work, not having any reward, and it's about having to make decisions that are hard. And so I think that's why I see it more as 'big girl', because it's not something whereby you're all in it together..."* (Sue)

The burden of responsibility described by all women in the current study is confirmed by the literature on the experience of women in leadership positions (Burke & Davidson, 1994; Davidson & Cooper, 1983, 1986, 1988; Jacobson, 1985; Nelson & Quick, 1985; Offerman & Armitage, 1993; Stevenson & Pinn, 1995; Weeks, 1994). For example, the women coordinators in Weeks' (1994) study described the managerial component of their jobs as 'setting them up' to take the full brunt of responsibility for all decisions made within their organisations, despite the implementation of participative decision making processes and the presence of strong staff support for those decisions. Likewise, Jacobson (1985, p.83), emphasised that the dilemma for women leaders is that despite cooperative, respectful and inclusive approaches to management of staff and decision-making procedures, women managers "are still in charge and have the final responsibility to see that everything is done right." Furthermore, since amalgamation with mainstream health services, this burden of responsibility is likely to be even more pronounced due to the introduction of a

more hierarchal management structure which embraces a culture of individual (manager) responsibility over more collective approaches.

Davidson and Cooper's studies on the issues affecting women managers (1983, 1986, 1988, 1992) support the experience of the women in the current study, especially with regard to their perceptions about the *"hard things", "hard decisions"* and those aspects of their jobs about which they feel most responsible. For example, Davidson and Cooper (1983) in their study of women managers, listed 35 work situations which women managers reportedly found most difficult and taxing about their jobs. Among the top ten situations listed in Davidson and Cooper's study were those mentioned by the women in the current study, such as: work overload; staff conflict, staff shortages and other staffing problems; role conflict; dealing with organisational restrictions and climate; feeling time pressured; and having to manage situations over which they perceived they had little or no control (p.63).

Finally, Karen, Sue and Clare mentioned not only feeling that the burden of responsibility weighed heavily on their shoulders much of the time, but that having to do the *"hard things"* and make *"the final, difficult decisions"* often left them feeling somewhat estranged from their co-workers. For example, Karen described some of the managerial aspects of her job as not just having to do the unpleasant things that no-one else wants to do, but sometimes requiring her to *"miss out on the fun"* that other staff were having through their direct work with clients and through working on specific community projects. This experience of feeling isolated was also articulated by the

other women managers in this study, and it is this sub-theme that forms the focus of the next section.

Isolation

All coordinators mentioned that they have felt lonely or isolated in their role as coordinator at some time or another. Most commented on this in relation to feeling disconnected from other staff or from the day-to-day, service delivery issues, with so much of their time being taken up with meetings, planning committees and negotiations with the wider system. As Karen stated:

> *"...I am one step removed from women and working with women, but at least I still have a sense of being reminded all the time by working with other workers that that is what I am here for. And that is what we are here for. If I as a coordinator lose sight of that, then that's not a good thing to happen."*

How much the notion of collectivity remains and still has an influence on this aspect of their work is hard to say. Certainly, all women talked about feeling equal with their co-workers, sharing common goals, and working together in a democratic and participative way. However, what differentiates them from other staff members is their level of managerial accountability and responsibility, which necessarily heralds a departure from the *"good old, flat collective structure"*. They do not just 'coordinate' anymore, they 'manage'. Having to be the one that makes the *"hard decisions"* or who needs to keep their distress to themselves in order to support and protect staff were commonly cited as the reasons for feeling set apart from co-workers.

> *"The other thing too is that you can't talk about how you feel with workers often, you know, that you've got to keep every bit of hurt and pain, that's either caused by something they've said or done, to yourself. And if they complain about anything, or another worker, then you know you can't talk about that with anyone else, you've got to keep all that to yourself. And there's not always a place for debriefing that."* (Clare)

> *"...a lot of work is we're all in here together and we're all equal, you know, relatively equal, and we're all involved in talking about something. But when you go and do this other stuff you're not. You're actually quite separate. And you haven't got your comfort zone with you, you haven't got all those people there, all around you who you can look at and who'll you know give you nice feedback, you actually have to you know manage....manage on your own I think."* (Sue)

The amalgamation of women's health services with generic, mainstream services has certainly challenged the notion of true equality between all co-workers, and has made the divisions between management positions and other staff positions more visible. The comments of the women in the current study are confirmation that the hierarchal structure that has been imposed on them has been divisive to some extent, putting distance between them and their co-workers, and contributing to their feelings of isolation.

Hoatson and Dixon (1997), in their analysis of the impact of the introduction of competitive tendering and contract processes on community-based organisations, reinforce the findings of the current study. They claim that the previously collaborative and supportive relationships between feminist health services have been undermined as community organisations are pitted against one another in order to compete for limited government funds. As Egan and Hoatson (1998, pp. 44-45) observed, due to tighter budget restrictions and

> changes to roles, resources and boundaries, this work of supporting organisations through advice, problem solving, linking, skills training and mentoring (has) diminished: Thus contributing to a sense of isolation and to some extent diminished relevance.

A number of other studies on the experience of women managers have yielded findings that support the sense of isolation experienced by the women in the current study (Davidson & Cooper, 1983; Marshall, 1993; Mawson, 1993; Still, 1988; Sheppard, 1989; Weeks, 1994). In particular, Davidson & Cooper (1983) found that middle managers, like the women in the current study, felt more isolated than their senior management counterparts. This finding was attributed to the lack of support from other female peers, that is, the lack of contact with other women working in comparable roles in like-minded organisations.

Sheppard (1989), Marshall (1993) and Mawson (1993) also reported that many of the women managers who participated in their research felt a lack of connectedness with their colleagues, and often felt lonely and isolated in their jobs. Weeks (1994) found similar sentiments existed among the women coordinators she interviewed. They described feeling isolated and separated from their co-workers by virtue of their unique positions as coordinators of their services, despite having established good team cohesion and support. They also spoke of their sense of isolation due to an inability to seek support from other organisations, due mainly to "organisational loyalty" rather than an explicit sense of competition or rivalry (p.163).

The implications of such isolation among the women in the current study, and for women leaders generally, is that more supportive networks need to be established. As it stands, support for these women appears to be ad hoc, and while they are clearly committed to supporting, de-briefing and supervising their co-workers, little seems to be available by way of supervision, mentoring or leadership for them. This is

particularly true for the women in the current study, whose immediate supervisors or 'line managers' are from a non-feminist, mainstream culture, and whose support, therefore, may not be seen to be relevant or appropriate. This finding is supported by Mawson (1993) who suggested that women managers lack support networks that are relevant to them, especially as many of the existing managerial networks are male dominated or either explicitly or implicitly "men-only" (p.63).

Few practical solutions to the problem of isolation and lack of support for women managers working in small, community-based services can be gleaned from the available literature. For example, Egan and Hoatson (1998) suggest that in the current climate of competitiveness between feminist and community-based services, the difficulties - of which mutual support is one - need to be openly named and confronted. Mawson (1993, p.63) proposes that management needs to "create policies to help minimise or eliminate men-only networks" and that male mentors and mixed group networks (based on occupational groupings and work skills) may offset feelings of isolation among women managers and help to reduce work stress. Weeks' (1994) respondents suggested that isolation in the job can be addressed on an individual basis, by seeking the services of a therapist or other trusted woman, with whom to share work-related difficulties. The need for confidentiality in this process was implied in Weeks' study, especially since her respondents mentioned that organisational loyalty was a significant deterrent to seeking external supervision or support.

Whatever the mechanisms for obtaining support, the findings of this study reveal that supervision and care for women leaders and managers is inadequate. Furthermore, the

experiences of the women in the current study are supported by women in similar positions of leadership, both in terms of the lack of adequate supervision and the desire to feel connected to others and supported in the workplace. One implication of these findings may be to identify the need for future studies to explore and analyse the current systems for support of women leaders in organisational settings and to research how best these support processes and networks can be enhanced, expanded and made more accessible.

Summary and analysis

The findings of this chapter have elaborated on the sub-themes of the previous chapter regarding the importance of feminist management principles by describing the components of feminist leadership shared by the women coordinators in the current study. The significance of the transition from 'coordinator' to 'manager' was described, and the need for each of them to clarify their leadership role in relation to staff, and to set boundaries and parameters around staff and team tasks was emphasised. The core components of feminist leadership such as: team-building; participatory decision-making processes; the care, support and empowerment of staff; and the focus on process and woman-centred outcomes emerged. The contrast between the visibility of their public roles and the invisibility of many of their managerial tasks was highlighted as an important, shared feature of their work, as was their sense of personal responsibility for the overall functioning of their centres. Finally, a common experience of feeling isolated in their roles as women leaders and managers was revealed - a finding which was found to be consistent with studies of women who occupy similar positions of leadership.

In summary of the above findings, a model of feminist leadership is presented in Diagram 3 on the following page, illustrating the core components of feminist leadership as described by the women managers who participated in the current research. This model highlights the key roles and strategies used by each respondent to identify and carry out their leadership tasks, and provides a visual representation of the leadership processes intrinsic to their everyday experience as women's health centre coordinators.

In support of the Feminist Leadership Model that emerged from the shared leadership experiences of the women coordinators in this study, several authors on feminist leadership identified similar essential components of feminist leadership as those described here. For example, feminist leadership has been defined as a model of management which utilises strategies such as: empowerment of staff; a contextual understanding of power issues; decision by consensus; delegation; shared values with a customer focus; working with others for change; attending to the interrelationship of leaders and colleagues; and an expectation that colleagues can and want to initiate, create and have ownership for work projects (Lanza, 1997; Loden, 1985; Martin, 1993; Rajotte, 1996; Strachan, 1994).

DIAGRAM 3: FEMINIST LEADERSHIP MODEL

Guiding Principles
Feminism, Empowerment, Social Model

↓

Organisational Structure
Team-focussed
Based on equity

↓

Management Style
Collaborative, Inclusive, Democratic, Intuitive, Supportive, Flexible, Reflective, Facilitative, 'Relations-oriented'

↓

Primary Objectives
Woman/customer-focussed outcomes
Emphasis on quality and integrity of service delivery
Community-driven goals
Process-oriented

Key Roles

- establishing their identity as feminist managers
- upholding feminist principles within a traditional, mainstream, middle management culture
- clarification of roles - management/staff/services
- being the *"public face"* of their service
- building and maintaining a cooperative, cohesive team
- setting an example re women's health principles
- reassure, support, guide and empower staff
- advocates for women's health issues
- facilitating community leadership, cooperation & empowerment
- striving for 'feminist transformational outcomes'
- overall coordination and *"pulling things together"*

Key Strategies

- relying on *"clearly explicated baseline principles"* to guide their transition from coordinator to feminist manager
- establishing and maintaining clear, participatory, decision making processes
- supporting the diversity of women's roles - both staff and clients
- taking the final responsibility where needed
- keeping a *"calm"* exterior, especially during crises - leadership to staff
- providing regular staff supervision
- developing clear lines of communication and *"genuine feedback"* with staff
- using delegation to establish roles and responsibilities
- learning to *"take time to think things through"*- resisting pressures to respond to situations immediately
- increasing their visibility to staff eg using *"whiteboard diaries"*

Finally, it is important to acknowledge the difficult political and economic climate in which the women in the current study have developed their sense of leadership, especially given the numerous changes that have taken place in organisations over the past decade. To persist in carving out a distinctly feminist style of leadership and management within a broader organisational culture which is traditional, hierarchal and even hostile (or at least resistant) to feminist principles is testimony to the grit, vision and commitment of the women who took part in this study. Their role as agents of change in the future of their services, and other similar organisations, is not to be underestimated. To illustrate this point, Pearce's (1995, p.213) analysis of the significant and unique role that women leaders play in major organisational change processes found that:

> the initiation and implementation of change has repeatedly demonstrated the value of what have been traditionally considered to be female skills and attitudes. I'm not just talking about caring and being supportive but also about a commitment to and an abiding interest in how people think, feel, relate, communicate...I typically found that it was women who were open to change; accommodating in their approach to it; aware of its implications; tenacious in their search for solutions to problems posed by it; and understanding and supportive of those affected by it...They gave others space, and respected their expertise; identified others' concerns and accommodated them and above all, knew that change could be emancipatory.

Barker and Young's (1994) analysis of the contemporary theory of transformational leadership adds weight to the argument that the efforts of feminist leaders, like the women in the current study, have true emancipatory potential. They claim that attempts by women managers to re-define management principles along feminist leadership lines (such as those achieved by women's health centre coordinators) can result in new methods of leading and managing that may ultimately influence the way in which

organisations are structured. Such transformations may be instrumental in challenging the predominant male cultures of management that still exist in most organisations, and help to produce new organisational cultures "that will provide more favourable environments for female leaders" (p.16). The ability of women to become "transformational leaders" capable of such reform was also posited by Martin (1993), who echoed the comments of Barker and Young (1994) in claiming that the attributes of women through their preferences for leadership styles that are inclusive, caring, morally responsible, reciprocal, cooperative, intuitive and which integrate the many views of their colleagues is similar to those attributes demonstrated by proven transformational leaders.

Thus the women in the current study are, by their feminist leadership and management styles, already helping to create a revolution in mainstream management circles. While they may perceive the battles to be extraordinarily challenging, and no doubt they are, they are not without gain. The more women who rally to counter-impose their unique, feminist approaches on the established patriarchal modes of organisational management, the more momentum and validity such participatory and empowering styles of leadership will achieve (Loden, 1985). If this results in what Martin (1993) and Barker and Young (1994) claim to be possible - the development of more women-friendly organisational structures - then the women in the current study will have truly upheld the social reform agenda of the women's health movement through establishing their identity as feminist leaders.

The following chapter explores the way in which the women managers in this study have used their leadership role to develop a range of strategies and skills in their negotiations with the wider political and health system for the continued survival of their centres.

CHAPTER SIX

Working With The Wider System

Introduction

Each respondent in this study described their shared, daily experience of having to negotiate a complex web of political, management and power issues. They all mentioned the need to be able to *"think on their feet"*. Their jobs required them to quickly assess situations with funding bodies, government officials, senior management staff and the wider community and bureaucratic system. The need to be alert to current political trends and community resources was also emphasised. They all described a sense of feeling under threat, having to deal with diminishing resources and a political context that constantly undermined the value of their work and principles regarding women's health services.

This chapter describes each of the sub-themes that emerged in relation to each coordinator's everyday experience of interactions with the wider system of funding bodies, government departments, bureaucrats, politicians and community representatives. The four sub-themes: loss of autonomy; political awareness; power issues; and strategies and negotiations; reveal the challenges made by the wider system to the autonomy of women's health centres. These themes highlight the need for each coordinator to develop a keen political awareness and an appreciation of the power issues that operate internally and externally to their centres, and the strategies and negotiations undertaken by them as women managers in order to deal with a range of managerial and wider system issues.

In particular, this chapter explores the strategies and processes developed by the women in this study to maximise their success and efficiency in negotiating with their major stakeholders. The implications for management training are also discussed, especially in relation to improving the use of networking skills, and in recommending that management training courses teach managers to understand and utilise the political and power structures within their organisations. The chapter concludes with a summary of the strategies employed by the women managers in their everyday negotiations with staff, funding bodies, politicians, bureaucrats and the wider community system.

Loss of autonomy

In their dealings with the wider system, all coordinators expressed strong sentiments relating to feeling under threat, not so much personally, but in terms of their services being lost through amalgamations with other generic, and even hospital-based, services. In the broadest sense, they all shared the same opinion, that the existence of women's health centres was once again being called into question. They felt that the 'Why women's health?' catch cry of previous eras was being repeated, challenging their sense of identity and autonomy as managers of specialist women's health services.

Karen and Clare spoke of their frustration arising from spending so much time on *"fighting the same struggles over and over and over again about autonomy and independence"*, a task which necessitated being away from the everyday management of their centres. As repetitive, demoralising and energy-sapping as this aspect of their

work was reported to be, all women were adamant about not giving up the struggle to fight for as much autonomy and identity as possible.

> *"So the confidentiality and the maintaining of safe places for women, is at the moment being challenged obviously through amalgamations, but it is also being challenged through information technology."* (Sue)

> *"So a lot of our time and energy here has been put into focussing on that amalgamation and ensuring that this centre maintains its distinctness and autonomy as much as possible within the bigger organisation."* (Karen)

Some coordinators expressed grave doubts regarding the future of their centres, perceiving that the recent amalgamations and privatisation policies of the current government were not only stripping them of their identity but destroying their work. These fears were clearly and commonly stated:

> *"I think one of the fears even of amalgamating with the generic services is [about the] loss of our feminist face and always having to answer to somebody else.."* (Clare)

> *"One of the things that has worried me is that they'll all [women's health centres] gradually get eaten away into nothingness. Like they'll get spread over the system, and you won't have a defined women's health centre in a region any more."* (Sue)

Sue put it in terms of the further marginalisation of women's health through progressive funding cuts. The result for her has been to be more involved with policy and broader women's issues, in order to:

> *"...maintain a profile for women, not just for women's health, because the profile for women has just been cut and cut and cut and marginalised; and so some of the things we do now are not just with women's health but are with other women's organisations to just ensure that there is a profile there."* (Sue)

The concerns expressed by the women managers in this study about loss of autonomy and independence due to amalgamation with larger, bureaucratic health services is supported by Hughes' (1996) analysis of the impact of current government policies on community-based services. The cost of amalgamating with larger organisations is that many community services may lose their independence through greater government control, and that the role of communities and agency staff in decision-making in local services may be diminished (p.39). The significance of losing community participation is not to be underestimated, as women's health centres have always fought to include the community in decision-making as part of their fundamental principles of community empowerment. In the new contract climate, it has been just as important to continue to strive to include a consumer (community) perspective, so that women's health centres can satisfy both their feminist ideals as well as criteria for funding.

The threat of loss of independence as well as loss of community participation has been further increased with the introduction of government contracting policies, such as the Funder/Purchaser/Provider Model of health care delivery. Such policies may result in the exclusion of clients and community from service planning, and the previously cooperative model of communicating ideas, information and service designs could disappear under increased competition between services for the shrinking community health dollar (Hughes, 1996).

Egan and Hoatson (1998), reinforce the concerns of the women in the current study, and support Hughes' (1996) reservations about the impact of current government policies on community services such as feminist organisations. Not only are

community services such as women's health centres at risk of losing their autonomy and community input, but the mainstreaming of feminist services may ultimately mean "that some feminist services as we know them, may cease to exist" (Egan & Hoatson, 1998, p.13).

In further support of the findings of this study, Egan and Hoatson's (1998) interviews with a range of women working in feminist organisations yielded very similar results. For example, their respondents also expressed fears about the threat to their feminist identity, reporting greater internal and external conflict and tension from government pressure to mainstream work done by their services. Egan and Hoatson also revealed that for some services, embracing these governmental changes has resulted in such a diminution of their feminist principles that "their feminist roots are barely recognisable" (p.12). This is precisely what the women coordinators in this study meant when they stated their fears that amalgamation and the new contract culture would result in a *"loss of our feminist face"*. and that *"women's health centres will gradually get eaten away into nothingness."* These concerns are also supported by Weeks (1994) who stated that the non-feminist approaches and male dominance in positions of power within the larger organisations, with which some specialist women's services are being amalgamated, pose a real danger to the survival of the *"feminist face"* of women's services.

The comments from the women in this study regarding their concerns that women's services will be further marginalised under current government policies, and that the autonomy and integrity of their work will be destroyed is also supported by previous

studies. For example, Weeks (1994, p.293), noted that government policies which result in amalgamations of feminist services with generalist service organisations, such as hospitals or generic community services, "rarely allow any real autonomy to the smaller unit", and make the maintaining of a woman-centred focus on service delivery more difficult. In particular, amalgamation is likely to diminish the power of women's voices both within the women's service and at the management committee level, where any independent or legal power is at risk of being coopted by the vested interests of the board of the auspice organisation.

The loss of autonomy and the threat to the survival of their services emerged as core concerns of the coordinators in this study. The effect of changing political agendas on the centres has also necessitated a sharp learning curve for their managers with respect to the becoming more politically astute, as the following section outlines.

Political awareness

All coordinators described at least part of their everyday working life as requiring them to be politically aware. Being 'tuned in' to the political climate was identified as a vital part of their job. Sue described their tasks as coordinators of women's health centres to have been more and more focussed on ways to maintain *"a face and a consideration for women's health"*, requiring them to embark on what she termed as *"a political marketing exercise."* Other coordinators mentioned the need for each of them to be *"a political creature"*, and that they have been unable to luxuriate in idealism or, as Karen put it, to be *"naive about the world."*

They shared, too, a common experience in feeling that their work has been largely misunderstood by most politicians and bureaucrats. Their view of the few politicians and bureaucrats who did have knowledge and insight into the value of preserving specialist health services for women was that they were mostly women, who are *"in the minority in their positions anyway"*, and who were therefore not major stakeholders of political power. However, despite the small representation of women politicians and bureaucrats who are sympathetic to the ideals and goals of women's health services, these advocates are vitally important (Petersen, 1994; Weeks, 1994). For example, they provide a crucial avenue for women's health issues to enter the political network, and help the voice of women's health workers to be heard in arenas where they might otherwise be completely silent.

Government issues and agendas were frequently mentioned as having a direct impact on their jobs. This awareness was not stated in terms of policy (although clarification of this was sought during subsequent interviews) but with regard to needing to have an understanding of broader political tools, concepts and strategic positioning. Most coordinators demonstrated an advanced level of insight into the context of their work in the current political climate, and the ways in which changes in government policy had undermined their power to fight to maintain their centre's existence.

> *"...two weeks after my arrival to do this job I was part of, the other women's health managers had been informed that the government was going to radically change the way we worked, and that had a huge influence on me."*
> (Mary)

> *"One of the tools of change from the government was to put each of us [women's health centres] in a radically different context so that what we shared was our unique experiences that [then] wasn't necessarily transferable or applicable to any other one centre."* (Karen)

The shared experience of the women coordinators in this study with regard to their need to be politically aware in their jobs is well supported by a number of authors on feminist women's services (Broom, 1991; Martin, 1993; Radoslovich, 1994; Smith, 1992; Stevens, 1995; Weeks, 1994). All of these authors agree that an important role of feminist services is to lobby for change in order to improve conditions for women at not just the individual, community and social levels in society, but in the political arena too. As Radoslovich (1994), explains, women's health centres are charged with a responsibility to pursue health and social issues for women, particularly when certain issues recur in our society and are detrimental to the well-being of women. In practice, this process occurs by

> working with women on a one to one basis,...utilising research as an important tool,...running groups and tapping into the strength that women bring to supporting each other. The final step is taking the issue up at the policy and political levels (Radoslovich, 1994, p.61).

While many of the workers in feminist services are involved in these political actions, until the current study, no research had focussed on the role of the women who manage these services and their experience as leaders and activists in the political arena. The need for women's health centre coordinators to be aware of political issues and to incorporate this knowledge into their roles as managers, as described in this study, is supported by the literature on the experience of women managers working in a range of different settings (Ferrario, 1994; Fineman, 1995; Marshall, 1993; Martin, 1993; Quick, Nelson & Quick, 1990; Stevenson & Pinn, 1995; Strachan, 1994). For example, Marshall (1993) found that the women managers in her study were required to be increasingly aware of organisational politics and the interface of their

organisations with the current political climate, even though only a few of them "hinted" that they undertook an actively political role. According to Marshall (p.166), her respondents reported being "fascinated" by watching the "political power plays", but most "tended to sit on the sidelines of organisational politics" rather than get involved.

In contrast to the findings of Marshall (1993), Stevenson and Pinn's (1995) interviews with a range of women working in management positions found strong support for political awareness as well as action, with many of their respondents emphasising the need to engage in activities which challenged the "political monoculture." It should be noted that the women managers in Stevenson and Pinn's study were in senior management, bureaucratic or political positions, or in organisations (such as universities) which have a history of being "on the cutting edge of social change." The same can be said of organisations such as women's health centres, which have always had a prominent social reform agenda, suggesting that it may be more necessary for managers of these organisations to be politically astute, and to use this knowledge in a more active fashion.

In support of this suggestion, a number of authors on feminist women's services suggest that the tensions intrinsic to the relationship between many community-based women's services and the bureaucracy necessitate careful 'politicking', and a need by these services to fully understand the fluctuating political and power issues that affect them (Broom, 1991; Kenwood & Hanson, 1996; Radoslovich, 1994; Weeks, 1994). According to Kenwood and Hanson (1996) and Radoslovich (1994), a central

consideration for women's services in their dealings with the wider political and bureaucratic system is having to maintain a complex balance between being service providers as well as advocates for broader social and political change, while at the same time being directly funded by the system they seek to challenge. Little wonder, then, that a sample of women who now occupy management positions in these services reported a shared experience of having to acquire a degree of political savvy and the ability to understand and negotiate the changing political climate.

In further support of the findings of this study, White, Cox and Cooper (1992) classified their sample of successful women managers as "wise politicians" because of their ability to effectively understand and negotiate the political systems both inside and outside their organisations. White, Cox and Cooper also described the political styles of the women managers they interviewed as incorporating the ability to look beyond existing organisational, gender, social and managerial paradigms, thus enabling them to challenge the normative nature of politics and power, and intellectually bypass "the constraints allocated to women in society and organisational settings" (p.223).

White, Cox and Cooper's (1992) findings support the everyday experience of the women managers in this study who were found to embrace a broad and active political awareness, and a commitment to developing a clear understanding of the power relationships in their jobs. The following section examines the power issues identified by all the coordinators in this study, and describes some of their shared and differing perspectives to their analysis and management of these.

Power issues

All women managers in the current study discussed at some length the central notion of power. They all seemed to be very aware of the importance of power in their positions, their power, power of others and the system. Each of them was careful to clarify their use of the term *"power"*, particularly in relation to their use of it. For example, Clare talked about *"taking her power"* and being *"very careful about how I use my power"*. All talked about the need to name the power and to analyse and understand existing power relationships, particularly with reference to their funding bodies, and in relation to their own roles.

Some women managers needed to state their dislike of the word *"power"*, but seemed reconciled to its inevitable presence in her job. For example, Karen spoke of the need to balance reality with her natural idealism, musing about how much better the world would be if feminist principles of *"empowerment"* rather than *"power over"* were the primary mode of operation in the wider system. Other coordinators made similar comments, reflecting on ideal feminist practice of non-abusive use of power and their struggle to understand and negotiate the real *"power plays"* that are quite explicit in their everyday working lives.

> *"There's always been in this place quite a lot of attention paid to an analysis, I suppose, which is structural, which starts from the world and society and power relationships. I mean it's quite explicit in the way we work. I mean, it's been quite explicit in the way we talk about everything that happens, both to women out there and to us in here..."* (Mary)

> *"I don't think I realised, at first, by the position, by the nature of the job, that you are in a different position in terms of power, and even though we are very much a flat structure and try to eliminate that power, it is there..."* (Clare)

Most women managers in this study expressed feelings of oppression by their funding bodies, especially since the change to a more conservative, economically driven, federal government. The dominant government policy of increasing the privatisation of health services, including the amalgamations of women's health services with generic services were named as causal factors. The result of this had been a strong perception amongst coordinators that women's health centres were being even further marginalised by the government, with an ultimate view to being dismantled. Consequently, they have felt under constant and increasing pressure to fight to maintain existing services. Two coordinators mentioned that one of the *"tools"* that the government used was *"to distance us from our team and our management committee."* One coordinator saw it clearly as a deliberate act of power over them, of oppression, of a 'divide and conquer' manoeuvre.

> *"...if you took it as a version of oppression, the [funding body's] come around to have a good go at oppressing a group [women's health centres]. One of the responses of the oppressed group is to see that they haven't got a response back to the regime, and so they go inward and do each other over."* (Mary)

All respondents shared some of this feeling. The temptation to turn inward and criticise each other as a response to the pressures that the lack of understanding or political support from the wider system had created, appears to have been strong. However, this was only mentioned in the past tense, with comments about needing to create a *"unified front"*, feeling bonded by *"shared feminist principles"*, and wanting to make the time to meet and support each other in their roles as managers, taking precedence.

For example, Mary spoke about the need to *"use their power"* by remaining cohesive and to present as a unified team, to provide *" a grand and more powerful sense of, it's not just me and the workers and service you are dealing with."*. Clare and Sue spoke of needing to *"learn from these experiences"* and about recognising *"opportunities"* to maintain whatever power base they had. Karen shared some of her anger about the feeling of oppression, of feeling undermined, but most of all, *"the devaluing of the work we do."*

The comments of respondents in this study with respect to their experience of the power issues in their roles as managers highlight the dichotomous nature of power, whether it be individual or organisational. For example, all the coordinators described the oppressive and destructive aspects of power, while also recognising the potential positive benefits of learning to *"harness"* their power. This awareness of the positive and negative components of power, and the need to critically analyse power from a feminist perspective rather than simply dismiss it as a *"dirty word"* is well supported by feminist literature (Broom, 1991; Dwyer, 1989; Grant, 1988; Kanter, 1977; Marshall, 1993; Martin, 1993; Newton, 1995; Theberge, 1987; Weeks, 1994). For example, Theberge (1987) saw the potential of power as not just about male force and oppression, but as energy and creativity. Broom (1991) described power as more than just a negative "monolithic, threat-of-force, monopolised by people (men) with formal status or physical strength" (p.114). Nor, claimed Broom, is the "discourse of empowerment" just an attempt to "sanitise unsavoury male power and package it in an acceptable, feminised form" (p.114). Broom thus highlighted the positive and negative potential of power, and stressed the need for women to explore their own relationship

to power, their use of it, and the power exerted by others as well as the power differentials inherent in western society.

The ability of the coordinators in their roles as managers to grapple with their own feelings about power, and to work towards understanding the power relationships operating within their services and in the wider system is strongly supported by some feminist authors who believe it to be vital skill for managers to use their power in their organisations as an opportunity for positive change (Kanter, 1977; Marshall, 1993). Kanter's (1977) analysis of the role of women in organisations in relation to the use of their power supports the findings of this study. Like the coordinators, Kanter (1977, p.63) recognised the positive potential of organisational power, defining the appropriate use of one's power in the workplace as "the ability to get things done, to mobilise resources and use whatever it is a person needs for the goals he or she is attempting to meet."

Likewise, Marshall reinforces the insight of the women in the current study in acknowledging the value of learning to use their power as managers constructively, especially in times of great organisational change when "power means commanding scarce resources in the organisational system, and is thus heavily dependent on one's position in the organisation's opportunity structure" (Marshall, 1993, p.98). Consequently, Marshall (1993) suggests that managers are in prime positions to use their power to utilise resources in order to maximise opportunities for staff and for carrying out organisational directives. Use of one's positional power, not personal

power, can therefore be highly constructive, and can work for the benefit - and empowerment - of all.

The need for the women's health centre coordinators to learn to understand and use their power in order to empower themselves, others and their service, is further supported by the work of Broom (1991) and Weeks (1994). Both authors emphasise the relevance for women working in feminist services to understand the duality of power relationships and "to acquire specific skills relevant to the exercise of power, in order to attain and function in key positions (in society)" (Broom, p.114). The feminist managers interviewed for Weeks' (1994) study, like the coordinators in the current study, highlighted the importance of developing a thorough awareness of the power issues operating around them, and stressed the benefits of "naming the power, and its boundaries, in the roles of both coordinator and committee chairperson" in order to "demystify it and give clarity to people's roles" (p.162).

Understanding the duality of power, as demonstrated by the women coordinators in this study, and recognising the danger as well as the opportunity of organisational power, is challenging and thus has implications for management training. The findings of this study suggest that management training should include formal instruction on how to define power in the workplace, openly name it, and learn to *"harness"* it appropriately. Negotiation skills training which deals explicitly with power in relationships and how to deal positively and effectively with it, is also indicated. A survey of the literature on management training, particularly for new managers, did not reveal any explicit mention of power, nor how to deal with relationships where power

imbalances would be inevitable. However, much of the feminist discourse on women in the workplace discussed the role of power, although this was mainly in relation to social and gender issues, work principles, sexual harassment, stress management, and not specifically directed to managers or management training (Fagenson, 1993; Martin, 1993; Newton, 1995; Weeks, 1994).

A few exceptions are to be found in the work of Colwill (1993), Marshall (1993), Hearn and Parkin (1995), and Stevenson and Pinn (1995) who discuss the relevance to managers of understanding power relationships in the workplace. Two publications even provide models for mapping organisational power (Hearn & Parkin, 1995; Marshall, 1993). However, while these authors contribute much to the literature on management, especially for women managers, none constitutes a comprehensive training package. The findings of this study imply that managers would benefit from training that enables them to acquire the appropriate skills to negotiate issues of power in the workplace, rather than have to learn them in an ad hoc fashion. On this point, Chusmir and Franks (1988) and Mawson (1993) strongly agree, suggesting that management training should teach women supervisors and managers about the use of power, politics and resources in the organisation context. This is particularly relevant for women managers in small, community-based organisations who often come into management positions without formal management training. Much stress and personal struggle may be avoided by providing the necessary managerial skills beforehand rather than leaving managers to learn on-the-job, especially when their roles are already time-pressured, isolated and emotionally demanding.

Strategies and negotiations

> *"Being strategic, being a central part in all the negotiations, it's vital. Being in on what's going on and finding ways to make a space for women's health, it can be tricky, and I built up a whole host of tactics to get us in there, get us to the negotiating table..."* (Mary)

> *"We need to be in there, being visible, being part of all these negotiations, because the ground can get shifted before you even know it. So people understand and want, strategically, for us [coordinators] to be involved..."* (Karen)

Closely linked to their awareness of political agendas and power issues, all coordinators spoke of having had to develop a strategic approach to their everyday working negotiations. Put simply, it appears that they have had to get 'street smart' by doing *"deals"*, building *"illusions"*, monitoring shifting power bases, and developing ways to *"strategise things"* in order to help their centres to survive. As Mary described it, *"we built up a whole host of tactics"* in order to successfully negotiate for what they needed. These tactics involved intensive lobbying of people on committees, and of rallying support from others in a way that was tangible to management and funding bodies.

Developing informal (as well as formal) networks and connections with other organisations and public offices were commonly cited as important ways of getting results, establishing support and of setting up negotiations and strategising. Since the recent amalgamations, however, this seems to have become more difficult, as Sue described:

> *"[I] had very strong connections in the bureaucracy. Like, I always knew who to ring. I always knew who to tap. You knew your way of getting round the system. Now it is different, and so you have to play it much harder in the, you know, the bigger environment."*

All coordinators agreed that while formal connections with the bureaucracy were easier to achieve, the establishment of trusted, informal contacts were more difficult, especially in times of enormous change and mainstreaming within larger bureaucratic systems. The frequency with which colleagues and professional contacts changed jobs as a result of the state of flux in most government services and departments contributed to the problem of maintaining relevant and useful contacts for any period of time. The difficulties inherent in being female managers and feeling isolated and even excluded from the more traditional informal networks (usually male-dominated) were also mentioned. As Sue stated, these difficulties have been exacerbated by having to associate directly with a much larger bureaucratic network, especially as this has meant being part of a traditionally male-dominated management structure, and therefore having to build networks within a patriarchal system.

Many authors support the findings of this study about the usefulness of establishing both formal and informal networks by managers in their work with the wider system as well as within their own organisations (Fagenson, 1993; Hartman, 1993; Korabik, McDonald & Rosin, 1993; Marshall, 1993; Mawson, 1993; Northcraft & Gutek, 1993; Radoslovich, 1994; Stevenson & Pinn, 1995, Weeks, 1994). The formation of organisational networks and alliances is widely endorsed as vital to managers in order to improve organisational support, deal with power issues, provide personal support and mentoring, and in assisting with negotiations with politicians and the broader work arena.

While some authors claim that women managers have long been excluded from the more traditional, powerful, and male-oriented informal networks, often referred to as the "old boy" networks (Korabik, McDonald & Rosin, 1993), "the men's room" or "the locker room syndrome" (Marshall, 1993), this is beginning to change (Northcraft & Gutek, 1993; Marshall, 1993; Richbell, 1976; Stevenson & Pinn, 1995). As more women occupy management positions, women managers are beginning to develop their own power bases using social opportunities to foster informal professional connections. Women's business networks are on the increase and may soon challenge the traditionally male-dominated exclusive networking clubs and organisations which will "no longer be able to afford to exclude knowledgeable and insightful women from their informal executive inner circles" (Northcraft & Gutek, 1993, p.225).

Stevenson and Pinn's (1995) study adds further support to the experience of the women coordinators in the current study regarding the importance of networking, especially in relation to negotiating with funding bodies, politicians and lobby groups. For example, the women managers interviewed for their study "frequently mentioned" the importance of forming alliances and networks with other women and men to help with a wide range of everyday work negotiations.

> Such alliances are often established across political and geographical boundaries as needed, to deal with (an) issue. The need for more effective male-female alliances was also often mentioned - that this really *'would be powerful'* for dealing with issues; also for attacking *'patriarchal structures, even if they are in women's groups'*! The phenomenon of these kinds of alliances is hopefully an emerging challenge to traditional mateship alliances" (Stevenson & Pinn, p.280)

Another strategy mentioned by all coordinators was the need to balance their idealism with a strong practical approach. The commitment to maintaining their ethics, feminist principles and sense of personal integrity in their negotiations with the wider system was related to this concept. For example, Clare and Karen described having to match their desire to work from a strong feminist management base with not always having the resources to carry through this ideal in practice. Sue and Mary, summed up these sentiments as follows:

> *"I found a wonderful, wonderful phrase from a friend, which is 'ethical pragmatism'. How do you become pragmatic and still maintain an ethical framework?"* (Mary)

> *"And I see that as one of the biggest challenges, now, how to be pragmatic, and how to maintain those principles and look at different ways of using them."* (Sue)

Finding ways to utilise their core principles in a practical and often time-pressured context was reported by all coordinators in the current study to have been achieved by adapting or modifying their styles of management to suit the organisational context and/or issue at hand. That is, their management strategies and styles have *"evolved"* according to their roles.

> *"I actually had to review my style to be mindful that I now sat in a structural position, and that structural position had a far greater impact on others than formerly when I wasn't in a management position."* (Mary)

Their different styles and methods are closely linked to themes in this chapter about their use of power, and the development of, and reliance on, good policies and written guidelines. For example, Karen spoke of the importance of having a *"strong policy*

framework" which has been *"developed by staff and management committee"* in order to guide the decision making process for herself as well as for others. This, she said, has acted as a safeguard against inconsistent or erratic decisions, and allowed staff to be aware of how final decisions were derived.

Perhaps not surprisingly, all coordinators also shared the notion that a high degree of organisational ability is essential to their success. They all spoke of having developed a range of strategies and *"systems"* to help them keep on top of their enormous workloads as managers. They all seemed to be very confident of their efficiency, whilst recognising that sometimes even the best organisational systems break down. Most commonly cited *"systems"* were diaries, lists, lists of lists, whiteboards, coloured stickers and post-it notes, self-sent phone message reminders, and for one coordinator *"a really great administrative assistant"*.

> *"So my diary and myself became bosom buddies, and yellow stickers for the next lot of check lists and you know - it is a skill base I have. I am very organised. I have a very good system. I can see now why systems are so important."* (Mary)

They also mentioned a common belief that the recognition and the setting up of good management structures was vitally important to them. This seemed to be particularly true for them in times of turmoil or uncertainty, that clear management structures, strategic plans and stated principles for their services were what they had to fall back on, amidst negotiations with the wider system of funding bodies and government departments.

> *"In order to survive those really difficult political times, having the structure, the management structure that we set up, and having those clearly explicated principles, have been the really important things for me."* (Sue)

Mary and Sue also mentioned that an important practical strategy, when employing staff, has been to always keep in mind the political and philosophical aspects of the work, as well as the more explicit goals of the service. While these are not the major criteria when recruiting new staff, they are relevant to the maintenance of a cohesive team (shared, or compatible, philosophical beliefs), and to matching individual skills of workers to existing as well as possible future projects. Other practical strategies seemed to be harder to define, requiring an intuitive approach to knowing when to act quickly and when to spend the time to *"think things through."* For example, Sue, Karen and Clare talked about the need to *"act quickly"* in times of conflict or dispute, especially with regard to staffing and client matters.

> *"I think one of the things I am really conscious of, people come to complain, clients come to complain, workers come to complain, whatever, I have concerns. I address them as quickly as possible."* (Clare)

> *"As soon as I am presented with a problem, like I'm driving back to work and I've gone through [in my mind] and I've strategised things..."* (Karen)

The experience of the women in this study in their roles as managers of small, community-based women's health centres, particularly in relation to the practical strategies developed by them to carry out their everyday work, is supported by the literature on contemporary health service management, as well as the research on the challenges faced by feminist services in the current economic and political climate in Australia (Eagar, 1992; Egan & Hoatson, 1998; Hoatson & Dixon, 1997; Kenwood & Hanson, 1996; Kovner & Neuhauser, 1994; Laris, 1992; Marshall, 1993; Still, 1988; Umiker, 1994; Weeks, 1994). For example, a number of authors support the necessity of well-developed organisational and managerial systems to the role of managers,

especially the use of clear management structures, strategic plans and mission statements (Eagar, 1992; Kovner & Neuhauser, 1994; Laris, 1992; Still, 1988; Umiker, 1994). Moreover, Marshall (1993) suggests that in times of great organisational change and uncertainty (as experienced by the women's health centres in the current study) well-controlled organisational plans and procedures are essential for increasing service stability and provide a measure of certainty or order amidst the chaos of change.

In support of the experience of the women managers in this research, many authors endorse the use of strong policy frameworks which have been derived in consultation with staff and the management committee or hierarchy, to guide both policy development and implementation (Eagar, 1992; Kenwood & Hanson, 1996; Laris, 1992; Umiker, 1994). As Umiker (p.34) observes,

> Policies are broad guidelines for reaching goals or meeting standards. They reflect the philosophy and values of an organisation...(and) permit managers to be flexible...A sound policy is one that is needed, achievable, flexible, enforceable, acceptable, understandable, and fair.

Clear policy frameworks and written guidelines are especially important in new organisations or those undergoing rapid and/or extensive changes (Marshall, 1993; Umiker, 1994). Without appropriate policies, organisations and their managers risk management by crisis, wasting time by negotiating the same issues over and over again with external and internal stakeholders (Eagar, 1992; Laris, 1992; Umiker, 1994; Weeks, 1994). Thus, clear policies, as identified by each coordinator in the current study, are essential to save time and increase effective communication in all negotiations between managers, staff and the wider system, as well as providing what

Brown (1992) conceptualised as "flexible order." In particular, the development and implementation of good policy frameworks are an important strategy to reduce external and internal conflicts to which small, community-based services in the current competitive contract climate are especially prone (Egan & Hoatson, 1998; Hoatson & Dixon, 1997), as well as providing a mechanism for accountability and accreditation (Weeks, 1994).

Finally, the somewhat complex strategy of balancing one's idealism with pragmatics, as described by the women managers in this study, is strongly reinforced by several feminist authors (Broom, 1991; Dwyer, 1992; Weeks, 1994). This seems to be a particularly crucial strategy when congruence between feminist principles and practice and mainstream management processes is low (Dwyer, 1992). Finding an appropriate balance between principle and practice can be both challenging and rewarding (Hawkeshurst & Morrow, 1984; Weeks, 1994). As Weeks (p.144) highlights, retaining one's integrity and "sanity" can be especially difficult in services which are marginalised, treated as "alternative" or "other" and which view the world from a "non-dominant" perspective. While Weeks did not expand on the implications for managers in particular, her analysis did emphasise the difficulties for workers in such services who are, by virtue of their marginalised status, continually placed in the position of "going against the stream." For managers, whose jobs are already isolated, and especially for women managers, who are still considered a minority in management positions, the pressures of conforming to mainstream practices while still maintaining alternative (feminist) management principles must be considerable. Certainly, the findings of the current study suggest this to be the case, as women

coordinators struggle to balance the pragmatics of working in increasingly mainstreamed, under-resourced services while attempting to uphold their personal ethics and feminist ethos.

Summary of findings

The findings presented in this chapter reveal a number of strategies used by these women managers in their everyday negotiations with staff, funding bodies, politicians, bureaucrats, and the wider system. To summarise, these strategies included:

- being politically aware and well-informed;
- creating strong policy frameworks and written guidelines;
- identifying and understanding the power issues;
- being guided by the clearly explicated baseline principles of their centres;
- setting up clear management structures;
- developing and maintaining highly efficient organisational systems;
- developing good formal and informal professional networks;
- being prepared to engage in intensive, strategic lobbying for support;
- having a strong commitment to maintaining personal and professional ethics and integrity;
- balancing idealism with pragmatics; and
- employing intuitive interventions, such as knowing when to act quickly and when to wait.

This chapter also provided a detailed review of the literature in relation to the experience of the coordinators in this study, revealing considerable support for the

strategies and skills used by these women managers in dealing with a range of managerial and wider system issues. The complex array of skills required by them in order to negotiate with the wider system and to deal with issues relating to loss of autonomy and the fight for survival, understanding the daily political context and *"power plays"*, and generally negotiating with staff, funding bodies, bureaucrats and other stakeholders, raised questions about the need for relevant management training.

One implication of these findings has been to suggest that managers, especially those new to the job or those who have not had formal management training, may benefit from management training that provides practical strategies on how to understand and deal with the political and power structures within their organisation. This is particularly relevant if the wide range of skills demanded of the women in this study are indicative of those required of women managers elsewhere. Given the degree of support provided by the literature for the experiences of the respondents in this study, it seems likely that the findings of this study may be generalisable to women managers working in comparable settings. Furthermore, the apparent lack of published material for management training programmes would suggest that further research is needed to address the way in which political awareness and knowledge about how to handle power issues in organisations can be effectively incorporated into management training packages.

A further implication of this study is a financial as well as organisational one. If organisations begin to recognise the need for managers to have access to job-specific training (for example, teaching managers to deal with political and power issues), such

a commitment will require the allocation of adequate time and financial resources. The long-term cost benefits would be worthwhile, particularly for women managers who come into management positions without any formal management training, as was the case for two of the managers in the current study. Such provision for training support would be likely to reduce the personal costs to managers of job stress and strain caused by having to develop the required managerial skills on the job, especially given the time-pressures, isolation and lack of support often associated with women managers' roles. This latter point is taken up in the next chapter, which explores the demanding nature of the job as described by the women managers in this study.

CHAPTER SEVEN

Demanding Nature Of The Job

Introduction

Given the degree of diversity and the challenges inherent in the everyday experience of women's health centre coordinators, it is a measure of the consistency of coordinators' *shared* experience that a common theme emerged regarding the demanding nature of their job. This theme was reflected by all participants and constituted three main categories: the job is always changing; the work is emotionally and physically taxing; and the boundaries between their work and personal life need to be clear.

The experiences of the coordinators in the current study point to the unique difficulties faced by women managers, not only in terms of their roles in economically and politically vulnerable, marginalised and under-resourced, feminist services, but also with regard to the special stressors affecting women who juggle career and family lives. As this chapter reveals, the combination of these stressors, together with the added burden of the diverse and demanding nature of working in front-line, community service organisations, such as women's health centres, can have significant physical and emotional effects on women managers.

Another key finding of this chapter is that while the women in this study have experienced their jobs to be incredibly demanding, they have also discovered several useful techniques for managing their personal stress levels. Maintaining a healthy balance between work and non-work life, and looking for the *"opportunities"* amidst all the *"chaos and turmoil"* of their everyday working lives as women's health centre

coordinators, are amongst the main strategies for coping with their *"challenging and stimulating"* jobs.

The changing dimensions of the job that make it *"never boring"* and *"full of surprises"*, as well as stressful, emotionally and physically demanding, are described in the first part of this chapter. The implications for the women in this study, and for women managers of marginalised and small organisations generally, are presented later in the chapter. The findings of this study are also examined in detail in relation to current literature, and finally, the strategies employed by women's health centre coordinators are summarised and discussed.

Job changes

> *"... two weeks after my arrival to do this job I was part of, the other women's health centre managers had been informed that the government was going to radically change the way we worked, and that had a huge influence on what it [this job] means. Because the job I initially sought has never been available to me."* (Mary)

This quote encapsulates the degree of change that the women managers interviewed for this study had experienced since taking up their current positions as coordinators of women's health centres. All commented on how much their jobs had changed, and that these changes were on-going and *"relentless"*. In summary, these changes fall into two main categories: fundamental staff and job description changes; and changes that constitute everyday variety in their work.

With regard to fundamental changes in their job descriptions, all coordinators mentioned how they had been caught up in negotiations with the government and

health services bureaucracy over the nature of their jobs. Where they had previously had clearly delineated roles as coordinators of relatively independent specialist health services to women, they were seeing their jobs change as the very structure of their organisations changed. The impact of amalgamation and the increasing dominance of the contract culture meant that for all coordinators, the jobs they had originally taken up, had been dramatically re-defined.

All women described that they had struggled with the bureaucracy to adequately define their roles, through on-going negotiations within the new hierarchical structure of their organisations. As a consequence, a common element to their experience of their jobs was having to deal with lots of turmoil, chaos and change on a daily basis.

> *"...to know that the story was changing every day would be quite threatening and disconcerting."* (Sue)

> *"...you are in an environment where the picture changes constantly..."* (Clare)

Most of the turmoil and change came from not knowing from one day to the next how changing government policies would affect their centres, whether women's health would be totally subsumed into generic health services, or even whether the coordinators would still have jobs in the future.

Changes in government policy, and the resulting uncertainty about the structure, form or viability of their centres, produced a difficult and demanding climate for all coordinators and staff in their centres. This lack of security and the context of continuous change was accompanied by increasingly high staff turnovers, as the following quote describes:

> *"In the middle of all this [uncertainty about my job] I managed staff changes. I think the first eighteen months we had twenty-two major staff changes...so we had enormous changes...No answer, no guarantee, and an ever-changing configuration."* (Mary)

As Sue expressed it, at one level she was dealing with the *"bigger picture of whether women's health centres were going to survive at all"*, while on another level she was fighting for her own job. In amongst these major battles, she was also continuing to manage the numerous fluctuations in staff, with high turnovers, but even more demanding, the changing moods and insecurities amongst her staff. Ever present, was the sense of responsibility for the smooth running of her service, responding to daily queries from staff about the provision of everyday needs, such as stationery, while managing the bigger issues of whether women's health would continue to exist in the future. Karen described the process of moving between these extreme and changing levels of her job as manager as *"you keep going from the macro to the absolute micro!"*

A particularly demanding aspect of the job, according to both Karen and Clare, was the realisation that their staff rely on them for a huge range of information, as well as support. Again, the shared experience of feeling the pressure of having to be flexible enough to keep sight of the broader vision and issues of the service while still being available to answer staff queries of a more daily nature, was expressed. For example, in the early days of her job as coordinator, Clare was constantly surprised by the range of questions from staff that she was fielding:

> *"I didn't expect people to come and ask me the things they ask me. I was often quite surprised by it [although] now it can be really useful."*

Clare quickly learnt that while she was an important, central resource person to her staff, this could be *"tiring, incredibly tiring"*. In particular, the pressure of being expected to be available to her staff all the time, left her feeling frustrated and over-responsible, although it was also a helpful way to keep a connection with her staff and their on-going projects. Karen's comments were similar, saying that staff *"expect me to know everything!"* and this could be a burden at times.

Most of all, the need to be able to respond to a varied and often extreme range of issues in the natural course of any one day at work, resulted in a sense of frustration for most coordinators in this study. As Karen articulated it:

> *"And that's one of the things about my job. I thought my work was pretty fragmented as a community health worker, you know...but it is nothing compared to this job...I mean, it's just bits. It is really bitty."* (Karen)

Other coordinators agreed, saying that chronic under-resourcing meant that they did not have adequate staff to whom they could delegate a share of the *"odd jobs"*. This was usually further compounded by the service delivery focus of their centres which meant that front line staff were often too fully committed with seeing clients and running community projects to be available to pick up some of the daily loose ends regarding the practical administration of the service. According to Mary and Clare, having to pick up on these varied and *"bitty"* tasks added to the fragmented and chaotic flavour of their jobs, and sometimes undermined a sense of clarity about what their role as managers involved.

An interesting finding in this study was that while all the women described the stress of working in the *"ever-changing configuration"* of their jobs, they also emphasised

that these changes were not entirely negative all the time. For example, every respondent mentioned that their work was *"never boring"*. While comments about their roles as coordinators were described jokingly as being *"full of surprises"*, these comments were explained to have a dual meaning. That is, for all the stress and demands of the changes and challenges in their roles and working environments, there was also a simultaneous acknowledgment that this variety and uncertainty provided them with constant interest and excitement. They all stated that they were stimulated and challenged in their roles as managers in ways that resulted in them never feeling bored, stale or professionally stagnated. Furthermore, each woman spoke of possessing an energy and willingness *"to take on new things and new challenges"*, although their energy to follow through on this fluctuated depending on how *"under fire"* they felt by the wider system.

> *"...challenging. Never boring. And I think that is the thing that is really interesting about it, even though I've been in this position for something like five years, and I think I could say I've never got bored, which not too many people could say in their jobs."* (Sue)

> *"In all the time I've been here I have felt that...there's enough stimulating stuff that is happening that I haven't felt stale or bored..."* (Karen)

> *"It is a very different experience to, you know, my previous work...there are surprises here."* (Clare)

While Mary did not use the same words as the other coordinators to describe her way of seeing the positive side of the huge demands of her job, she did acknowledge that the difficulties and challenges of being a women's health service manager in a very unstable economic environment had its benefits:

> *"So it was a [time of] very big change and uncertainty. And so this is where for me personally, my style is, I have had to live in chaos. That is my style. So chaos suited me quite well, and I had to own that."* (Mary)

Each of the women in this study attributed the demanding nature of their jobs to the fact that they were coordinating their centres through a period of change in Federal and State government. Changes in policy and the move to increased institutionalisation (through amalgamation with large, bureaucratic organisations) and privatisation had resulted in massive changes to the management of generic health services as well as specialist women's health services (Egan & Hoatson, 1998). As a consequence, the amalgamation of health services, and the new contract culture had re-shaped the relationship between government and community service organisations, like women's health centres (Hughes, 1996). The introduction of the concept of market forces into the community services sector dramatically altered the culture and structure of such organisations, representing a radical swing away from grassroots management principles. These changes have had profound implications for the management of community service organisations, such as women's health centres, creating a more complex, hierarchical management structure (Kenwood & Hanson, 1996).

For the women managing these centres, their jobs have gone through a protracted evolutionary process, as they have negotiated their roles with the new management hierarchy and attempted to carve out a place for feminist management within a business focussed, mainstream management culture. While their efforts in this regard have been largely constructive, their achievements as coordinators of women's health centres in the 1990s have not been gained without considerable physical and emotional effort. The personal toll that their jobs have taken on them is the focus of the following section.

Emotional and physical strain

> *"Wherever I am and whatever work I do...what I need to learn is, it gets better, it gets worse, it gets better, it gets worse, and I never ever feel, 'Ah, I've got over that. It is going to be smooth.' Because it is just not like that. This job, it's like a...yeah, just like a rollercoaster."* (Clare)

All coordinators spoke of the emotional, mental and physical demands of their jobs, commonly describing their work as being *"really, really hard"* at times. One Coordinator, Sue, described the emotional strain as almost a physical pain, *"really burnt and hurt"*, from which she had seen previous coordinators suffer for extended periods of time.

Many of the coordinators used evocative language to describe the toll the job takes and has taken on them. The following quotes give examples of how *"pushed"* they have been in their everyday working lives:

> *"... sometimes you have to do the really horrible stuff. And you hear that from some of the other Coordinators and I think, "Oh, God, this is just really, really awful."* (Sue)

> *"And there have been times over the years when I've just said....you know, "This is just really hard. This is really, really hard and I don't know how I'm going to handle this."* (Karen)

The difficult aspects of their jobs, the *"really horrible stuff"* was mostly attributed to the constant changes in the economic and political climate, and the number of changing demands this placed on them. For example, Mary described the pressure to conform to the *"mainstream, bureaucratic regime"* as a continual source of stress. In particular, the struggle to maintain the integrity of her centre, hold on to the *"baseline*

principles", and to stay personally *"sane"* contributed to considerable anxiety and self-doubt:

> *"And so that [dealing with the bureaucracy] was a struggle. It was a perennial struggle and still is. And one that I am not so angst-ridden about now. There are some days where I for my own survival [I] will take a known course that will help me connect with people so that where we have the discomfort is over what, I think, are the real issues. So that can be a doozey of an experience."* (Mary)

Other coordinators echoed Mary's experience, stating that some of the most difficult and demanding moments in their jobs as managers of women's health centres have been to do with the degree of conflict, frustration and tension between themselves and the bureaucracy. The imposed changes to their services due to government strategies such as amalgamation, and the constant negotiations regarding the impact of these strategies on the core philosophy and principles of their centres were reported to be *"emotionally and physically exhausting"*. The continual fight for the survival of their centres, the strain of having to work with shoestring budgets, the uncertainty of future funding, and the energy required to mediate and resolve conflicts between staff amidst all the change and turmoil, were also mentioned as highly demanding aspects of their jobs as coordinators.

Staffing issues represented a common theme for coordinators, both in terms of the enjoyment of the job, but also the pressures. Having to be always available and accountable to staff and funding bodies, and being *"interrogated"* on their opinions and their ideological principles were mentioned as main sources of emotional strain. The amount of time and energy spent maintaining good working relationships with

staff, while often rewarding and a source of support and satisfaction, was also reported to be emotionally draining at times.

> *"...there is maintaining that relationship stuff all the time and that perhaps is where one of my biggest stress factors actually is around, you know, always thinking about how to work with those sorts of issues."* (Clare)

Mary described this emotional pressure as being available to staff and being expected to have all the answers, keeping everything running smoothly and keeping staff motivated and *"on top of things"*. Karen referred to the same issues as stressful, and of feeling like everyone's *"mother"*, picking up after staff, chasing them up for their time sheets and fielding continuous questions.

> *"So it is a bit trying sometimes. I just think, 'Oh my God, I'm busy too. I don't want to follow this stuff up' ...I sometimes feel really impatient. You know, when people come to me with things. I feel I've got to make out I'm not, but inside I'm going 'Oh for god's sake! Find out yourself!!"*

While most women in the current study described the leadership aspects of their job as mainly rewarding, a *"challenge"* and a *"privilege"*, the isolation and sense of responsibility inherent in their roles as managers was also reported to be emotionally and physically demanding. Having no-one to talk to about their work, and the need to support and *"protect"* staff as part of their caring, supervisory role as women managers meant that emotional support for themselves was not always available, adequate or appropriate from co-workers. The best support often came from ex-coordinators, family and friends, although this was usually ad-hoc and after the day's crises were over. One coordinator Clare, expressed a desire to meet with other coordinators of women's health centres on a regular basis, and hoped that this research might act as a catalyst for her and the other participants in the study to meet and

discuss their experiences. However, she stated that their busy work schedules and long distances might make regular meetings of this nature unlikely.

The amount of work and the number and range of demands on them all the time were also reported to be major stressors in their jobs. They all talked about having felt overwhelmed by their workloads on many occasions, despite having developed very efficient and organised ways of getting their work done. The inability to cope with all the demands of the job did not appear to be related to the number of years in the coordinator's position, with all coordinators referring to their individual struggles to adjust to the sheer volume of work. For example, Clare attributed this stress to her lack of experience, however, the coordinator who had been longest in the job also reported her workload to be enormous.

> *"Maybe it's just lack of experience [and] that will come later when I've been longer in the job, but I just can't pick up on the huge things like that myself because it would send me over the edge at the moment, with the workload, I mean, I am always on the edge."* (Clare)

> *"How do I do it all? Because there is much more than I can do. I've always been fairly organised and I've always been pretty productive in the sense that I can get through a lot...So I'm quite good on getting stuff done. And sometimes I do feel overwhelmed."* (Sue)

Most of the women described the job as eventually taking a toll on their health and energy levels, some even manifesting serious physical symptoms. All coordinators spoke of having experienced periods of utter exhaustion and fatigue. Physical symptoms ranged from not having the energy to cook meals, *"I've gotten into eating take-aways far too much"*, to feeling chronically fatigued, *"a persistent weariness in my entire body"*, to extreme physical debilitation, *"sometimes lying flat on my back [at*

work] because I couldn't sit on a chair". Three of the four coordinators mentioned having had to take one or more considerable periods of leave from the job, or to reduce working hours from full-time to part-time in order to manage mounting physical symptoms of prolonged work-related stress.

> *"And I also took four months off during last year. I took long service leave and annual leave and went for four months because I was buggered. I really did need a break. By then it had been two and a half to three years of really hard slog. And I knew I needed a break. I knew I was coming close to the edge and starting to burn out. I wasn't burnt out but... I felt like I might have been on the slippery slope."* (Karen)

> *"And what it resulted in for me personally was, I think it manifested physically. I ... I was in a Jobs in Jeopardy programme for a while because my health was so poor that I was having to consider- quite physically- whether I could keep my job...So I was conducting repeated amalgamation meetings, sometimes lying flat on my back because I couldn't sit on a chair. And so for me personally at that level, it was draining and it required me to really actively manage my own physical well-being, which, you know, you get between the rhetoric and the reality of being in women's health."* (Mary)

> *"...Yeah but, in spite of all those difficulties and the complexity of it, I like the job, but it is tiring. I reckon I've aged, lots...I feel the stress in my face, and my lines. Not that there is a problem with aging in itself, but the fact is this job has precipitated a lot of [stress], you know, and sometimes just tiredness in my body, you know. Like, when I get home and I don't want to do this, I just want to eat out every night now. I really do. I just don't want to go home and cook, I don't have the energy..."* (Clare)

Some Coordinators even talked about a time limit or a *"use by date"* in the job, because it was recognised by them to be such demanding work, so physically and mentally challenging. For Sue, this was an issue with which she has had to come to terms.

> *"I felt there was a use-by date for Coordinators of women's health. And that concerned me a lot last year, and I actually did start looking for other work, and then I suppose I went through a phase of realising there is still a lot that I feel I've got to give."*

For all the women in this study, staying in the job and coping with all the emotional and physical demands has been partly contingent on their ability to keep their work and personal lives as separate as possible. The importance of this strategy for mitigating their stress levels is described in the next section.

Maintaining a balance between work and personal life

All Coordinators talked about the importance of keeping the demands of work away from their home life as much as possible. Most admitted that this was or had been a struggle at times. Some mentioned the overlap between work and personal life was inevitable given their life principles, the demands of the job and the public profile of their positions. They were all conscious of being in the public eye, where their personal and professional integrity was on show, and where even the way they manage their lives outside of work may be examined by others. As Sue put it, one can feel quite intruded upon,

> *"Because you are personally challenged all the time, and because your work flows over into your life stuff, so the way you manage your life outside of work is something that is looked at as well. Like, 'Does she really maintain the line? Is she really a feminist?' And all of those things. They are the sort of things that creep in. Mmm. So things, you know, can be really tough..."*

Two Coordinators, Clare and Karen, emphasised the need to keep as much privacy as possible in order to limit the amount that their work already overflows into their home life. They stated the sheer workload as contributing to both the problem of work spilling into personal time, and the necessity to have a clear ambition to maintain boundaries between these two aspects of their lives.

Most of the time they were all successful at maintaining a balance between work and other parts of their lives, although all agreed that in times of greatest chaos and demand at work that *"keeping a balance, keeping work at work, it's well, it's hard to keep up, really hard."* The temptation take work home, despite making promises to themselves not to, was greatest when they felt under pressure to meet deadlines or felt overly responsible for some project or funding concern.

> *"So I think I've been good at maintaining a balance between work and the rest of my life...[but] that balance gets wobbly at times."* (Karen)

> *"And I do take work home. I promised myself that I wouldn't because I actually have a family...so I go home and try not to do it."* (Clare)

> *"I don't take it [work] home although I used to. I don't work on weekends. I don't take work home at night anymore."* (Mary)

The value of keeping up the *"struggle"* to prevent work from spilling over into their non-work lives is discussed, along with each aspect of the demanding nature of their work, in the remainder of this chapter.

Overview and analysis

The demanding nature of working in such unpredictable and ever-changing circumstances is well documented and supports the experience of the women interviewed in the current study. Much has been written on the pressures, difficulties and stressors for workers who are having to negotiate their jobs through periods of rapid and wide-sweeping organisational change (Beehr, 1995; Brockner, 1988; Burns, 1992; Davidson & Cooper, 1983; Farber, 1983; Kahn, 1981; McCrimmon, 1997; Sarros & Sarros, 1991; Woodward & Buchholz, 1987). According to Sarros and Sarros (1991, p. 44), change in the workplace "results from both external and internal

forces" which operate on organisational systems to produce differing levels of unpredictability and chaos. They summarise the external forces necessitating organisational change as: the marketplace, through increased, often aggressive competition; changes to government laws, regulations and policies; fluctuation of labour markets; and economic and political changes and their impact on organisational climates.

The internal forces that lead to change are often a direct response to external factors and include: redesigning organisational strategies in order to keep pace with economic, political and social development; changes in the nature of the organisations work force and conditions of employment; and changes in employee attitudes to work and life (Sarros & Sarros, 1991, p.45). This summary of the factors that lead to organisational change supports the description by the women managers in this study regarding the forces precipitating the changes in their working lives. The changing political and economic climate and the need to consequently re-define their roles as a result of the imposed hierarchical re-structuring of their services were mentioned as significant changes which have influenced their centres.

Several authors link both the *rate* of change and the *imposed* nature of such organisational change to worker perceptions of stress (Beehr, 1995; Cherniss, 1982; McCrimmon, 1997; Muchinsky, 1993; Woodward & Buchholz, 1987). As the rate of organisational change increases, so do the demands on the worker. This is further compounded if such changes are involuntary or imposed from outside the individual

and/or their organisation. As McCrimmon (p.16) states, worker perceptions of stress and strain are likely to be increased when:

- major organisational change occurs;
- employees have a lot personally invested in the status quo;
- change is imposed;
- the pace of change is high; and
- employees have a strong fear of losing control.

For the women interviewed in this study, many of the above components were present in their stories about their work and the degree of change that they have endured in their everyday working lives as coordinators of women's health centres. Certainly, their descriptions about the level of organisational change through amalgamations with generic health services, and the rapidity with which these changes took place, especially in Mary's case where her job was radically re-defined just two weeks after her employment, are reflected in McCrimmon's (1997) criteria for job stress and strain. Furthermore, the coordinators have revealed in this study how personally invested and passionately committed they are to their jobs, and how fearful they have been that the core philosophies and purpose of women's health services will be lost through the imposed changes made by the incumbent government and its focus on corporatism and the centralisation of health services. It is little wonder then, that they described their jobs as highly demanding and stressful. That the literature on worker stress supports their experiences merely underlines the taxing reality of their working lives.

In addition to the link between worker perceptions of stress and the rate and involuntary nature of organisational change, is the association between *role* changes and job stress. Changes to their roles as managers, especially the re-classification from 'coordinator' to 'manager', emerged as a common and powerful sub-theme to the *"ever-changing configuration"* of their everyday working lives. The resultant lack of clarity about their roles, and their struggle to define these, was reported to be a particularly demanding and stressful component of their experience.

The relationship between lack of clarity about worker roles, commonly categorised in the literature into two main aspects called role ambiguity and role conflict, and worker perceptions of stress, is extensively documented (Bedeian & Armenakis, 1981; Beehr, 1995; Brief, Schuler & Van Sell, 1981; Brockner, 1988; Burke, 1998; Harris, 1985; Jayaratine & Chess, 1984; Korabik, McDonald & Rosin, 1993; McCrimmon, 1997; Muchinsky, 1993; Sarros & Sarros, 1991; Thompson & Powers, 1983). This tension is even more pronounced when it affects on managers of organisations, whose roles are central to the overall functioning of their service, as well as being pivotal to the well-being and productivity of their staff (Davidson & Cooper, 1983; McCrimmon, 1997; Nelson & Quick, 1985; Quick, Nelson & Quick, 1990). As McCrimmon (p.38) states, the climate of economic change has required

> organisations to continually restructure themselves, forcing all managers to adopt new roles...(consequently) managers are increasingly required to 'float' between various functions with less well-defined boundaries. Many are uncomfortable with this ambiguity.

Furthermore, the economic, political and social roots of stressors such as bureaucratic red tape, emphasis on accountability and quantifiable outcome measures rather than qualitative processes, all contribute to the high levels of role ambiguity and conflict for managers and workers alike (Cherniss, 1982; Carroll & White, 1981; Dressel, 1980; Muchinsky, 1993; Pines, 1982). Higher stress levels resulting from increased fragmentation, change, uncertainty, conflict and ambiguity in work roles are, as Dressel (1980) asserts, due to the nature of the western political system and the policy making process. Cherniss (1982, p.83) concurs, stating that

> inadequate funds result from legislation that is largely symbolic and meant only to serve the political needs of legislators. Fragmented and uncoordinated service systems...result from the politician's efforts to satisfy the demands of competing interest groups. The politicians need to demonstrate visible results leads to (worker) goal displacement (such as emphasis on the number of clients served rather than on the quality of service).

The ability to deal with such role ambiguity, conflict and change varies according to the personality of the individual, although the perception of difficulty in coping with such changes may still be reported to be high (Cooper & Payne, 1991; Hobfoll, 1988; Muchinsky, 1993; Nelson & Quick, 1985; Quick, Nelson & Quick, 1990; Sarros & Sarros, 1991; Semmer, 1998). This supports the findings in the current study, particularly where some coordinators found differing aspects of their jobs to be more stressful than others. For example, Mary claimed that she enjoyed the *"chaos"* of change and uncertainty in her job, stating that it *"suited me quite well."* Nevertheless, despite each of the coordinators being able to see some positive aspects to the high degree and rate of change in their roles and everyday working lives, they all reported

significant emotional and physical symptoms of stress, resulting, in most cases, in having to take considerable time away from their jobs in order to recuperate.

The negative impact of changing and conflictual working conditions on the emotional and physical well-being of the women in this study, is reinforced by the work of Hoatson and Dixon (1997). From their research into the effects of economic rationalism on community service providers in two small inner Melbourne suburbs, they found that

> the changing environment has resulted in considerable stress...Nearly all organisations have felt under threat, have had resources withdrawn and are more anxious. Redundancies have eroded morale. Difficult decisions about boundaries, increasing output, and enforced role changes have created tension within organisations as workers and committees struggle to balance the meeting of needs with an imposed centralised policy agenda. One community health centre had been so destabilised by uncertainty that it has been essential to invest resources in team building and visioning activities in order to effectively support staff (p.48).

Furthermore, Hoatson and Dixon found that some workers were so damaged by the stressful working conditions that mediation was required in order to salvage work relationships, and to talk out the conflicts to "see if new understandings (could) be built" (p. 49).

The pressure of having to defend the principles and integrity of both themselves and their centres, as expressed by the women managers in the current study, is also supported by the work of Marshall (1994). Marshall's thesis on why women leave senior management jobs suggested that the demands of dealing with daily challenges to one's integrity and legitimacy is likely to make women managers feel significantly undermined, as well as contribute to feelings of stress, tiredness, and even illness.

Grimwood and Popplestone (1993, p.102) found similar experiences amongst women managers whom they surveyed:

> Being ignored, undermined, put down and devalued is stressful, and of course stress is, in any case, an everyday fact of life in personal social services work: by its very nature the work is stressful. Increasing demands and diminishing resources to meet them further increase the inherent stress, particularly for people who really care about the quality of the service.

As this chapter revealed, all coordinators mentioned not only the degree of change and uncertainty as stressful, but the *"sheer volume"* of the work as particularly demanding. This finding is supported by the job stress literature, which identifies "too much work", or role overload, as a primary source of stress at work (Beehr, 1995; Burns, 1992; Cooper & Payne, 1991; Kahn, 1981; Korabik, McDonald & Rosin, 1993; Sarros & Sarros, 1991). Feeling quantitatively overloaded at work, as one coordinator, Sue, described as having *"much more work than I can do"*, creates a time pressure on workers, which, when combined with the added responsibility of management can result in a serious accumulation of 'executive' stress (Burns, 1992; Kahn, 1981; Quick, Nelson & Quick, 1990).

Furthermore, studies on the stressors specific to managers have identified several key contributors to executive stress, which support the experiences of the women managers in the current study. These include prolonged informational overload; conflicting external environmental demands, such as the pressure of competition for funding, or unpredictable market conditions; and the pressure of interpersonal demands, such as dealing with staff conflict, or encouraging good team building (Burns, 1992; Nelson & Quick, 1985; Quick, Nelson & Quick, 1990). In particular, the pressures on middle

managers, such as women's health centre coordinators, are even more pronounced as "the problem becomes one of balancing one's loyalties and defining and meeting one's commitments to those above and below the hierarchy" (Edelwich & Brodsky, 1980, p.22). The pressure to balance loyalties can also contribute to feeling overloaded in the job, particularly amongst women in middle management, as they are more likely to favour a collaborative style of management, and will therefore spend more time and energy negotiating the differing needs of co-workers and supervisors (Davidson & Cooper, 1988).

Quantitative overload can also arise due to the lack of ability by a manager to delegate tasks to other workers, as was reported by the women managers in this study. This inability can be a function of inadequate resources, and when combined with feelings of "being exceptional or isolated, may induce (further) blocks to delegation" (Davidson & Cooper, 1982, p.16). Davidson and Cooper's statement supports the experience of the coordinators in the current study who stated that both the lack of staff to whom they could delegate and a feeling of isolation were contributing aspects to the demanding nature of their jobs.

A key sub-theme explored in this chapter was the way in which each coordinator experienced the emotional and physical strain of their daily work. The link between work stress and needing to take time away from work due to ill health was suggested as all women described the physical and emotional toll the work had taken on them. Comments such as *"a total weariness"*, *"physical exhaustion"* and feeling *"worn"* or *"prematurely aged"*, were commonly used to describe this aspect of their experience.

While researchers are still investigating the relationship between stress and illness, the literature supports the experience of the women in this study by confirming that stress can be directly or indirectly associated with a range of physical and emotional symptoms (Beehr, 1995; Burke & Richardsen, 1996; Burns, 1992; Cox, Kuk & Leiter, 1993; Grimwood & Popplestone, 1993; Handy, 1995; Marshall, 1994; Muchinsky, 1993; Nelson & Quick, 1985; Quick, Nelson & Quick, 1990; Schwartz, Pickering & Landsbergis, 1996). As Burns (1992, p.1) observes:

> An overload of stressors at any one time, or the accumulation of stressors over time, may predispose people to illness and disease. Many health researchers believe that wear and tear on the body and mind from continually adjusting and adapting to stressful situations increases susceptibility to a variety of stress-related illnesses.

Broom (1991), had much to say about the irony in the high incidence of worker stress, illness and burnout in women's health services, especially given the role of such services in helping to improve the health and well-being of its clients. She and other authors (Egan & Hoatson, 1998; Martin, 1990; Riger, 1984; Weeks, 1994), attest to the highly stressful nature of the work in feminist services, and the correspondingly high rate of burnout amongst workers. According to Egan & Hoatson (1998), the primary causes of worker stress in feminist services include: the difficult and emotionally demanding nature of the work; the small size of their organisations (therefore necessitating workers to do more of everything); and the lack of resources. They further suggest that the combination of these factors result in a work environment "conducive to burnout and major conflict" (p.8).

Several previous studies on women working in feminist services support the comments of the women managers in the current study regarding their experience of the demanding and pressurised nature of their job. For example, Broom (1991), in her interviews with women working in women's health centres found that while many of the women enjoyed their jobs, job satisfaction had often been achieved at great personal cost. As Broom states, "nearly all of them have found it challenging and exhausting. For a few, it has been a shattering turning point in their lives" (p.84). Similarly, Egan & Hoatson's (1998) study of women working in a range of feminist services found that many of the women "spoke of their experiences of leaving services damaged, resentful and feeling betrayed" (p.8). Hunt's (1994) study also revealed the demanding nature of the work of women in community health services, and the physical and emotional strain experienced by workers.

While many studies of women working in feminist services have focussed on workers generally, virtually none have explored the effects of work stress on women in feminist management positions. One exception has been Weeks' (1994) study, which explored the leadership and staff team issues of ten coordinators of several different types of women's crisis and community centres. Interestingly, the coordinators whom she interviewed reported very similar symptoms and causes of stress to the women in the current study. For example, the women managers in Weeks' study identified feelings of "fatigue, exhaustion and stress, even a feeling of pain", most often attributed to the long hours at work, information overload and pressure, frustration with bureaucratic procedures, and funding problems (p.163).

Maintaining a balance between work and personal life was an important sub-theme which emerged from this study. All coordinators mentioned that the all-encompassing and sometimes personally intrusive nature of the job (for example, being the *"public face"* of their centres), had led them to become protective of their personal lives, and to make the boundaries between life at work and life outside of work, very clear. The "spill over" of stress from work to personal and family life (and vice versa) is not uncommon among professional women, having been found to be a common theme in a number of studies of working women (Brett & Stroh, 1994; Bromet, Dew & Parkinson, 1990; Burke, 1998; Chapman, Ingersoll-Dayton & Neal, 1994; Crouter, 1984; Davidson & Cooper, 1988; Grimwood & Popplestone, 1993; Higgins, Duxbury & Irving, 1992; Kirchmeyer, 1992; Korabik, McDonald & Rosin, 1993; Pleck, Staines & Lang, 1980).

The need to keep the boundaries between work and home is a particularly important issue for women, as the "problems of integrating work and family lives still fall more heavily on women than men" (Bromet, Dew & Parkinson, 1990). This can be especially difficult for women managers, who are often juggling core management roles, not just at work but in the home. A 'work-family conflict' may result, whereby the balance between work pressures and home pressures can become skewed, causing additional stress on women managers (Burke, 1998; Greenhaus & Parasuraman, 1994; Gutek, Repetti & Silver, 1988; Higgins, Duxbury & Irving, 1992; Korabik, McDonald & Rosin, 1993; Stoner, Hartman & Arora, 1991).

The difficult, yet important, *"struggle"* by the women managers in the current study to maintain a balance between work and personal life was reported to *"get wobbly at times"*. According to research by Grimwood and Popplestone (1993, p.102), on women managers working in a social services department, some 90 percent of their respondents experienced a similar struggle in balancing their work and personal life:

> Reconciling their two roles, paid work and domestic, is, of course, another major stress factor for women. Not surprisingly, women managers with children find themselves less able to relax than do men when they return home from work. Indeed, coming home is often another source of stress for them. At all level of management, tiredness ranked as the stress symptom most common to women managers.

The pressures for married women and women with children can be considerable, as they juggle home and work lives. Ruzek (1986, p.202), referred to this tricky balance of multiple roles as the "double burden" afflicting career women. Where their male counterparts often report marriage and family as a source of quality emotional and practical support for their careers, working wives and mothers often experience the direct opposite (Nicholson & West, 1988). Grimwood and Popplestone also cite particular difficulties in maintaining a balance between work and home life for women managers who are single and/or lesbian due to "other stresses concerned with the lack of social acceptability of their lifestyles" (p. 103). While the women in the current study did not mention sexual or marital preferences in relation to the pressures of keeping work out of their personal lives, difficulties of this nature were implied by comments about the way in which others may question what they do in their private lives, such as *"does she really maintain the line? Is she really a feminist?"* It is little wonder then, that according to the research on women managers, regardless of marital status, family composition, or sexual preference, they have been found to be more

susceptible to stress linked with their private lives than their male manager counterparts (Davidson & Cooper, 1983, 1988; Grimwood & Popplestone, 1993; Korabik, McDonald & Rosin, 1993; Marshall, 1994; Nicholson & West, 1988).

Consequently, a number of authors emphasise the importance of keeping clearly delineated boundaries between work and personal lives as an effective stress management strategy (Greenhaus & Parasuraman, 1994; Hall & Richter, 1995; Quick, Nelson & Quick, 1990). This confirms the experience of the women in the current study who reported the personal benefits of maintaining an optimal balance between work and home life, even though working on this balance was sometimes difficult to sustain. Furthermore, in helping workers to reduce or manage the stress associated with trying to maintain the balance between work and personal lives, social support has been found to be instrumental (Chapman, Ingersoll-Dayton & Neal, 1994; Frone, Russell & Cooper, 1991; Grimwood & Popplestone, 1993; Korabik, McDonald & Rosin, 1993; Marshall, 1994; Muchinsky, 1993; Parasuraman, Greenhaus & Granrose, 1992). Establishing a corporate dialogue on the work-home balance and making the struggle of trying to maintain this balance a "discussable" topic at management level is a strategy recommended by Hall and Richter (1995), whose work supports the women in the current study - all of whom have spoken out about the importance of maintaining this balance, as evidenced by its emergence as a significant sub-theme of this chapter.

Making promises to themselves such as *"I don't take work home at night anymore"*, was only one of several coping strategies identified by the women in this study in response to the demanding nature of their work. Other strategies mentioned by

coordinators to reduce stress or simply to cope with the unpredictability of their jobs included:

- being highly organised;
- seeking social support from co-workers, family, friends, other coordinators, or ex-coordinators;
- seeing the positive aspects of the changing nature of their jobs as *"stimulating"* *"never boring"* and *"full of surprises"*; and
- taking recuperative leave from work when their level of physical and/or mental stress became too high.

A summary of the literature on the mediators of job stress and burnout supports the use of the stress management strategies employed by the coordinators in this study. For example, being highly organised, having clearly established priorities and good time management skills are important strategies to help keep stress at work under control (Burke, 1998; Burns, 1992; Davidson & Cooper, 1983; Kirchmeyer, 1992). Keeping a positive outlook and looking for the opportunities in a changing work environment are also useful tools to cope with work stress (Burke, 1998; Burns, 1992; Edelwich & Brodsky, 1980; Lincoln, 1991; Murphy, 1998; Sarros & Sarros, 1991). Many authors also emphasise the need to take 'time out' from work, especially when feeling overwhelmed with the demands of work, although all authors agree that such periods are most effective when utilised daily as a primary preventative measure rather than used as a 'lump sum' to offset serious stress symptomatology (Burke, 1998; Burns, 1992; Muchinsky, 1993; Nelson & Quick, 1985; Quick, Nelson & Quick, 1990). Building in regular breaks is widely regarded as one of the most effective methods of

avoiding excessive stress reactions, although managers find these breaks hard to justify if they are feeling overly responsible or accountable for the continued productivity of their organisations (Burns, 1992; Muchinsky, 1993). Effective delegation is also a recommended strategy for reducing the workload of managers (Davidson & Cooper, 1983; Loden, 1985; Sarros & Sarros, 1991), although in the current study this was reported to be an unreliable option due to lack of staffing resources.

One of the most effective mediators of worker stress reported in the literature is social support, especially quality support from co-workers and supervisors (Burke, 1998; Burns, 1992; Kahn & Byosiere, 1995; Korabik, McDonald & Rosin, 1993; Quick, Nelson & Quick, 1990; Sarros & Sarros, 1991; Schumaker & Brownell, 1984; Winnubst & Schabracq, 1996). This has important implications for the current study, where it was obvious from respondents' comments that accessing adequate and appropriate support from within their centres was often difficult.

Further research may be useful to explore and analyse specific and realistic strategies for support of management staff working in under-resourced organisations, especially in those services - like women's health centres - that are particularly vulnerable to changes in the economic and political climate. One outcome of such research may be to help managers to better develop support networks within or across organisations.

At the very least, future research on the topic of support for managers may help to give wider recognition of the problems faced by them, especially those working in small, marginalised and/or under-resourced organisations. Such research may also provide

formal validation of the need for managers to take time out of their busy schedules to meet with like-minded colleagues on a regular basis. For women managers in particular, this may help to off-set the feelings of isolation, and regular support from women in similar positions may assist in the generation of creative ideas about delegation and other impossible tasks facing managers in smaller organisations. Certainly, the ability of managers, male or female, to embrace leadership roles which allow them to create opportunities for organisational change, as is the case for the women managers in this study, must be significantly impaired if these same managers are not adequately supported in their jobs, and become physically and mentally exhausted by the constant demands placed upon them. The following, final chapter summarises these and other implications of this study for managers, and makes further recommendations for future research.

CHAPTER EIGHT

Summary and Conclusions

Introduction

This phenomenological study of the lived experience of women's health centre coordinators has described their everyday working roles, and extrapolated the shared meanings of being a woman manager in specialist, feminist, community-based organisations. Four distinct aspects of their shared experience emerged: the importance of shared principles, passions and rewards; their feminist leadership role as managers of specialist health services; working with the wider system; and the demanding nature of their job.

However, the significance of this study lies in the documentation of the parameters of their experience, rendering visible those processes and strategies developed by them in their unique roles as feminist managers. It describes, in their own words, their philosophical and practical approach to management, one which clearly differentiates their work from mainstream, male-dominated, management traditions. In turning up the volume on the world of women's health centre coordinators, this thesis also provides an exposition of the external pressures that contribute to their everyday experience. It lays bare some of the political and economic dilemmas posed by the current climate of changing government policies and corporate management trends.

This final chapter summarises the findings of the study, highlights the strategies used by women's health centre coordinators in their everyday working roles, and clarifies the implications for managers working in similar settings, for management training and for future research.

Summary of findings

The thesis began with a broad brush sketch of the theoretical and contextual framework for the study in Chapter One, providing a rationale for its undertaking, and an outline of the main research objectives. Chapters Two and Three explicated the methodological and procedural steps in conducting the research, and clarified the potential limitations of the study. Chapters Four to Seven described and analysed each of the four emergent themes, exploring the component sub-themes in detail. Diagram 4, on the following page, summarises the composition of each theme.

In keeping with the tradition of phenomenological studies, as well as the purpose of the final chapter of this thesis, these themes are synthesised to form an exhaustive description which captures the *essential structure* of the lived experience of women's health centre coordinators. This process is illustrated in Diagram 5, on page 219. As a first order analysis of data, the information presented in this diagram provides documentation of the experience of women's health centre coordinators that was previously lacking from the women's health literature.

Diagram 4: A summary of how each theme was comprised of its component sub-themes or categories (also a partial audit trail for the analysis of data)

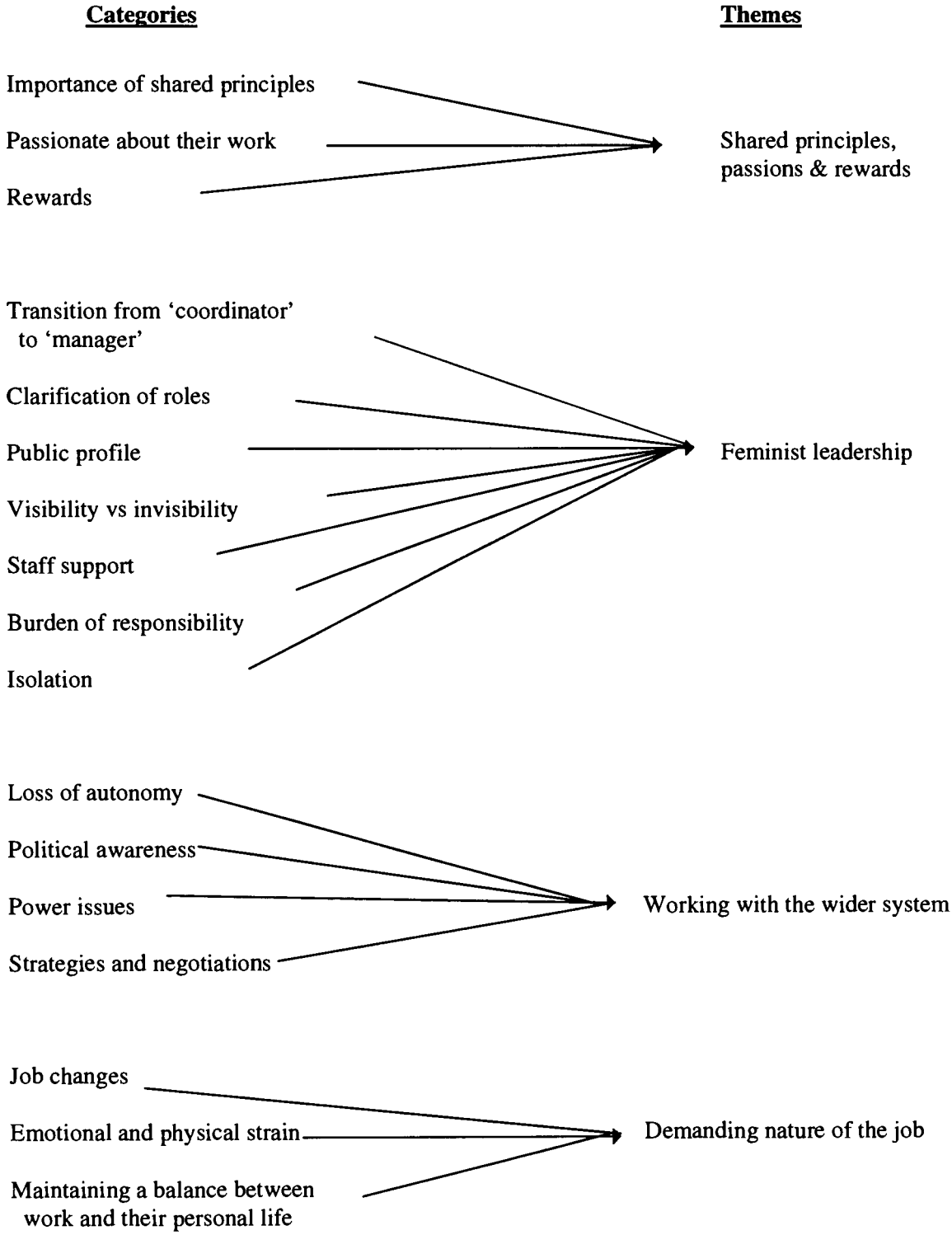
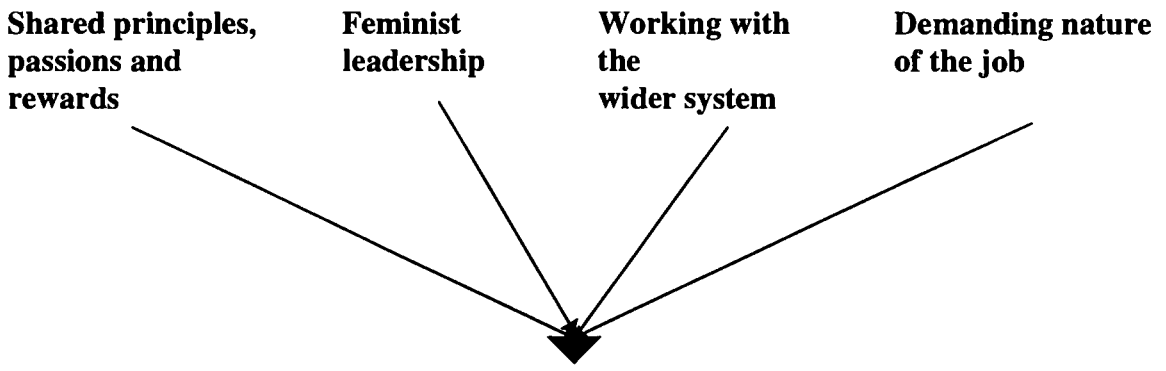


Diagram 5: The synthesis of core themes to form a description of the essential structure of the lived experience of women's health centre coordinators



Their everyday experience is one of a balancing act of many different roles, including daily implementation of feminist leadership and management principles, negotiating and decision making skills, while remaining ever mindful of current political trends and fluctuating agendas. Their core feminist principles provide them with the guiding framework for their work, and are a potent source of passion, job satisfaction, motivation and commitment in their everyday working lives. Their jobs are highly demanding, and, although never boring, the constant variety and change can be emotionally and physically draining. In particular, lack of resources, and the fight for the continued integrity of their services provide an unremitting element of challenge. Role clarity, good organisational skills and clear boundaries between their personal and work lives are essential factors in their daily work. Developing and maintaining collaborative working relationships between themselves and upper management, funding bodies, and especially with their co-workers, is also a vital part of their role as feminist managers and leaders.

However, this thesis does more than produce a snap shot of the working lives of women's health centre coordinators. A significant feature of the study is its second order analysis of the strategies employed by coordinators in carrying out their work, and its exploration of the many factors that have influenced - and continue to influence - their roles as feminist managers. This aspect of the findings has import beyond the confines of women's health centres because the strategies documented here may have applications in other small, community-based services. Certainly, the findings suggest that the experience of the women managers in this study parallels those of feminist managers elsewhere. It follows, therefore, that this thesis has a contribution to make to the study of women in management more broadly, as well as responding to the lack of research information regarding women managers working in feminist, consumer-based organisations.

A concrete example of the value of this thesis in producing more than just a first order description of the experience of women's health centre coordinators, is provided by the range of practical management strategies which emerged as a result of this study. While this exposition of their daily working tools of negotiation, lobbying, teamwork, and application of feminist management principles is tantamount to holding a mirror to their work and reflecting back to respondents what they already know, it has intrinsic value in validating their shared experience. It also has significance in sharing with others their hard earned knowledge about the 'how' of feminist management praxis, as well as adding clarity and importance to what they already do. In order to highlight these strategies with concision, Table 2, on the next page, summarises the findings of this aspect of the study.

Table 2: A summary of the daily strategies used by women's health centre coordinators

Feminist leadership	**Working with the wider system**	**Coping with stress**
* establishing clear, participatory decision making processes	* being politically aware & well-informed	* keeping clear boundaries between work & personal life
* supporting the diversity of women's roles	* creating strong policy frameworks & written guidelines	* being highly organised
* taking the final responsibility where needed	* identifying & understanding the power issues	* seeking social support from co-workers, family & friends
* keeping a *"calm"* exterior, especially during crises	* being guided by the clearly explicated baseline principles of their centres	* focussing on the positive aspects of their jobs
* providing regular staff supervision	* setting up clear management structures	* taking recuperative leave from work when needed
* developing clear lines of communication & *"genuine feedback"* with staff	* maintaining personal & professional ethics & integrity	* utilising their job satisfaction to keep going in difficult times.
* using delegation to establish roles and responsibilities	* developing good formal and informal professional networks	
* resisting pressures to respond to situations immediately	* engaging in intensive, strategic lobbying for support	
* increasing their visibility to staff	* developing highly efficient organisational systems	
* applying feminist management principles to enhance the self-esteem of workers and clients	* using community liaison opportunities as a deliberate marketing strategy to educate others about their work	
* using intuition and a sense of timing	* balancing idealism with pragmatics	

Another example of the importance of this study arises from the management strategies described by women's health centre coordinators. These strategies underscore the centrality to feminist practice of *processes*, not just *outcomes*, a finding consistent with other research into the experience of women working in women's health services (Broom, 1991; Hunt, 1994; Weeks, 1994). However, the significance of the current research is its foray into the difficulties for women managers of maintaining a focus on process-oriented leadership amidst a mainstream management and economic culture that increasingly promotes outcome-oriented activities over other performance indicators. For example, Chapter Four concluded that the impact of having shared, core feminist and social perspectives of women's health is double-barrelled as these principles add both a positive focus for coordinators as well as presenting some practical management difficulties.

Chapters Five and Six explored in more detail the difficulties of managing from a feminist leadership model, outlining the effect that economically and politically driven policies of mainstreaming and rationalising women's health have had on women's health centre managers' definitions of themselves and their roles. Chapter Seven highlighted the personal toll for all respondents of defending their feminist beliefs, and their struggle to find a balance between mainstream versions of the new managerialism and their own feminist interpretations of 'good' management practice. Again, the dual effects of having a common feminist ideology emerged: on one hand these shared principles were reported to provide a buffer for work-related stress, while simultaneously contributing to the tensions of working in a wider system that is hostile to their core beliefs.

Also of potential relevance to other small, under-resourced, community services, are the findings presented throughout this thesis regarding the degree of change that women's health centres have endured, and its effects on the physical and emotional well-being of the women who manage them. According to a number of contemporary authors, this pattern of rapid change is affecting a range of community-based services, not just women's health centres (Egan & Hoatson, 1998; Hughes, 1996; Hoatson & Dixon, 1997; Kenwood & Hanson, 1996). In fact, the 1990's have heralded a period of such sweeping, and constant, change that many commercial companies, government departments, and private enterprises have invested millions of dollars on 'change management' strategies in order to minimise the risk to staff and productivity (Duck, 1993). As Duck implies, too much change can be detrimental to staff well-being, as Chapter Seven revealed, with all coordinators describing the negative effects of working *"in an environment where the picture changes constantly."* In several cases, the physical and mental repercussions of the continuous demands of the job necessitated long periods of leave from work. This *"everchanging configuration"* of the workplace was further compounded by the lack of resources to deal with the change - no million dollar change management strategies had been made available to the women's health centres in this study.

Chapters Five and Six also highlighted the effects of rapid and fundamental change on not only the role of women's health centre coordinators, heralding a change in name to 'manager', but also on the funding and structure of their centres. For example, both chapters identified the influence of changes in government policy which have resulted in the trend to mainstream women's health services, and the consequent loss of autonomy of

their centres. Amalgamation with large, generic health services, such as hospitals, has also imposed a hierarchical, bureaucratic infrastructure on the previously two-tiered structure of women's health centres, undermining their egalitarian philosophy of management, and threatening the feminist principles upon which they were founded.

Interestingly, this thesis revealed that respondents considered the previously flat structure of women's health centres to be unrealistic in everyday practice. Their comments also suggested that the practical difficulties of working from a collective management structure had been reduced, in part, by the new managerialism, although, on balance, the latter had created more tension than it resolved. For example, the new line of management imposed onto women's health centres through amalgamation, meant that coordinators were, more than ever, thrust into a public role as advocates for their services, as well as being the 'line managers' for the women who worked in their centres. While respondents were clearly uncomfortable with the obvious divisions this new structure created in their services, they suggested that similar divisions had been present, although much less visible, under the previous collective arrangement. Coordinators still made *"the final, final decision"* under the old structure, and with the incorporation of feminist leadership principles as part of their new title of manager, the women in this study have still managed to preserve the collaborative component in the decision making processes of the past.

These findings suggest, therefore, that the new managerialism may contribute something positive to women's health centres: a more open approach to already existing, and

arguably necessary, divisions of labour (White, Hodgson & Crainer, 1996). However, it is the totalitarianism of the new managerialistic doctrine that currently threatens the integrity of these feminist women's services. As this study has discussed, traditional management structures and approaches are patriarchal in nature, outcome focussed, and employ strategies which are antithetical to feminist leadership principles which recognise process, empowerment, and context (Martin, 1993). Moreover, the current research has shown how the women who run women's health centres are witnesses to the devaluation of their services' founding principles by the imposition of traditional management cultures and structures. This finding, together with the other results presented in this summary, point to the need for further research into the current issues facing women managers in community-based services.

Implications for future research

Overall, these findings raise a number of questions about the future management of feminist services located within a political, economic and managerial climate that espouses ideals of practice that are radically different to those of the women's movement. These questions are:

- What are the real virtues in the new managerialism, and how can they be incorporated successfully into feminist services, without threatening the extinction of the latter?
- To what extent are feminist principles important to retain, and at what cost?
- If the new managerialism is here to stay, and feminist principles are important to defend, what role does management training for feminist managers play, and how can it be improved?

- Given the climate of change, as reported in this study to be evident in the current health care sector, and its obvious toll on workers, is there an argument for future stability, so that rapidly adapting services can take time to consolidate corporate learning and knowledge?

While this study offers a springboard for exploring these questions, future research that specifically focuses on the issues for feminist managers working in a range of feminist and non-feminist settings would expand on the current research as well as respond to the questions it has generated. For example, comparative studies may help to further clarify the similarities and differences between feminist and mainstream management praxis, and resolve the points of conflict for managers operating from different ideologies and within diverse organisational cultures.

Conclusions

This chapter has summarised the findings of the study and underscored its contribution to the literature pertaining to women in management. In addition to providing direction for future research, this thesis has demonstrated it specific relevance to women managers working in a range of feminist, community-based organisational settings. One of the primary strengths of this study, lies in its documentation of the experience of a cohort of feminist women managers, enabling women in similar organisations to access their knowledge, as well as having visual proof, in writing, of its existence. Without such journalling, the problems faced by women managers working in feminist services remains invisible, with the fight against these difficulties resembling shadow-boxing.

However, this study not only sheds light on the experience of feminist managers in today's climate of corporatism, the new managerialism and rapid change, it identifies the emancipatory potential of feminist leadership principles. In particular, the research has highlighted the issues facing feminist leaders, and has illustrated how the coordinators in the current study defined their responses to those issues using a model of feminist leadership. The study concludes that feminist managers, like those who participated in this research, are helping to create a revolution in the mainstream management arena by providing an alternative approach to managing organisations that is meritorious on many levels. As proof of the value of women's approaches to management - and their reform potential - male-dominated management and executive networks are having to include women, not just because it would be discriminatory to do otherwise (and consequently litigious), but because they increasingly perceive that women in management have much to contribute.

Furthermore, this research has illuminated the original contribution made by respondents to the social reform agenda of the women's health movement. It follows in the footsteps of previous research which has shown how women working in women's health centres have helped to shape the provision of health to women through their pioneering spirit (Broom, 1991), and the development of specialised women's health practices and processes (Hunt, 1994). The current project has extended this knowledge, by elucidating the emancipatory potential of women's health centre coordinators through describing their efforts to incorporate feminist leadership principles within traditional management

structures and cultures and against the backdrop of a highly volatile economic and political climate.

Most importantly, however, this thesis has centred on the voices of the women who participated in the research. It is their experience which provided the context for the second order analysis and authorial reflections on their stories. It is only through the exceptional quality and quantity of their insights that such detailed analysis has been possible. This project has focussed on a managerial perspective which has highlighted the empowering, social reform nature of the everyday work of women's health centre coordinators and their roles as feminist leaders. It is best concluded in their own words:

> *"What do I want to do with the rest of my life? I want a job like this where I can still create a kind of revolution in some ways, exposing injustice and fighting exploitation...And what I do here [as a women's health centre coordinator] is facilitate other people doing that work."* (Karen)

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APPENDICES

APPENDIX A

Edith Cowan University
Faculty of Health and Human Sciences

Dear

I am writing to invite you to participate in the research project which is entitled:
"Centred Voices - A phenomenological study of the lived experiences of women's health centre coordinators".

My name is Jodie Moyle and I have worked for 12 years as a psychologist in a number of non-government settings. Over the years I have worked as a counsellor, consultant and family therapist during which time I have developed a special interest in women's health issues. I am currently studying for a Masters Degree in Health Science at Edith Cowan University.

Further details regarding the research project may be found in the accompanying form. After you have had time to read the enclosed material, I will contact you to see if you are willing to be interviewed and to arrange a mutually convenient appointment.

Yours sincerely

Jodie Moyle.
BSc., Dip App Psych., Dip Hyp., Reg Psych., MAPS.

APPENDIX B

Edith Cowan University
Faculty of Health and Human Sciences

CONSENT FORM

Project Title: Centred voices: A phenomenological study of the lived experience of women's health centre coordinators

Researcher: Jodie Moyle, Phone: (w)[redacted]/(h)[redacted]/(mobile)[redacted]

The purpose of this research is to describe the everyday experiences of women's health centre coordinators. The central question to the study is "what is it like to be a women's health centre coordinator working in the current health system?" In essence, I would like to know what are the thoughts, feelings and stories associated with being a coordinator of a women's health service. It is hoped that this study will increase community awareness and understanding of the type of work you do. Such information will add weight to the growing body of knowledge about women's health centres, and may be useful in future funding submissions.

Interviews will be informal in nature, conversational in style and will, hopefully, last for approximately one hour. More than one interview may be necessary to allow time for participants to reflect on the first interview, and to create an opportunity for the researcher to obtain a full and complete understanding of the experiences of women's health centre coordinators. However, a limit of three interviews will be imposed for practical reasons. All interviews will be conducted in private and interviews will be audiotaped. All participants will be able to stop the tape at any time during the interview or request that certain comments be edited from the tape if they so wish. No individual will be identified on tape. Each tape will be labelled with a code number only as will the corresponding transcripts. When the research has been completed, all tapes will be erased. In the meantime, the tapes will be kept in a secure location where no-one, other than the researcher and transcriber, will have access to them. In the final report, no participants or their centres will be named, and any quotations used will remain anonymous.

THIS IS TO CERTIFY THAT I,_____

Hereby agree to participate as a volunteer in the above named project. I agree to be interviewed and for these interviews to be tape recorded. I understand that only the researcher will have access to the data obtained, and that there will be no identifying evidence on disks, cassettes and transcripts. I also understand that the information may be published, but my name will not be associated with the research.

I understand that I am free to decline to answer any questions. I also understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

Participant_____Date ____/____/_____

Witness_____ Date ____/____/_____

Researcher_____ Date ____/____/_____

Witness_____ Date ____/____/_____

APPENDIX C

Bracketing Memo: An example of the researcher's attempt to identify her own presuppositions, knowledge and potential biases about aspects of the study.

I am aware that my interest in commencing this research was borne out of hearing women's stories about working in community centres, and women's health centres, and that I found these stories fascinating and emotion-charged. I was hearing words relating to their experience like *'undervalued', 'under-resourced', 'no-one out there is interested in what we do', 'we can't get enough funding', 'I have to be a jill-of- all- trades in my job'* and the like. I too, have worked in community-based services, albeit in consultancy roles, rather than 'hands on' and part of the community worker milleu.

As a consequence, some of my presuppositions were as follows:

- They may feel that their jobs hold little reward both in terms of salary and the kind of work they need to do under pressure all the time (much of my contact with women's community workers - not managers - had been peppered by complaints from them about each of the above);

- Coordinators may find themselves the 'meat in the sandwich' between the 'front-line' workers and higher level management;

- They may have difficulty in speaking openly about their experiences as they may feel the need to present a certain image, like a 'closed ranks' type of approach;

- Their jobs are likely to be important to them, not just as a source of income, but because of a strong feminist link to the value of supporting women against a patriarchal health system (my previous coursework in women's health issues, as well as my many years as a counsellor working predominantly with women, and liaising with affiliated women's services suggested that this may true of the study group);

- I knew from my previous studies that the whole health system in Australia was undergoing serious financial cuts and restructuring as a result of the prominence of the economic rationalist model, so I anticipated that these women may have issues relating to these cuts and other funding concerns;

- I assumed I would be unable to obtain 'pure phenomenological essences' regarding these women's experiences as women's health centre coordinators given that I had made a methodological decision - based on feminist research principles and the so-called 'new' phenomenology most suited to nursing, feminist and social science research - not to ask the women to bracket their pre-suppositions.

APPENDIX D

Examples of Significant Statements of the Everyday Experience of a Women's Health Centre Coordinator and Corresponding In Vivo Codes

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'Middle Management Issues'
(partial extract from 35 significant, original statements)

Significant Statements	In Vivo Codes (formulated meanings)
1. "That was a big challenge for the organisation to go through, because it was really finally moving away from the good old fat collective structure, which was never that really."[1:446-9]	*1.* They now need to manage up as well as down.
2. "In order to survive those really difficult political times, having the structure, the management structure that we set up, and having those clearly explicated principles, have been the really important things for me."[1:641-644]	*2.* The setting up of good management structures is vitally important.
3. "It wasn't just the service that was looking at what we were doing. We had a whole bureaucracy and a whole government and we had a sector (looking at us)." [4:465-7]	*3.* They feel checked from both sides, from staff and higher management.
4. "We weren't coordinating a team any more. We were managing in a system, and that's been a big head-shift to me, that I do manage a centre now. I don't coordinate it." [4:170-2]	*4.* From a personal perspective, it's been a big transition from their previous jobs into a management position
5. "So my diary and myself became bosom buddies, and yellow stickers for the next lot of check lists and you know - it is a skill base I have. I am very organised. I have a very good system. I can see now why systems are so important." [4:521-5]	*5.* They all acknowledge the need for a high degree of organisation in this job.

APPENDIX E

An Example of how the Nud.ist Computer Program referenced each line of a transcript by numbers

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Q.S.R. NUD·IST Power version, revision 3.0 GUI.
Licensee: Jodie Moyle.

PROJECT: JT1NUD.TXT, User Jodie Moyle, 4:41 pm, May 29, 1997.

++

+++ ON-LINE DOCUMENT: JTAPE1
+++ Document Header:
* No Header

+++ Retrieval for this document: 1082 units out of 1082, = 100%
++ Text units 1-1082:

1 Tape 1
2 *Topic:Women's health centre coordinators
3 *Interviewer: JM
4 *Respondent: "Sue"
5 *Date: 10.4.97
6 *Duration: 65 minutes
7
8
9 I: All I need to ask you is, what is it like to be a Women's Health
10 Coordinator? I get the easy part. [laughter]
11
12 R: Is that your opening question?
13
14 I: Yes. My only question!
15
16 R: Well, to start with I suppose the word that one uses is
17 challenging. Never boring. And I think that is the thing that is
18 really interesting about it, even though I have been in this position
19 now for something like over five years; and I think I could say I've
20 never got bored, which not too many people would say in their jobs.
21 I also think it is a great privilege to be in this position, in that -
and I
22 don't believe that it is just for us people who are Coordinators. I
23 think that if you are committed to women's health and if you have a

political view of life, you actually then can get to act out your passion within your work, which is something that I think is a privilege. And that is why it is rather scary if you actually think of moving on, because you know that probably any other job you get you will be asked to compromise a lot of your own political, emotional beliefs. So that is why I think it is a privilege in a couple of ways, like, it is a luxury that you can work in a position whereby you can do things that you feel are important. And there aren't too many other jobs where you can do that. So that is one of my big concerns about moving on, I suppose.

I: Mmm. Yes.

R: So I think there is no doubt that it is hard work, because being in the position of being a Coordinator...(*identifying title deleted*)...of a service, is the one where you are sort of walking the line between the management of a service where you try and maintain all those principles and where you try and live and work them all the time, and you are the line and the interface between that service and the big world, and often when you go out into the big world you realise that where you are working is quite a protected environment, because number one, pretty well everyone on your staff agrees with the principles that your service is working with, and that there is that commitment and vitality and passion; and then you move out into a world where those things are questioned, marginalised, labelled in derogative ways and, yeah. It is not so friendly. Yeah. So I think that is probably one of the biggest challenges and I think that the position that I have of being the [manager] of (*name deleted*) service particularly has those challenges, and I often get a sense from the staff that they sort of send me out to be the big girl, you know, to do the grown up stuff.. [laughs]

I: To do the 'grown-up stuff'?

R: Yeah, to do the grown-up stuff. Absolutely. Yep. And that is when you go out and you face the people in the suits. And when you are always thinking well, how do you play this game, because in a sense you don't want to be so challenging that they won't listen to you, or that they will just wipe you off or just immediately stereotype you, and they will do that anyway as soon as they hear what service you are from. A whole lot of stereotypes you can see flash across their face.

I: You see the look in their eyes?

R: Absolutely. Yep. But then I think what you have to learn is how

to work with that and not allow that to occur; and I have found reasonable success, I suppose, with that. That, I suppose, is possibly one of the strengths that I take with my work. But I think it is hard being in a position where you are constantly marginalised. I think that is one of the things that I find really hard in terms of what I look at longer term and the bigger picture of my work. I think, well, how long do you sustain energy for working in an area that is marginalised, particularly when you see changes of government.

I: So how do you?

R: Well, I suppose the thing for me, that always keeps me going, is actually looking back at the principles of our work and saying, "Well, they may be marginalised but I believe they are really important." And it is also - I think one of the challenges has been about how you maintain those principles, which is about having services which are managed by women and for women, that advocate for women and believe in women and listen to women's stories and all of those sorts of things, and look at women's position in society. And I think that I suppose one of the strengths that I have had in dealing with that is by being able to draw a line that is about being pragmatic but not losing those things. And that is where, as Women's Health Centre Coordinators, I think we have had some tension, because it is about how far you toe the line and maintain the philosophy and things, and how much you can play that and still maintain the service without losing it in the process; and I think that is a really hard, that has been the hard thing politically - is, well OK, do you dig your toes in and say, "Stuff them! You know, we are Women's Health and they have got to give us what we want and, you know, how dare they?" Or do you say, "OK," - which is what we came to over the last few years - "these are our bottom lines, and beyond those bottom lines we don't move." And then how do we negotiate those bottom lines within this new environment? And that is pragmatism, basically. And I see that as one of the biggest challenges, now, how to be pragmatic, and how to maintain those principles and look at different ways of using them.

(partial transcript of first interview with "Sue")

APPENDIX F

Example of a Category with its Component In Vivo Codes

An important part of the job involves middle management issues

1. They now need to manage up as well as down.
2. The setting up of good management stuctures is vitally important.
3. They feel checked from both sides, from staff and higher management.
4. From a personal perspective, it's been a big transition from their previous jobs into a management position.
5. They all acknowledge the need for a high degree of organisation in this job.

APPENDIX G

Example of results of the pilot study

Table 1. Examples of Significant Statements of the Everday Experience of a Women's Health Centre Coordinator and Corresponding In Vivo Codes

Significant Statements	*In Vivo Codes*
1. When I first took over here...there was an awful lot of conflict happening.	*1.* There was much past conflict to overcome.
2. I sometimes lose sight of the fact that I'm the manager and all these other things actually impose on my work.	*2.* She feels imposed upon by the day to day running of the centre.
3. It becomes very draining on me personally, because it's an awful lot of giving out every single day, there's giving out, encouraging, supporting...	*3.* Her job is highly emotionally demanding on an everyday basis.
4. I actually can't come into work and say, OK I'm going to do this, this and this.	*4.* She can't predict what she will be doing from day to the next.

Table 2. Example of a Category with its Component Codes

Strategies are an important part of her everday working life.

a. Attempts to implement change need to be carried out gradually.
b. She has strategies in place to overcome staff negativity.
c. Any conflict which arises needs to be addressed immediately.
d. She has learnt to identify priority tasks for each day.
e. She knows how to sell ideas to staff.

APPENDIX H

Exerpt from researcher's data analysis journal

Sample of memo relating to the theme 'Demanding Nature of the Job'

14th August, 1997

Seems to be a current thread of working until they drop, stories incorporate words like 'burnout', 'emotional rollercoaster', the work is 'really, really hard' or each woman talks about doing difficult task, often around staffing problems 'the really horrible stuff'.

I'm interested in what the emotional toll must be, all women talked about needing to take time off or feeling like they have been on the edge of control, sliding kind of...?

Interesting concept of 'use by date' used by one woman, others alluded to it, wondering how long they could reasonably keep up the pace, withstand the pressures, stay in the job.

Need to look into the relationship between work and personal lives, maybe see if there's a connection between these for each woman - maybe about maintaining boundaries or juggling a kind of balance between the two - or more?

Emotional responsibility for the smooth running of their centres...wonder if this relates. Need to be available at all times, 'hard to switch off', worrying about the place when she's not there (Clare) - check if this is an emerging aspect or a function of experience in the job.

Issue of self-protection or competition with previous coordinator in the job - is this a real issue common to all, or situational/personal for one woman only?

Need for self-protection?

- boundary keeping
- develop strategies?
- gatekeeping on own ability and giving out to others all the time

Personal costs?

- availability to all staff
- a lot of emotional giving out
- personally very draining
- overcoming staff negatives, fear of change, change in responsibilities - or is this more management stuff about role clarity and staffing issues - possible overlap?

and a strong sense of equity for all women. She seemed to really care about her work, and became quite passionate at times when she talked about her direct work with the workers and her willingness to learn from them. She also seemed to carry a mantle of weariness about her, as if the job had been truly very difficult, and as she spoke about this tiredness I could sense that she really had been close to burnout at one stage not too long ago. Her commitment to her work was such a strong element during our conversation, this was not a woman simply talking about a 9 to 5 existence for whom the 'after hours' was her real life, instead she seemed to be a synthesis of career woman, working mother, wife and committed feminist.

At the close of the interview, when she felt she had talked as much as she needed in order to cover all the parts of her experience as a women's health centre coordinator, she mentioned how helpful it had been to have someone to talk about her experience with. She mentioned that she and the other coordinators are so busy and so geographically scattered that meetings are not held often enough, and certainly their busy agendas don't allow time for such 'self indulgence' as to discuss feelings or experiences about their work. She hoped that my research may help in that communication process, and she said she would be very interested to read the comments of other coordinators as they emerged from the research. The isolation that Clare had spoken about was evident at this point, she really seemed to lack any tangible emotional support in a job that seemed very time and energy consuming. I had already heard two of the other coordinators talk about the isolation and the all-consuming nature of the work, and I began to wonder if I would be able to make sense of these elements in the bigger picture. I was also determined to not mention either of these aspects in my next interview to test whether they would emerge naturally. This hadn't been a problem so far, as none of the women needed any prompting, whatever they considered was important to mention seemed to come freely from their own accounts of their experience. Indeed if the lack of support from each other was an issue, it would emerge of its own accord.

I really like phenomenology! It is so natural and respectful of people's experience, I like that I'm not in control of way the story develops. It also feels very comfortable and familiar, like counselling, it enables people to discover their own narrative without my hardly needing to do anything - except to provide a context and a purpose for it to occur.....

Appendix J

A summary of the key principles for practice

in women'scommunity health services

1. A definition of health which adopts the WHO's social model of health.

2. There should be community/consumer involvement in making decisions about the provision of health care at community, State/Territory and national levels.

3. Health services should promote effective targeting of health and related services to meet women's needs and improve their health outcomes.

4. Health services should recognise the special disadvantages experienced by particular groups of women in achieving equity of access, and the need for specific policies to address these.

5. Women as consumers, providers, workers and researchers should be equitably represented at all levels of health planning, policy development, implementation and evaluation of health care.

6. The main emphasis of health care systems should be on prevention and primary health care within the community. Resource allocation priorities should reflect this emphasis.

7. Health services should recognise the rights of women to:
   * be involved in, and have control of, decisions about their bodies;
   * have their dignity and physical integrity respected; and
   * have services provided by health carers who are well informed and sensitive about women's health needs.

8. Health services for women should encompass their lifespan and reflect their various roles in Australian society, not just their reproductive role.

9. Health services should recognise that women as consumers should have access to:
   * a variety of health care services, including women's health services; and
   * the information necessary for them to make informed choices about their health, and give informed consent to health treatment.

10. Organisational structures should promote multidisciplinary teamwork and order to address the social and environmental factors that inhibit health and well-being.

APPENDIX K

Examples of feminist definitions and beliefs of women working in one women's health centre in Australia.

Our Beliefs as Feminist Health Workers

What beliefs we bring to our work with women who have survived childhood sexual abuse:

1. *Healing is possible.*

2. *Working in a group can accelerate and support your growth and healing.*

3. *Safe places are essential for your healing. It is possible with a group to create another safe place in your life.*

4. *You can undertake a group journey towards healing and it is important for you to make an individual commitment to that journey.*

5. *You are the expert in your own healing.*

6. *You deserve all the resources and information we can provide to facilitate your healing journey in this group.*

7. *Child sexual abuse is about an abuse of power in a relationship.*

8. *Child sexual abuse is <u>never</u> the child's fault.*

9. *In the process of healing, women are reclaiming their lives through free choice and feeling in charge of their lives.*

WHY FEMINISM?

Feminists argue that the world is "sexist".

Sexism is the method by which the oppression of women is institutionalised, legitimised and perpetrated within this society. It is frequently so internalised by members of society, that it is perceived as "normal", "natural" or "true". For example, the notion that "knowledge" exists only if it can be rationally (ie. emotionlessly) argued, places a particular value on knowledge. It makes knowledge an essentially male-defined commodity, since men are taught to think in this way. (Generally, women are taught to think in emotional terms, in preparation for "their" role as the nurturers and supporters within society.) Definition of "human nature" is another abode of sexist assumptions. Until recently, few questioned the idea that to be biologically male or female predetermined a set role in society, beyond the limits of those physical differences. "Masculinity" and "femininity" were perceived as "natural" outcomes of biological differences. This type of definition led to the legitimisation of clearly differentiated sex-role stereotypes for men and women in society. Social structures such as hierarchy as a means of organisation, and the family as the "building block of society", similarly took on a status as "normal".

> Sexism means ... that men are more important than women;
> ... that therefore their work is more important than women's;
> ... that women are intended (or were designed) to complement men;
>
> and therefore ... that women in society are defined in relation to men.
>
> (Rowland 1984:9).

Feminists challenge these assumptions, and seek to redress the inequalities brought about by a society based on these beliefs. They argue that men (sometimes qualified to describe Anglo-saxon, able-bodied, heterosexual, middle class men) determine the values-base of society. That because they are the dominant power group within society, they have the means to very significantly influence the culture of the whole society. That they determine the dominant culture. That this occurs through all systems within society - the media system, the capitalist system, the church system, the "justice" system, the education system and the health system.

> THE HEALTH SYSTEM: The legitimate self-doubts, tensions and fears arising from women's training (... women really only have two roles - as a sex object or as a mother/wife!) are consistently treated as neuroses. Women are taught to accept the authority of a (male) doctor who "knows", to accept drugs of dependence to block their tension, to use drugs with known side-effects and possible linkages with cancer to control their reproduction. The health system has not contributed to improving womens' self-concept, and arguably has not contributed to improving womens' physical or mental health.