Best Practice in Women's Health: Outcomes, Processes and Pre-conditions

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The pre-conditions, processes, and outcomes associated with best practice in women's health at the primary health care level are discussed. The paper draws on a study which identified projects that exemplified best practice in relation to: collaboration with consumers and communities; the adoption of a social model of health; the collaboration between providers at different levels of the health system and government; and addressing immediate health needs in a way which recognises the underlying conditions which cause ill health. The methodology involved identifying 187 recently published and documented episodes of primary health care practice. Using ratings and reports from 90 experienced referees from around Australia, the 187 case studies were reduced to 25 which the referees agreed represented 'best practice'. A more detailed investigation of these 25 studies was undertaken to determine what structures contributed to the good processes and outcomes. Of these, eight were women's health projects, with six undertaken by women's health services in Victoria. The paper outlines the kinds of outcomes, processes and pre-conditions which are associated with best practice as illustrated by one of the Victorian women's health projects. The findings from this research project provided practical, informative and useful models of best practice which can be of assistance to women, health workers, policy makers and government.

Over the past decade or so women's health practitioners in various locations around Australia have endeavoured to respond to women's needs by generating a rich and diverse range of programs, projects and service delivery models. Many examples of good practice have emerged from this committed exploration, some of which have been recognised at state and national levels.

This paper draws on a study which included some of these published accounts of women's health projects and submitted them to detailed review and analysis in order to identify the elements associated with best practice. The paper provides an overview of the whole study, *Best Practice in Primary Health Care*[1], its purposes and methods, and illustrate its findings with reference to a women's health case study from Victoria.

Best Practice in Primary Health Care, (Legge et al., 1996) was undertaken by the Centre for Development and Innovation in Health, the National Centre for Epidemiology and Population Health and La Trobe University with funding from the Commonwealth Department of Health and

Family Services. We hoped that by undertaking this project we might contribute to the strengthening of the primary health care sector by documenting, disseminating and analysing case studies of best practice in primary health care. Primary health care is a complex concept. It is useful to think of it as a narrative or story. It is a narrative about a sector of service delivery (the primary health care sector); about a set of principles of practice; and about a set of project outcomes that would be achieved if the norms of primary health care were realised in the primary health care sector.

The study was designed around a structure, process, and outcome framework, with the specific objectives being to:

- delineate more clear!y the kinds of outcomes which are currently being achieved in primary health care in Australia;
- identify more clearly the patterns of practice which led to excellent outcomes; and
- define more clearly the pre-conditions or structures for that practice and those outcomes;
- identify possible themes and directions for professional development activities which would support primary health care practitioners in their striving for best practice;
- identify possible directions with respect to policy and program development which would help to create more favourable conditions for good practice in primary health care; and
- identify and publish benchmarks of best practice in primary health care with a focus on the networking, social health and developmental functions.

Methods

Our methods involved a three stage process where, to begin with, we collected as large a sample as possible (within the limits of resources) of recent, well documented accounts of episodes of primary health care practice in Australia, focusing on the social health, networking and developmental aspects of primary health care. A wide range of health journals, recent monographs, conference proceedings and bibliographic sources were scanned.

One hundred and eighty five published (or public domain) reports in accordance with four selection criteria, were identified. To be included, case studies needed to:

- describe passages of practice undertaken within the primary health care sector in Australia;
- be reasonably well documented with respect to process and outcomes;
- be recent; and
- include the networking, social health or developmental aspects of primary health care practice (as distinct from purely clinical or single discipline professional work).

The objectives of the next phase of the study were, first, to explore the relationships between project outcomes and selected aspects of practice and, second, to select, through a peer review process, a subset of 25 cases of excellent practice for more intensive study. Five criteria were established for including cases in this phase of the study. These criteria corresponded to the networking, social health and developmental aspects of primary health care practice. The criteria were cast as aspects of practice and comprised:

- consumer and community involvement;
- collaborative local networking;
- vertical networking;
- macro/micro balance (integrating a concern for the micro or immediate issues with the longer term or macro issues); and
- change consciousness.

For inclusion in the sample for the reviewer evaluation study, at least three of the study criteria had to be judged to be present in significant degree in the case study. Ninety-nine case studies were selected

from the larger data base and were dispatched, each to a panel of three reviewers. Reviewers were asked to provide a single global outcomes rating (in relation to the case as a single entity) and to comment on the relevance, to the outcomes achieved, of each of the five aspects of practice listed. Details with respect to the methods and findings of this study are presented in the full project report (Legge et al., 1996).

Twenty five cases which had been rated most highly in the reviewer evaluation study were identified, and at least two people who had been associated with each case, were interviewed in seeking to clarify:

- the outcomes which had been achieved;
- the strategies of practice associated with the achievement of those outcomes; and
- the pre-conditions for those strategies of practice.

All of the documentation on each of the 25 cases was then analysed with a view to drawing together a coherent account of the outcomes achieved, the strategies of practice deployed and the pre-conditions for those forms of practice. A detailed account of the method of analysis and findings with respect to outcomes and pre-conditions is presented in the full project report.

Findings

The findings and conclusions from the study were based on an analysis of all the data relating to the 25 cases evaluated by the reviewers as exhibiting outstanding outcomes. Eight of these 25 cases were women's health projects. Most of the women's health cases illustrated all of the aspects of our findings. I will illustrate the characteristics that we found to be associated with best practice by referring to one case study, *Paps I Should* (Webster & Wilson, 1993).

Paps I Should tackled the complex issues associated with addressing the low rates of cervical screening amongst women with disabilities. These women reported that while existing material tended to have an emphasis on the physiological aspects of the Pap test, they required information on how they could negotiate the process of having a test and about alternative positions in which the test could be taken. Women with intellectual disabilities suggested that existing information was presented in a way which could not be readily understood by them. This meant that these women were undergoing a Pap test without comprehending what the test entailed (raising issues with regard to informed consent), or were not having tests because they were unaware of their importance. The *Paps I Should* project aimed to improve knowledge and understanding about pap tests for women with disabilities as well as to increase health professionals' awareness of the issues associated with cervical screening for disabled women.

Initiated by Women's Health West (located in Melbourne's Western Suburbs), the project was a partnership between the Service, women from the Disability Support Group, the Melbourne University Department of Community Medicine, the Family Planning Centre, the Department of Health and Community Services Victoria, and the Centre for Social Health. A range of strategies were used, including professional education, advocacy and peer education. By utilising peer education strategies the project reach was able to be extended to women with disabilities who were also from non-English speaking backgrounds.

To return to the findings from the interview study, the pre-conditions for best practice in primary health care seemed to be associated with:

- clarity of need - the immediacy or starkness of the need;
- strength of community;
- supportive policy and program environment, at the state and/or national level;

- supportive organisational environment including a clear organisational purpose; and finally
- inspirational leadership.

These pre-conditions for best practice seemed to be present in the *Paps I Should* project. For example, there was an authoritative national policy, the National Women's Health Policy which provided a framework of principles, a broad definition of health, and which emphasised the importance of addressing systematic issues as well as the needs of individual women. Organisational structures and practices at Women's Health West also ensured the participation of women with disabilities in the management of the Service and the project. For example, they were represented on the Committee of Management and the project team. In addition, members of the support group were directly involved in the production of a video about cervical screening, as they actively participated in the researching, writing and editing of the script and shared the task of acting in the video. There was a clearly articulated vision regarding women's participation and health at the Service level; service structures which provided for work at the micro and macro levels; a service culture of critical reflection; staff with a strong commitment to women as well as strong participation by women in the community.

Our study found that the processes that were associated with best practice seemed to be:

- consumer and community involvement;
- collaborative local networking;
- strong partnerships; between primary and other levels of the health system;
- intersectoral collaboration;
- macro/micro balance; or working in ways which address immediate health issues but which also contribute to the underlying causes of that need;
- organisational learning, such as review, evaluation, critical thinking, and research; and
- good management, including risk taking, flexibility, and access to resources.

How did *Paps I Should* illustrate these process elements? The processes adopted in this project that seemed particularly important were: the high level of control exercised by the disabled women involved (they determined the project processes, nature and the content and form of the health information); working in ways that recognised both the need to improve current health practice and to work on longer term strategies, such as curriculum development for nursing and general practice degrees; intersectoral collaboration; mobilising more centrally located expertise, for example, the skills contributed by the Centre for Social Health in relation to professional training; and regular critical reflection and evaluation of practice by the project team.

Our study identified a number of different kinds of outcomes that were associated with best practice. These included:

- the outcomes we value for today that is, immediate health gains;
- the outcomes we value for tomorrow, such as improvements in the social conditions for health and strengthening of health care programs and services; and
- the outcomes we value for "the day after tomorrow", for example, community, institutional and professional capability-building.

The significant outcomes achieved by the *Paps I Should* project appeared to include: a probable improvement in the health status of women with disabilities as screening rates increased; personal development of many of the women involved in the project; role models provided to other women with disabilities; strengthened networks for the women; new links between women with disabilities and a range of agencies and services; improved practice among

professionals providing Pap smears; a major contribution to the field in regard to screening and primary health care services for women with disabilities; and intersectoral progress towards the conditions for better health for women with disabilities.

Conclusion

That the outcomes associated with best practice included capability building and institutional strengthening is significant. Much of the discussion about health outcomes is often focused on immediate health gains. Based on our study we would argue that the outcomes that enable health practitioners and community activists to work more effectively for continuing improvements in the social conditions for health and for improvements in programs and services, deserve greater recognition. Further, these developmental outcomes can become the pre-conditions for the next episode of practice, thus contributing to a dynamic circular relationship between pre-conditions, processes and outcomes. *Paps I Should* also illustrated this potentially dynamic relationship. For example, increased and strengthened women's networks will support the community's and women's capacity to advocate more effectively for improved services which may lead to the next round of projects.

That these developmental outcomes can be nurtured, supported and encouraged by certain policy and funding environments was also evidenced in our study. Among other things, there is a need to invest in policies and programs which support the developmental outcomes of primary health care practice as well as the individual woman's health gains.

Whilst not without their weaknesses, The National Women's Health Policy and Program do provide principles, guidelines and objectives which can assist services and practitioners to focus their attention on those developmental outcomes, which reflect some of the best achievements of women's health practice in Victoria.

Notes

1 This paper is informed by the larger study, *Best practice in primary health care* (1996) by Legge et al., which is available from CDIH.

2 WHO and UNICEF (1978). *Primary health care: Report of international conference on primary health care at Alma-Ata.* Geneva: WHO.

3 A useful introduction is Fischer, F., & Forester, J. (Eds.). (1993). *The argumentative turn in policy analysis and planning.* London: UCL Press.

4 See, for example, Szirom, T., Wilson, G., & Cameron, J. (1997). *Victorian evaluation of the second phase of the NWHP.* Melbourne: Success Works and CDIH, and Barnett, K., & Radoslovich, H. (1996). *Just health for rural women.* Adelaide: South Australian Health Commission.

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