Thesis Topic:

Does the organisational culture of the Rockhampton Women's Health Centre have an impact on women who use the service?

If so, in what ways does it impact on them?

Submitted by Marilyn Leeks

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Marilyn Leeks.

CONTENTS

Summary

In Australia women's health centres were established as alternative health services for women. They were run "for women, by women". The women's liberation movement in the late 1960s inspired women to critique and analyse the decision-making structures and gender divisions within western society.

Women's health has been controlled for the past few hundred years by the medical system and many women were dissatisfied with the health care provided. Working together in small groups feminists built alternative organisations, with or without government funding. These relatively small centres and their supporters have successfully placed women's health on the political agenda.

They have also been models of alternative organisations, deliberately creating cultures which gave women access to decision-making and planning. The Rockhampton Women's Health Centre is one of these centres situated in a regional Queensland town, population of 69,000 people, a conservative town in a large beef producing region. The two large stone bulls at the northern and southern entrances to the town are prominent cultural and economic icons of the region.

This paper explores what women in Rockhampton think about the Centre's culture and how relevant it is to their health care.

Introduction

The Rockhampton Women's Health Centre is one of many women's health centres which have been established in Australia in the past twenty years (Broom, 1991:p.xii). Women's Health Centres in Queensland have been established as primary health care services with a particular focus on health promotion (Queensland Women's Health Policy:1993). The Rockhampton Women's Health Centre defines itself as a feminist organisation providing a primary health care service in a regional Queensland town (Rockhampton Women's Health Centre Strategic Plan:1992-1996).

In Queensland the Brisbane Women's Health Centre established in 1972, remained the only centre until the Labor government was elected in 1990. During the preceding twenty-three years, the conservative government had refused any Commonwealth money for women's health services. The Rockhampton Women's Health Centre was opened in May 1991.

Women working in women's health centres have conscientiously developed primary health care services, taking seriously the principles of women's participation and control over their own health. This commitment has been demonstrated in the cultures of the organisations which includes the ways in which the organisations have been

structured, the physical environments and how decisions are made. All of these aspects are fundamental to a primary health care service. Women's health centres have taken time and energy to build organisational cultures which respect and value the opinions of women who use the services and they have built pathways through which women can effectively participate in the organisation.

The majority of women who worked to develop the Rockhampton Women's Health Centre were feminists who were acutely aware of the twenty year history of women's health centres throughout Australia. The possibility of funding and the dearth of services and resources for women in the region provided the impetus for a small group of women to gather and consider the possibility of establishing a Centre for Central Queensland.

After confirmation of the funding, the group used the local media to invite women to three visioning workshops. These gatherings provided an opportunity for Rockhampton women to express their hopes and ideas for the Centre and to participate in working groups which implemented many of these ideas and hopes. This process aimed to explore women's commonalities, value diversity and to move forward from this shared understanding.

Women stated that they wanted the Centre to be a place of hospitality and a place for women to go "with or without problems". The Centre should be a warm accepting environment where women could access counselling, groups and information about social and political issues effecting their health and well-being. Many women involved in these workshops and subsequent public meetings had little or no knowledge of women's health centres in other states. There was strong agreement between women about what the Centre should be like and what services should be provided (Archival Records: Rockhampton Women's Health Centre:1991).

This research project invites women working at the Rockhampton Women's Health Centre and women who use the services to discuss and describe the culture of the organisation five years later. This project does not attempt to define the organisational culture, rather it offers the views of some of the workers and women who participate. The research explores whether this culture is as significant to women using the Centre as it is to workers, and their agreements and differences.

Primary health care and women's health centres

Women's health centres in Australia have been pioneers in delivering models of primary health care. They have provided services in which women can participate in the planning and decision-making of the

organisation and the type of services (Shuttleworth and Auer in Baum:1995,p.258. Broom: 1991,p.154). This level of community participation in developing and influencing health services is consistent with primary health care principles.

Since 1978 following the United Nations Declaration of Alma Ata on Primary Health Care, the principles of primary health care have been recognised in both "first" and "third" world countries as the cornerstones of effective and affordable health policies (World Health Organization:1978). Australian author, Cheryl Cooney defines primary health care as

> *...effective health care geared towards the community, for the community by the community, with the emphasis being on the preventative rather than the curative end of the health care continuum. It is an approach to health which emphasises equity, community participation, accessibility of services and the importance of the environment in determining the health of individuals and communities (1995,p.314).*

The second significant event to impact on the direction of health care was the Ottawa Charter for Health Promotion (World Health Organisation:1986). The Ottawa Charter reiterated the Declaration at Alma Ata and defined four key areas of activity:

1. building health policy
2. creating supportive environments
3. strengthening communities
4. developing personal skills (Baum:1995,p.3).

As South Australian health academic Fran Baum explains the Ottawa Charter set the direction for "a newly defined public health movement" (ibid,p.4). The "new public health" emphasises the need for people using health services, as well as workers, bureaucrats and politicians within the health system, to be part of discussions and decision-making about health care and to consider the impact of other sectors of public policy on health and illness (Baum et al:1992,p.304).

Queensland Health released their Primary Health Care Policy in 1993 in which the government declared a refocussing of the state's health services towards primary health care. Primary health care takes a social view of health in which health is considered in terms of socio-economic and environmental factors as well as disease and disability (Queensland Primary Health Policy:1993).

Prior to the Declaration of Alma Ata and the Ottawa Charter, women in Australia had developed an approach to health care based on these principles. In 1974, when the first women's health centre was

established in Leichhardt, women recognised that they "would not be able to control their lives unless they could control their own bodies" (Wass:1992,p.193. Broom:1991,p.1). During the next five years centres were established in South Australia, Western Australia, the Northern Territory, Victoria and Queensland.

The final communique at the "Women's Health in a Changing Society" Conference in 1985 claimed that

> *the women's movement has contributed to public health and social policy by shifting the priorities in health to primary health care and community involvement.*

Australian health activist Chloe Refshauge argued at the Conference that public health policies should concentrate on preventative strategies, promote the participation of the community members, work towards the decentralisation of services and provide care which is centred in the community in which people live. There should be a philosophical shift to self help and deprofessionalisation of health care ((Refshauge:1985, Conference Proceedings).

By 1989 when the National Women's Health Policy was launched there were around 40 women's health centres in Australia, providing primary health care services for women - some operating with government

funding and others still seeking government support (Broom:1991,p.9). The first National Women's Health Program which provided funding for the implementation of the Policy supported the establishment of new centres.

Dorothy Broom, women's health academic and author, notes that the concerns of women throughout Australia voiced during the consultations leading up to the formulation of the National Women's Health Policy in the late 1980's, were similar to the motivations of women involved in centres in the mid-1970's (ibid,p.129).

In 1993 the National Women's Health Program Evaluation and Future Directions Report quotes Jo Wainer from the Women's Electoral Lobby.

> *It is essential to remember that the practice of medicine and the modern health system were developed without the involvement of women. Therefore women's experience is not included in medicine and the health knowledge base (1993,p.xxi).*

Women have advocated for women's own experiences, knowledge and skills to be accepted as a valued part of the information base of public health policies, and to take into account the implications this would have on women's health (Doyal:1991,p.286).

In primary health care literature, scant attention has been given to the contribution made by women's health services beyond the fact that they have been instrumental in putting women's health on the political agenda. A closer examination of the organisational cultures of women's health centres as community health services appears to be non-existent.

Feminist theory and women's health centres

In Australia, women's health centres grew out of the women's liberation movement in the early 1970's (Broom:1991,p.xii). The women's movement, brought women together in small groups to share their experiences (Jenkins and Kramer:1978,p.69). These women developed an awareness of their relationship to each other and to what they defined as a patriarchal society that oppressed them (Jenkins and Kramer: 1978,p.70). This small group process developed by radical feminists in the late 1960s and early 1970s, became known as consciousness-raising, "a process of education and reconceptualization" (Eisenstein:1984,p.35).

A slogan of radical feminists was "the personal is political". This slogan connected the private, invisible and isolating questions and experiences of women to a visible social reality which could be analysed and

challenged. Radical feminism grew out of the lived experiences of predominantly white, middle class women.

Consciousness-raising also contributed to feminist theory "the notion of the commonality underlying the diversity of women's experiences" (Eisenstein:1984,p.38). Radical feminists saw themselves as part of a grassroots movement, a women's culture concerned with providing feminist alternatives in literature, music .... and health services (ibid,p.84). The notion of cultural separatism, promoted by radical feminists was seen as a strategy for change, even for service projects (Fraser:1989,p.136). It was not enough for women to cope better or to succeed in patriarchal society, radical feminists saw that they had to bring about social and political change (Jagger:1988,p.279). The creation of alternative organisations as women's spaces would give women control and power over their decision-making processes and structures. Feminist health centres have highly valued the notions of separate space and being organisations "by women for women".

Women's health centres developed through women sharing their own unsatisfactory experiences of health services and identifying that they were not alone (Broom:1991,p.xiii). Strategies such as conscious-raising groups and the notion of cultural separatism were used by the women who worked to create women's organisations. Nancy Fraser observed that in the United States cultural separatism was a short-term

necessity for women' physical, psychological and moral survival (1989,p.136).

In her introduction to Contemporary Feminist Thought Hester Eisenstein proposes that at the heart of feminism is an egalitarian impulse which seeks to free women from all forms of oppression - political, economic, and sexual self-determination (1984,p.xix). Socialist feminism has emphasised these links between feminism and other social justice agendas. This imperative has influenced both the internal structure of women's health centres, the types of services provided and where they are located.

Michele Barrett and Anne Phillips point out that in the last ten years the apparent consensus (of 1970s feminism) has broken up. As feminist analysis and theory have developed and been challenged, the answers are no longer as clear as they appeared to be to some feminists twenty-five years ago. Barrett and Phillips outline key elements which have contributed to this process.

The political impact of black and migrant women and women from the third world, and their criticisms of the racist and ethnocentric assumptions of white western feminists, have challenged the extent to which western feminists can claim the commonality of women's experiences. In contemporary theory there is a questioning of the

distinctions previously made between sex and gender, and the appropriation and development by feminists of post-structuralist and post-modern ideas has had an outstanding impact on feminist thought (1992,p.4).

Contemporary theory has increasingly engaged with dominant or "malestream" theories of social and political life which has led away from a radical feminist theoretical approach (Gatens in Barrett and Phillips:1992,p.121). Moira Gatens elaborates further that what she calls deconstructive feminism is distinct from radical feminism in that it does not take women's biology as somehow enabling her to produce pure or non-patriarchal theory (ibid,p.122).

A politics of difference has also emerged as a challenge to modern emancipatory politics and consequently to radical and socialist feminism. Anna Yeatman explains that the politics of difference has acknowledged the different experiences of oppressed groups and individuals and the interlocking oppressions of many of these experiences. It would seem impossible to subsume these differences under one universal category of oppression (in Caine and Pringle:1995,p.54). Yeatman cautions that the universal human subject which is presupposed in emancipatory politics, may still be relevant however it can no longer be accepted uncritically, without considering its exclusivity(p.56).

A feminist orientation to the politics of difference means that we each recognise that any standpoint we take is necessarily partial and based on the way in which we are positioned in relation to class, race, educational background and any number of other factors. Our subjectivity has been formed within a multiplicity of discourses (Pringle and Watson in Barrett and Phillips:1992,p.69).

Such fundamental changes in feminist though are described by Michele Barrett as a "paradigm shift" (in Barrett and Phillips:1992,;.205). If there is no longer a consensus about what constitutes feminism and even for some, what constitutes women, how do feminist organisations define their difference from non-feminist organisations and services, without excluding difference within their group? Radical feminists began by defining the different experiences and values of women, and feminist separatism can be seen as an early expression of such gynocentric feminism (ibid,p.161) However this position excluded the experiences of many women.

Women's health centres have employed and worked with many women from non-English backgrounds and Aboriginal women. However the organisational cultures have strongly reflected white middle class women's experiences.

The collective action taken by radical feminists has been understood by them as dismantling patriarchy and liberating women. Post-modernism removes any sense of completion or finality in this project. Postmodern perspectivalism does not do without standards of validation but they cannot be accorded transcendent status (Yeatman:1994,p.2).

> *Emancipation is always relative to an established discursive order which is already of the past, a new discursive order with its own peculiar modes of domination having been ushered in through the process of emancipation* (Yeatman:1992,p.7).

In examining the organisational culture in a women's health centre, the feminist assumptions informing the organisation can be uncovered and an understanding developed about how women in a regional town interface with an alternative health organisation.

Organisational theory and the relationship to women's health centres

Feminist women's health centres have been established in socio-political contexts where bureaucracies are the dominant organisational structures. The rational-bureaucratic organisation as first described by Weber, is defined by dimensions such as hierarchical organisation of

authority and the formalisation of rules which are enforced by supervision from top level personnel. Work relations between staff are impersonal and employment is based on specialised training and formal qualifications with the result that maximal division of labor and specialisation of jobs occurs (Rothschild-Whitt:1979,p.519).

The sociology of organisations has been developed by academics and consultants from the perspective and positions of male-dominated authority structures who have shown a reluctance and lack of preparedness to deal with issues concerning the gendered nature of organisations (Sheriff and Campbell:1992,p.31.Smith and Hutchinson:1995,p.7). Organisational theories reflect the practical concerns of their creators, both the scholar(s) and the organisational participants whose actions are described by the theories (Calas and Smircich in Mills and Tancred:1992,p.223). Smith and Hutchinson have argued that masculinity is embedded in the procedures, assumptions, processes and formal rules of contemporary bureaucracies (Smith and Hutchinson:1995,p.67).

Sexuality is a core component of gender domination in organisations. This aspect is emphasised by Joan Acker in her work. She points out that behaviours such as sexual harassment are perceived as deviations of gendered actors rather than as fundamental components of organisational structure (1990,p.142. Gutek, B. in Hearn:1989,p.67).

In the book The Feminist Case Against Bureaucracy, Kathy Ferguson argues that there are two ways in which women's experiences in bureaucracies have shed light on how this structure marginalises women. The first is the persistent patterns of dominance and subordination in the bureaucracy which parallel the power relations between men and women in society. Secondly, many women have suggested that in the public sphere, the caretaking and nurturing experiences which have been embedded in women's traditional roles should be conceived in a new way. Through the individual and collective experience within an organisation these roles can be validated (1984,p.x). Ferguson claims that feminist critiques go beyond others by creating alternative models of organisation out of the concrete and shared experiences of women (ibid,p.27).

Gender neutrality in organisations cannot be ignored as Elizabeth Moss Kanter summarises,

> *While organisations were being defined as sex-neutral machines, masculine principles were dominating their authority structures* (cited in Acker:1990,p.143).

In human service organisations such as women's health centres, the core activities are the relationships between the staff and clients. The success or failure of the organisation to effectively provide a service, is

largely determined by the nature and quality of these relationships (Jones and May:1992,p.83).

A client's assessment of the quality of a service is based on factors such as the level of trust in workers and the organisation, the compatibility between the client's goals and the goals of the worker, and the extent to which staff treat clients as people rather than as objects or cases (Jones and May:1992,p.325. Walker and Mitchell:1994,p.6). In traditional welfare services, people approach the service asking for help, however they are not able to demand to participate in decision-making, to see a policy changed or to redirect resources (Jones and May:1992,p.145).

Sheriff and Campbell point out that a large proportion of research by female sociologists has been concerned with the hierarchical relations between organisations and their clients. Such studies in the area of social services and health organisations have emphasised the relative powerlessness of clients in their relationships with bureaucracies (1992:p.39).

Alternative Organisations

The 1970s was a decade which gave rise in western countries to a wide array of work organisations that self-consciously rejected the norms of rational-bureaucracy and identified themselves as "alternative

institutions" (Rothschild-Whitt:1979,p.509). In the Australian context, organisations emerging from the women's movement formed a significant group espousing collectivist principles (Jones and May:1992,p.218). Lee Jenkins and Chris Kramer claim that such organisations drew upon the experience of women's consciousness-raising groups which suggested that institutions were not unalterable or self-evident (1978,p.71).

In her exhaustive study of alternative institutions in the United States, Joyce Rothschild-Whitt challenged the norm of rational-bureaucracy in organisational theory and attempted to develop a model of collectivist organisation (1979,p.509). A collectivised democracy as she describes this model of organisation, is directly opposed to Weber's monocratic, formal bureaucracy. She noted that both hierarchical models and alternative models of organisations represent ideals which are not attainable and in practice, organisations are hybrids (ibid,p.510).

However researchers, Nancy Hooyman and Lynn Cooper have outlined significant characteristics which are usually present in some form in feminist organisations. These include the valuing of women's perspectives and experiences; a notion of wholeness and the elimination of false dichotomies or artificial separations ; a reconceptualisation of power; principles of democratic structures; the valuing of process; and an orientation to fundamental structural change (1986,p.167). The

elimination of false dichotomies refers to the separation between worker and client evident in hierarchies (ibid,p.168).

Part of the feminist project has been to create organisations which are examples of the collectivist democratic model - nonhierarchical and egalitarian organisations that would demonstrate the possibilities of nonpatriarchal ways of working.

By aiming to eliminate or minimise dominant-subordinate power relationships, feminist organisations sought to enhance the development of women's skills and facilitate cooperation (Riger:1994,p.276). Contrary to the hierarchical structure of bureaucracies which in providing goods or services to clients, place the clients on the lowest rung of the class structure, feminist organisations have endeavoured to place clients' concerns as the primary reference point in designing other aspects of the organisation (Ferguson:1984,p.123).

In understanding that part of their role was to be an alternative to the mainstream health bureaucracy, women's health centres in Australia and overseas have focussed considerable attention on the way in which they were structured and how decisions were made - how they organised their services internally (Brown:1992,p.73).

The first women's health centre in South Australia at Hindmarsh sought to operate as a collective and to equalise decision-making power amongst its members (Auer:1990,p.210). According to Australian academic Wendy Weeks this collective model or organisation has become the central expression of feminists' social and political organisation (1994,p.134).

In describing the Hindmarsh Women's Health Centre, researcher Helen Radoslovich, writes that staff and labour were shared and everyone participated in all areas of work. The decision-making processes were consensual and everyone - paid or unpaid - participated in the process (1994,p.18). Claire Shuttleworth and Jocelyn Auer reflecting on the growth of women's health centres in South Australia, believe that the centres have been ahead of their time in terms of their organisation. The women involved in the centres anticipated that the organisational features such as shared decision-making, multi-disciplinary teams and cooperative working styles would promote mutual respect between staff members and that this sense of respect would extend to women in the wider community (in Baum:1995,p.261).

Women's health centres have had and some continue to have, structures of community management which enable women using the services to participate in the management of the service. This structure

"makes real" the primary health care policy rhetoric that people should participate in the planning and development of health services. However community management has been another neglected area in the literature of community participation and health (Laris in Baum:1995,p.88). Most health care organisations are still structured in a hierarchy, information and decisions flowing from the top down (Barker and Young:1994,p.17).

The web is a metaphor which has been used to describe the structure of relationships in feminist services. It emphasises the connections between women in multifarious roles and positions, and the mutuality characterising these relationships. According to Anne Barker and Constance Young writing in the journal Holistic Nursing Practice, this image encompasses an ideal structure for health organisations in the postmodern period (1994,p.20. Meyerson in Frost et.al:1991,p.260).

Organisational researcher, Kathy Ferguson argues that when feminist services move toward becoming bureaucratic they risk losing their critical edge. She writes that power within bureaucracies is not change-making power, claiming that feminist discourse on organisational structure should penetrate the constraints and limitations of bureaucratic discourse and seek out the submerged discourse, implicit in women's experiences (1984,p.24,p.181. Deveux:1994,p.243).

One of the areas of potential loss identified by Claire Shuttleworth and Jocelyn Auer which could result from "mainstreaming" women's health centres in Australia, relates to the role which centres have played in providing a practical demonstration of an alternative to traditional health organisational structures and management arrangements (in Baum: 1995,p.256). Women working in the centres have deliberately addressed organisational culture as fundamental to providing alternative, acceptable health services for women. How decisions are made, how work is distributed, creating healing environments, valuing clients' experiences and power sharing are some of the important issues with which women's health centres have struggled and which have shaped their cultures. To understand the significance of this work it is necessary to briefly review research in organisational culture.

Organisational culture

Culture can be defined as a pattern of shared basic assumptions and is invented, discovered or developed by a given group as it learns to cope with its problems, to adapt to the external environment and to integrate internal forces and circumstances. The assumptions and behaviours become part of the groups culture when they have worked well enough to be considered valid and therefore will be taught to new members of

the group as the correct way to perceive, think and feel in relation to particular problems (Schein in Frost et.al.:1991,p.245).

Linda Smircich suggests that organisational actors are continually engaged in the process of "culturing" (in Frost et.al.:1985,p.72). People in organisations tell stories, they celebrate, ritualise, play and use figurative language. They participate in traditions that convey meanings, recall past experiences and act as symbols (Jones in Frost et.al.:1991,p.204).

An organisation's culture frequently reflects the vision and mission of the organisation's founder(s) with biases based on their own view of human nature, and on their personality traits and previous cultural experiences (Smith and Hutchinson:1995,p.64; Frost et al:1991,p.15).

American organisational theorist, Sandra Dawson defines culture as shared values and beliefs which are seen to characterise particular organisations (1992,p.136). Geert Hofstede defines culture as "the collective programming of the mind which distinguishes the members of one group or category of people from another" (in Dawson:1992,p.136). To alternative organisations, culture is very often consciously formulated as part of the oppositional standpoint in relation to the status quo.

Adams and Ingersoll describe the managerial metamyth which maintains the bias towards the rational-technical values of the formal bureaucracy in western societies. This metamyth promotes the notion that eventually all work processes can and should be rationalized, denying the notions of spirituality, mystery and qualities found in non-western cultures as having any relevance to organisations (in Frost et.al.1985,pp.230-231).

A cultural analysis of an organisation moves us in the direction of questioning these taken-for-granted assumptions, raising issues of context and meaning, and bringing to the surface underlying values (Smircich:1983,p.355). Our attention is focussed on the expressive qualities of the experience of organisation. It legitimates attention to the subjective, interpretive aspects of organisational life, providing an understanding that is closer to the lived experience of those who work in and are served by the organisations (ibid,pp.355-356). The values, beliefs and assumptions that underpin a specific organisation's culture become visible when they are translated into organisational structures and behaviours (ibid,p.66). The contents of an organisational culture are symbolic, ideational and variable (Frost et al:1985,p.36).

For the purposes of this project I will work with the definition of organisational culture as defined by the research participants. Workers

at the Centre and women who use the Rockhampton Women's Health Centre defined the culture of an organisation as being:

- the formal and informal aspects of the environment
- the philosophy, principles and policies
- the behaviour of people within the organisation
- the unspoken "stuff" about how the job is done and how workers are treated
- the ethos and ethics
- the patterns of interaction between people and
- the underlying philosophy and actual practice.

One participant summarised the culture as almost everything, written and stated and the unwritten and unstated, the conscious and sub-conscious (Appendix A). Participants' understandings are consistent with the definitions given by organisational theorists.

In women's health centres, women have put extraordinary time, energy and skills into creating alternative organisational structures, decision-making processes and "women-friendly" environments. Organisational culture in feminist organisations has been neglected in organisational and health literature.

Research Methodology and Method

Informed by a feminist, interpretive approach to research this project created an opportunity for women who work at the Rockhampton Women's Health Centre and women who use the Centre to express their views, exploring their different understandings of the organisational culture and its significance to them.

A methodology as defined by Sandra Harding is a theory and analysis of how research should proceed which includes accounts of how the general structure of theory finds its application in the research project (Harding, 1987:p.3). Chris Weedon writes that feminism in all its forms, shares a concern with subjectivity (1987:p.41). The contemporary feminist movement began with the slogan "the personal is political", insisting that women should define and interpret their own experiences, and re-define and re-name what has been previously named and defined for them (Stanley and Wise,1983:p.194). This project explores the bases of women's everyday knowledge as women and acknowledges the experiences of the researcher as a person in a situation (ibid:p.196).

Patti Lather proposes that to do feminist research is to put the social construction of gender at the centre of one's inquiry. Feminism, through the questions it poses and the absences it locates, argues that gender is central to the shaping of our consciousness, skills and

institutions as well as the distribution of power and privilege (1991:p.71).

As referred to in the literature review, poststructuralist theory has challenged the notion of feminists claiming to speak from their own standpoint on behalf of all women. This challenge is important for women's health centres if they are to be relevant to a broad cross-section of women. As Patti Lather points out the world is spoken from many sites which are differentially positioned regarding access to power and resources (1991:p.116). The term "women" signifies many different individuals and groups.

The notion of being conscious of the values and background experiences which researchers bring with them into the research project, is at the forefront of post-structural and feminist approaches to research. As researchers in the area of organisational culture, Adams and Ingersoll state that researchers cannot avoid telling the world about who they are (Adams and Ingersoll in Frost, 1985:p.225).

> *Scientists firmly believe that as long as they are not conscious of any bias or political agenda, they are neutral and objective, when in fact they are only unconscious.*(Namenwirth quoted in Lather, 1991:p.106).

This demands that the researcher be explicit to the best of her ability, about her role(s) and assumptions in relation to the project. My role as researcher is a culmination of a number of years of involvement in the Rockhampton Women's Health Centre. I was a member of the original steering committee which acquired funding for the centre and then became the coordinator, a position I have held for the past five years, being one of two original staff members who were employed when the organisation was established in 1991.

The notion of "standpoint" as explained by Nancy Hartsock is useful in exploring my role as researcher in this organisation. Standpoint is an interested position which can be interpreted as bias, and it also implies engagement in the situation (in Bowles and Klein:1983,p.285). It carries with it the contention that there are some perspectives on society from which, however well-intentioned one may be, the positions of other people with each other and the world, are not visible (ibid in Harding:1987,p.159).

As coordinator, my standpoint has been as a proponent or advocate of the organisation and its ideology. Patti Lather quotes Teresa Ebert's definition of ideology.

> *...not false consciousness of distorted perception but rather the organisation of material signifying practices that constitute subjectivities and produce the lived relations by which subjects are connected - whether in hegemonic or oppositional ways - to the dominant relations of production and distribution of power....in a specific social formation at a given historical moment* (1991,p.112).

Studying the organisation is yet another phase of my involvement. Dorothy Smith comments that sociology cannot avoid being situated, and therefore should take that as its beginning on which to build research methodology (Smith in Harding, 1987:p.91).

Peter Frost, a researcher of organisational cultures maintains that a researcher is always "positioned", representing a particular set of interests shaped by the personal and social characteristics of the researcher (Frost in Frost et.al.:1991,p.334). My role as a researcher gives me an opportunity to re-position myself, from coordinator to researcher, and listen to the perspectives of other women on aspects of the organisation which are significant but not always conscious for workers. Rather than seeing the investigation of a situation in which I have direct experience, as a problem, Dorothy Smith proposes that by accepting our territory, we can discover or rediscover the organisation from within (Smith:1987,p.92).

Feminist author, Dorothy Broom in the Preface to her book, Damned If We Do, a history of women's health centre in Australia, explains her difficulties in deciding in which "person" she would write her book (1991:p.viii). Although strongly committed to the women's health movement in Australia, she had not been directly involved in the development of any women's health centres. She chose to use the third person plural "they". As this territory is familiar to me and the research project arose out a personal interest to enter into a reflexive and interpretive process in relation to it, I am writing in the first person.

The method used in the research process is the feminist group interview which is chosen because my project is time-limited and as a research project quite small. I also understand this method as congruent with my methodology (Reinharz: 1992,p.222). The feminist group interview is similar to a focus group in several ways. They are small groups established by the researcher for a one-off group discussion of a topic. The discussion is led by the researcher who asks several questions and listens to the way in which the participants discuss the topics. The group interview is tape-recorded and the transcript is then analysed (ibid,p.222).

Due to unpredictable circumstances in women's lives such as sickness and childcare, I held two group interviews with women who use the

service. One group included four women and the other two women. The worker group consisted of four women.

Following the group interviews, there was an opportunity for participants to attend a third meeting, at which I presented a preliminary analysis of the research data. Participants were invited to critique my presentation and assess whether it reflected their opinions and ideas.

I invited women to attend the group interview by placing two invitations in the monthly newsletters of the Rockhampton Women's Health Centre. The newsletters are sent to, or picked up by women who are members and non-members of the organisation. I asked for responses from women who have used the Centre on at least two occasions (Appendix B). Apart from these limitations, women self-selected as research participants.

The times and venues for the group interviews was negotiated with each participant. The Women's Health Centre was accepted by each participant as an appropriate venue.

The goals of cultural research in organisations, according to north American researchers Deetz and Stanley, involves understanding, criticism and education (chapter 14 in Frost et al,1985:p.267). An

understanding comes from recording stories, metaphors and symbols, statements of beliefs and behaviours and practices, synthesising them and playing them back to organisational members for consideration. Secondly, criticism refers to the examination of conditions of consensus. An organisation's language and accepted means of expression usually enables easy, rapid expression of some things and yet block alternative expressions. Critique involves looking for the story that did not get expressed - that which is glorified and held above scrutiny is brought under examination (ibid:p.269). This research project addresses the first and second goals of cultural research in organisations as outlined by Deetz and Stanley.

Discussion

There were nine women who accepted the invitation to participate in the research project. Due to life circumstances, only six women actually took part. All of the women have been given other names and will be known in the research discussion as Kay, Mary, Dianne, Debra, Laurel and Chris. These six women were non-Indigenous with ages ranging from early twenties to around sixty years. They were women from vastly different socio-economic backgrounds. Three women were unpaid workers at the Centre either in the area of providing services or on working groups. All women had used a range of the facilities and

services provided at the Centre. The workers' names for this project are Lillian, Andrea, Ruth and Betty.

Women who have used the Centre

Four of the women had first come to the Centre during 1992, and two women had at least twelve months contact. The reasons they came to the Women's Health Centre included:

> *...saw it as a good place to meet women and a good place to meet lesbians....the day after I arrived in Rockhampton a friend brought me here to a planning day for International Women's Day.*

> *(I) wanted personal answers, soul-searching. Was aware of women's health centres but I was very reluctant. I read a newspaper article and started off with the 'Courage to Speak' course and it really opened my doors...*

> *(I) was referred by my General Practitioner....first time on the phone for counselling and second time (I) came in for counselling.*

> *I came to a meeting about women's attitudes to environmental issues...*

...at the time I was going to a group outside....someone in the group told me about a group happening on eating disorders at the Centre...

(I was) told Cheryl Kernot was visiting. My friend and I had been recently widowed, in our fifties and had to go on the dole. We came to talk to Cheryl to get Widow's Pension re-introduced....

Their reasons varied from the need for personal counselling and support to an interest in socio-political issues and a concern for the health and well-being of the broader community (Appendix A).

Women were asked to describe the specific culture of the Rockhampton Women's Health Centre after they had discussed their own understanding of organisational culture. All participants agreed that fundamental to the organisational culture was that the Centre was for women, by women.

Other significant characteristics were:

1. the physical structure of the house and the way in which it was decorated,
2. how women using the Centre were treated

3. how they perceive staff work together and make decisions,
4. the reaction within the organisation to conflict or stress, and
5. the fact that the Centre was a women's space, and
6. the impact of the external environment.

These features of organisational culture echo those characteristics of feminist organisations proposed by Hooyman and Cooper (1986,p.167).

The Centre is located in a large old house typical of what is architecturally known as a "Queenslander", and this physical structure helped to create for the women a positive, warm atmosphere. One participant, Chris, commented that the front entrance had two sets of stairs which symbolised to her that "*all ways lead to Rome and that there is no set way (of participating)*".

The physical aspects of the environment included the opportunity for women to enter the house at any entrance - back or front doors - and the absence of a reception area. Women enter the Centre through a hall and then into the library or lounge room.

Debra commented on the significance of the design of the ground level extensions with features such as the low windows at an appropriate height for children and people in wheelchairs and the carving of

"feminine" symbols in the beams along the ceilings in the large workshop/meeting room.

In addition to the structure of the building and rooms was the way in which the physical environment was decorated. This was highlighted by all participants.

> *Touches that I appreciate are the flowers, the artwork and the oils* (Debra).

Mary commented that it was not one specific feeling in the rooms, each room varied in its feel. She had seen decor change over the four years and had noticed that different women hung up different things on the walls.

Hospitality, the word used to describe answering the telephone or welcoming women into the centre, was also considered central to creating the homely, friendly atmosphere. Women could see that this welcome and the atmosphere was intentional. Strangers were welcomed and trusted to use the Centre and the library. Mary described her experience when she lived outside of Rockhampton and to came to spend the day in town with her three children.

We had a property ....I used to come and sit and feed the youngest, the oldest boys would go out to the sandpit. I used to sit down town and was uncomfortable. I felt more relaxed coming here and the kids felt better, more relaxed...

A symbol of this hospitality for the women was the bottomless cup of tea or coffee and the supply of bikkies which the women said made them feel comfortable. Kay commented that the organisation has this *"drop-in at any time and you're welcome"* situation which she saw as a fantastic thing for women. The other side to this policy was the stress which she thought must be put on staff as they don't have any type of private space in the house.

The non-judgemental atmosphere was important to Chris, as there was no label given to women as they walk in. *"You walk into Women's Health and it is on a name basis, you do not feel like a client or patient".*

All participants liked "the ethos" of the Centre, *the "respect stuff that I encounter at Women's Health" (*Kay). Participants saw the organisation as non-hierarchical. The symbol of this for Debra was again that women were able to enter the house from any entrance, there was no formal reception area and the layout of seating in the lounge/meeting area was circular. To her these features communicated a spirit of equality to women using the Centre.

Kay had observed the interactions between members of staff. To her there isn't a sense of someone being in charge and others underneath. However at times this has meant confusion for her as she works in an unpaid capacity at the Centre for three hours a week. At times it had not been clear to her where to go for some things. She saw the structure as both a strength and at time "*making things less clear*".

Mary had also observed that there was no hierarchy or attitude that "*I am a worker*". She saw that women had something to offer each other and to the house and the community. When she had participated in groups at the Centre the worker introduced herself as the facilitator, which she compared to the worker introducing herself as a social worker or another professional as in other health settings.

All of the women identified differences to other health services in the way in which the programs or services were provided. Mary gave the example of the broad range of health information which "*comes across as lively .... and gives lots of information*". Debra described the Centre as multi-faceted and holistic and whatever your needs are at the time you can tap into a lot of them - whether they are personal needs or to join a network or the organisation. The connections and friendships made between women who use the Centre and women and workers had an impact on Chris, Debra, Laurel, Dianne, Mary and Kay.

In reading and talking to different women, connected to Women's Health, Mary had understood that women using the Centre can add to committee meetings and the running of the place. *"It doesn't have to be a professional person it can be a lady who uses the services".*

Debra explained how the Women's Health Centre incorporates the ideas of members by having a review of the service in December, asking people what they would like to see in the following year and then staff incorporate these ideas. If a woman has something to offer it can be put up. In meetings, Debra felt that encouragement was given to anyone who wants to have a go at the roles involved. Although she hadn't been to meetings Mary had gleaned an *overall picture that women at the house get together and think "..well what should we do, where should we add to the house, what is needed?"*

Laurel and Kay described Monday morning staff meetings and the importance given to it by staff members as giving a message to other women that a value is placed on people being heard, people being informed and working cooperatively.

Kay, in her role as unpaid worker had closely observed stress among staff. When people are stressed and pushed, she saw that the space which should be given to others isn't, because *"someone can't cope with any more and that comes across"*. She adds, *"I pick up high stress levels at times and the language itself is stress language and there is a sense of rush. Sometimes it may be related to having a sick child or it could be related to other changes"*.

Over the past year, particularly during winter, Laurel observed that many staff had been sick. She interpreted this as people being stressed. She feels that the Women's Health Centre has become more a business in recent times. She has felt that it was not appropriate to just "drop in" as she had been used to doing.

To Kay the Centre empowers women and for her, *"it is one of the few areas in society where that happens"*. Mary observed that the culture of the Centre comes through the fortnightly newspaper articles. *"I don't have to have something wrong with me to come to the Centre - a self-help, educational emphasis."* At the Centre she felt that there is no right or wrong in anyone saying *"we will accept that, but we won't accept that"*. She had experienced staff listening to what women have to offer.

Debra, who had been involved with the Centre since 1992 had seen conflict emerging from the feminist philosophy. For her feminist philosophy being put into practice sometimes becomes dogma. The attitude of *"we're right and everyone else is wrong"* leads to conflict and for her unnecessary conflict between people, because of the other positive aspects of the place. Debra has been a member of the conflict healing working group at the Centre, and she realises that conflict is always present in any organisation. Although she has been aware of tensions between members, management committee and staff, she has been unsure of how much she needs to know and whether the tensions need to be addressed or are being addressed. As a member of the organisation, she has experienced the "*not knowing*", both of information and whether it is her responsibility to become involved.

Staff changes such as younger workers being employed who may have less experience have changed the culture of the Centre for Laurel. For her their language is different and they are starting out on their journeys and learning. The insecurity expressed within the organisation which Laurel linked to new workers was also noted by Kay. Kay had associated this feeling with the lack of funding security. The second National Women's Health Program on which the Centre largely relies for funding, finishes in June 1997 and neither the federal or state governments have made any commitment to continuing funding to women's health centres.

The insecurity of funding was one of two adverse external pressures on the Centre expressed by participants. Dianne, Mary and Debra talked about the criticism of the Centre by people in the community. There was misunderstanding in the community about what happened at the Centre by people who, according to Mary, *"jump in with their own concept of what goes on here, rather than open their minds to what goes on".* Chris had heard the notion expressed in the community that the Centre was brainwashing women against men. Debra commented that the negative ideas verbalised by some people must put a lot of pressure on women who use the service.

Paid Workers

The four women who work at the Rockhampton Women's Health Centre were interviewed in a group. Ruth has worked at the Centre for the shortest period of three weeks. Lillian and Andrea have been workers for eleven and twelve months, while Betty has been a worker for five years. Their ages ranged from early twenties to over fifty years - all non-indigenous, white women. They identified six areas which for them reflected the organisational culture. They are:

1. external forces

2. the ideology of feminism
3. how women using the Centre are treated (described by workers as hospitality)
4. how they perceive the way in which they work together and make decisions
5. the house and the way it was decorated
6. the language used and and some of the stories which are often told.

As the women who used the Centre had done, the workers recognised the impact of external forces on the organisational culture. The uncertainty of funding and *"working in a hostile environment as money may not be here after June next year"* was a concern to Lillian and she saw it effecting the organisation. To her this was in contrast to three years ago when the organisation was growing and it was exciting.

The Community Health Accreditation Standards Program (CHASP)which is a peer Accreditation review process for primary health care services in a community context is a second external force which Andrea considered may change the culture of the organisation (1993,p.vii). The CHASP sets standards which have to be met in order to get accreditation as a primary health care service. However Andrea pointed out that part of the culture of the Centre was *"to challenge such standards and push that edge"*. Some of the workers have responded by wanting to follow the CHASP guidelines closely as they perceive a

link between accreditation and future funding. Other workers such as Andrea want to challenge the process.

Such differences between staff members were also identified in relation to feminist philosophies and principles. Organisational change was discussed and Betty observed that an increase in the size of the staff group and the introduction of new workers had shaped the culture. Not all information sharing and problem-solving was able to happen at the staff meeting once each week. Betty saw that now *"more things may be sorted out between individuals".*

Although Lillian had only worked at the Centre as a paid worker for a year, she had completed one of her fieldwork placements as a social work student at the Centre. She expressed the frustration that a couple of years ago the culture seemed to be much more feminist. Now she perceived it as fragmented and "*possibly a bit diluted*". She explains,

> *At the moment for the last twelve months since I've been working, there hasn't necessarily been that equity of value of all women and women's ways of doing things. Because the feminism that was here - there were outbreaks of drama and those things still exist but at that time sisterhood seemed to be more the thing than today. Who upholds feminism now? I guess it's about how we do business here how we do counselling. The way we have conversations with people*

about how we do business. Feminism was about guiding all of that, but it was about how we lived our lives as well, how we were as women and how we made connections to other women.

Betty responded by focussing on how women were treated by workers and thought this had not changed. She saw Women's Health as holistic, woman-centred, empowering of women, offering them respect and acceptance. This was demonstrated partly through the workers' approach to hospitality. *"We value women who come in and what we offer"*. She felt that the Centre now focussed on issues which met more women's needs. The opinions of the paid workers on this issue were very similar to those expressed by the women who use the Centre.

Feminist philosophies and principles were still evident but Andrea felt it was up to workers whether they were followed or not. She saw a more subtle form of feminism influencing the organisation than a few years ago. More staff, new staff, she felt were reluctant to experiment with what is seen as "fringy" because funding was uncertain. She told a story of her own reaction a few days before when the coordinator had to answer a ministerial inquiry about how much money the Centre allocated to the Lesbian group.

I thought - is this going to effect our funding? - and I pulled myself up and I thought, we're falling back into line if we give the politicians what they want to hear, whereas we need to push the edges for acceptance of women.

Although she felt at times disillusioned with the change in the culture, she realised that change was part of life in this organisation. To her, respect and caring of women was an essential part of the culture.

Every woman regardless of her past experiences, education and knowledge is accepted as being able to contribute.

Women's choices and their right to choose was a fundamental aspect of the culture for Andrea.

Betty worked with women using creativity and when women participated in the creation of banners they looked for them to be hung on the walls and through them, identified with the house.

The women in the 'over fifty' group know if their banners have been moved and they want to know where they are. There is an identification with here and an ownership.

What workers say to women about looking after themselves they say to each other as workers. For Betty part of the culture was the valuing of workers. Supervision was provided for the support and development of workers and workers often marked important occasions with celebrations. Lillian observed that if workers are sick or their family needs them, workers say "*yes, you must go*". Ruth, a newcomer to the group, found the environment nurturing. A lot of emphasis was put on process, how workers were treated and how women were treated. She noted the difference between competitive, task-oriented environments such as the university. She saw that at Women's Health you still need to get tasks done and the tasks get done.

As part of her orientation process she had read Peace and Power which is used by staff and management committee members as a guide to meeting and decision-making processes (Chinn:1995). Although workers saw shared decision-making as part of the culture and everyone has the right and responsibility to put their views forward, Ruth didn't always see that happening.

> *Sometimes it is opened up and others have their say, but I haven't seen the process opened up as in the book.*

Another apparent anomaly was described by Andrea. She stated that the culture was to accept difference within staff.

> *There are people who don't go to supervision and all sorts of things in this place, because we say we have to respect your right to say no, but in time when people say no to more and more things how does that effect this house? ..... Everyone within staff would agree with the organisation's principles but individual people would have different perceptions of empowerment because of past experiences.*

Collectivism is part of the culture, but to Lillian this didn't mean being the same, which to her was undesirable. Betty felt that the culture gave women the freedom to work in a way which suits each person, with her own decisions being respected.

A theme throughout the group interview with workers was the change in the culture from what they perceived as stridently feminist to being shaped by a more subtle form of feminism. Lillian supported this concern with feelings of frustration and a sense of helplessness:

> *In two years what will differentiate us and ..... (a church based human service organisation in Rockhampton)? Hopefully they respect human beings as well.*

Participants' feedback

The third occasion to which I invited participants provided an opportunity for me to present my transcript of the taped group interviews. All women accepted the invitation and a mutually convenient time was made, however on the night three women were unable to attend due to sickness and forgetting. All of the workers who had been interviewed attended. At this gathering, Lillian commented that on the day of the group interview she was in a particularly questioning mood and now didn't feel as disillusioned about changes in the organisational culture. Debra, a woman who uses the Centre, commented that she saw such questioning as part of the Women's Health Centre culture, *"There is an awareness that there needs to be changes".*

The physical environment, they way it was decorated and the freedom it offered women to participate were highly congruent values between paid workers and women. They gave detailed attention to the environment describing the life-affirming "things" hanging on walls and tables covered with nice cloths. As mentioned by Betty, banners and other artwork which had been completed in groups were hung on walls when appropriate.

The cup of tea was also seen by workers and women as a powerful symbol of the organisation. Morning teas and lunches with unpaid workers and natural therapists and various celebrations either at the end of groups or among staff for birthdays or farewells, were part of women together sharing food and drink.

At the feedback session, workers commented that they had not spoken about the language used in the organisation and the stories told. It was agreed that to explore these aspects thoroughly would take a longer period of time and greater depth of interviewing. Workers briefly commented about women's conversations in the Centre.

Ruth observed that gossip was valued. It had been reclaimed and seen as a source of positive ideas. A second way in which language reflected the distinctive culture was in taking words that might be used to put women down and turning the meaning around. Lillian gave the example of the "High and Mighty" project. This project involved the Centre working with young women in secondary schools, using circus skills and games to promote positive body images. Naming the project "High and Mighty" turned the words around and gave them a positive meaning.

Betty spoke about language used at the Centre which draws on women's history. Words such as empowerment, choice, women's wisdom, herstory and gossip take us outside the language which we usually hear.

One participant, Kay compared the difference between the culture of the Women's Health Centre and a "mainstream" health service as like being on two different planets. Although this project does not address programs and services, women interviewed were convinced that the culture of the organisation did have an impact on what services were provided, how they were provided and how much control women had during their involvement with the organisation.

Laurel had recently been in two hospitals, seriously ill, and has seen a number of different doctors. She described how the confidence gained and the information learned at Women's Health had enabled her to feel comfortable communicating about herself with the doctors and hospital staff.

In summary the shared perceptions about organisational culture among women who use the Centre and workers were:

1. the physical structure of the house and the positive environment

2. how women who used the Centre were treated and
3. it was a women's space.

As Queensland academics Jones and May claimed, for organisations working with people, the effectiveness of the service depends on the nature and quality of the relations between the staff and people using the service (1992,p.83). The commitment which staff expressed in offering women respectful, democractic, and holistic health services was noticed and appreciated by the women using the Centre.
The women felt that they could participate and this was an important part of the culture for them. They were informed that they could participate at different levels in the organisation in three ways - by the way they were respected and listened to when they used the services; through newspaper articles; and by talking to other women and paid workers.

This greater self-reliance among people using the services and a high degree of community participation in health care planning and decision-making are fundamentals of a primary health care organisation (Primary Health Care Policy:1993,p.1).

Reflections and Critique

The research data largely reflects positive feelings and attitudes towards the Women's Health Centre and this was influenced by the fact that women who accepted the invitations were "wanting to give something back" to the organisation which they perceived had assisted them previously.

Concern was expressed by Debra about feminist ideology and how it caused conflict in the organisation. Feminism was also a prominent cultural issue for workers. However the women who used the Centre were more focussed on the practicalities of how the organisation demonstrated its ideology rather than discussing the "right feminism". Laurel expressed some insecurity about recent changes to the staff group and questioned the commitment of new staff to continue things as they were before.

Workers themselves echoed this concern. Lillian and Andrea expressed most concern even though they themselves had only been working at the Centre for eleven and twelve months. They questioned whether the current work group had the level of commitment to feminism that they had perceived among workers in past years and to what degree there was a common analysis and understanding of feminism. They

questioned what would happen if differences continued to be tolerated and increased?

The workers did not use terms such as radical or socialist feminism but their ideas reflected notions of radical feminism. During the research I omitted to ask participants to define feminism. Their ideas seemed to imply that in previous years there had been a sense of certainty and rightness about feminism and what the Centre was and how it should be run. They told stories about how workers had spoken and behaved which for them seemed to be more sure, more confident than how they were feeling or how they perceived their colleagues' behaviour.

Although the Centre's history includes many stories of conflict, the workers interpreted the open conflict among staff as reflecting certainty and confidence. There was a belief expressed that previous workers had a common understanding of feminism and that this had determined the development of the Centre.

As the researcher who had been part of this development, this material caused me, in turn, to reflect. In 1991, when the Centre was being established and a broad cross-section of women were invited to participate in its development, the rhetoric implied an inclusion of difference and indeed considerable effort was given to achieving this. What was not consciously understood at that time and became evident

to me during the research, was that different women were invited in as long as they acted within a pre-determined feminist ideological framework. This ideology incorporated aspects of both radical and socialist feminism and most definitely included an emancipatory feminist agenda. This feminist ideology was consistent with many other women's health centres throughout Australia and has been described earlier in this paper.

Another dynamic within the founding group was an acute awareness that this was a chance to establish an effective women's organisation in Rockhampton. A belief that it may be the only chance. This translated into an intensity and commitment to meet the very high expectations of what the organisation could be and what it could represent to the community.

Indigenous women were involved in early planning, however there was little or no ideological space for their specific experiences and wisdom. At this time local Indigenous women were not convinced that separate space and an exclusive focus on women was a strategy they could support. Tikka Jan Wilson describes such institutionalised racism in her article looking at the relationships between white feminists and Indigenous women in an Australian refuge (1996,p.2).

The Women's Health Centre has continued to dialogue with Indigenous women and women from non-English backgrounds and successful joint programs have been run. Even with this continuing dialogue little impact on the organisational culture has resulted.

Although including difference was seen as part of the culture by some research participants, current workers observed that in previous years there had existed a core group of women who held strong, agreed upon and expressed feminist beliefs. This group no longer exists and the organisation is being challenged to incorporate difference with the employment of new workers. In articulating what they see happening to the organisation, workers interviewed expressed feelings of insecurity.

A common ideology which is critical of the status quo, is an impetus for the establishment of many alternative organisations, and women's health centres are no exception. In the case of the Rockhampton Women's Health Centre the organisation was intentionally standing against bureaucratic organisation, patriarchal hegemony, the local socio-political environment and the medical health system. It was standing for women, egalitarian organisational structures and processes and a social model of health.

Anna Yeatman's challenge that although there may be still be a place for emancipatory politics and a universal subject (such as women), it

can no longer be accepted uncritically and the inevitable exclusivity must be considered and taken account of (in Caine and Pringle:1995,p.56). Feminist theories and politics have developed and for women's health centres to remain relevant and continue to have a frontier role within the health system, old strategies and organisational values must be challenged.

American researcher Kathy Ferguson and Australian Jocelyn Auer caution women's organisations faced with change, against being co-opted into bureaucratic structures and the mainstream health system (Auer in Baum:1995,p.256. Ferguson:1984,p.180-181). Ferguson argues that feminists need to continue to seek out submerged discourses implicit in women's experiences (p.243).

The interruption of the dominant feminist discourse within the Rockhampton Women's Health Centre may be a crucial factor in its future development. This experience is uncomfortable, old certainties are disturbed and even erupted. Compounding this challenge is the threat to future funding likely to happen within the next twelve months, during 1997.

At this time it is useful to listen to the women who have used the service. In this research project they have strongly stated that their concern is with the practical demonstration of the organisational values

and beliefs. For them, the organisational culture does have an impact on the acceptability of the services and facilities and the significant aspects which they described in detail are: the pathways to participation and a feeling of equity; the welcoming, life-affirming environment, that they are listened to and respected; and that the Centre is a women's space.

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APPENDIX A

COPY OF THE QUESTIONS ASKED OF WOMEN WHO USE THE CENTRE AND WORKERS

FOCUS GROUP QUESTIONS FOR WOMEN WHO HAVE USED THE SERVICE

1. What is your understanding of the word "health"?

2. What brought you to the Women's Health Centre in the first place?

3. (Approximately) how many times have you used/visited the Women's Health Centre?

4. What aspects of the Centre do you particularly like?

5. What do you think is meant by the "culture of an organisation"?

6. What in your opinion is the culture of the Women's Health Centre?

7. Have you used other Community Health Centres?

8. In your opinion are there differences between the services of the Women's Health Centre and another community health service?

   What are they?

9. Are there similarities between the services?

   What are they?

10. Other comments....

FOCUS GROUP QUESTIONS FOR WOMEN WHO ARE PAID WORKERS IN THE SERVICE

1. What is your understanding of the word "health"?

2. How long have you worked at the Women's Health Centre?

3. What do you think is meant by the "culture of an organisation"?

4. What in your opinion is the culture of the Women's Health Centre?

5. What are some of the stories which express the culture of the Centre for you?

6. What are the symbols which express the culture of the Centre for you?

7. What are the values which for you inform the life of this organisation?

8. Describe the way in which staff work together and make decisions?

9. Do you think that the Women's Health Centre is different to other community health organisations?

   If so, in what ways?

10. Other comments....

APPENDIX B

COPY OF THE INVITATION TO WOMEN WHO USE THE CENTRE

BELLYDANCING

Belly dance creates pelvic wellness and can give you an enhanced feeling of relaxation and well-being.

Bellydancing will continue at the W.H.C. with ***Annette Powell - yes!!*** she is still with us for a little longer.
Sessions will begin on Wednesday July 10 from 5.30pm - 7pm.
Phone 226585 to book a place.

WOMEN'S LITERACY PROGRAM

Carmel Martin has recently joined us at Women's Health to run a literacy program for women.
So...if you know of any woman who wishes to read, write or speak the English language more proficiently, please phone the Centre on 226585 and leave a message for Carmel.

An Invitation...

Many of you may know me. My name is Marilyn Leeks and I have been involved in the Women's Health Centre since 1990. This year, I am involved in research on the Centre for a study course.

As part of this research, I am wanting to talk to women who have used the services of the Centre. It is preferable if you have used the Centre on more than two occasions.

If you would like to be involved in this research, please contact me at the Centre on 226585 or at home on 277561.
Your participation would include a short chat with me on the phone about the project and then meeting with me and other participating women for 2 to 3 hours in a discussion group.
Your opinions and ideas would be kept confidential.
The topic of my research project is "Does the organizational culture of the Rockhampton Women's Health Centre have any impact on women who use the service? If so, in what ways?"

Another Invitation...

Miriam Therese Winter is a Medical Missionary Sister currently touring Australia. She will present a workshop/seminar in Rockhampton.

When : Tuesday July 16
Where : Birdcage Bar, Level 1, Union Bldg. Central Queensland Uni.
Time : 7.30 - 9pm
Cost : $10.00 (waged)
$ 5.00 (non-waged)
Supper included.

RSVP to Anne James on 271863 by July 9.

CHILD SEXUAL ABUSE HOTLINE PHONE 1800 646 532

The hotline will continue to operate for another month until mid-July and is open 24 hours a day.

A counselling and research hotline has been established for adults with past experience of sexual abuse of children in situations of current sexual abuse.

The new Qld Government will plan sexual abuse services based on the information they receive, so call if you want your voice heard.

APPENDIX C

RESEARCH DATA

RESEARCH DATA SORTED UNDER THEMES

(corrections and additions made following feedback session with women and workers and women have been given substitute names as agreed)

1. What is the understanding of health ?
(Women who use the Centre and workers)

(there was general agreement among women about their understandings of health)

physical, mental, spiritual, social and emotional well-being
includes preventative health strategies
-coping strategies to prevent illness e.g. good food and diet

holistic health - all aspects of life effect health

whole of lifestyle, every aspect of life

Having an understanding and being able to cope with stress or events as they come along

Well-being, balance, ease functioning to your own full potential
freedom to be who I am
connectedness to other people
confident and relaxed
inner strength
knowingness

We are all ultimately our own healers

Comfort and ability to function without pain

Differs from medical model of health in that the medical model looks at the negatives of health like if you are sick or if you have something wrong with an organ it focusses on negative side. At the women's health centre focusses on positive side of health.

Women's health centre looks more at preventative side.

Personal health is related to social structures around us, environmental too.
It is not an individual's body, mind and spirit well-being disassociated from the community. It is an integrated understanding.

Health is about how much the person feels that their health is in their hands and how much of their health and well-being do they look to other people to provide for them - important to have a sense of being able to take care of your own wellness. A person may live with some parts of not being well but finding wellness around disability or whatever the situation is.

Health is a way we see life - I could be healed and whole and very ill.

QUESTION 2: What brought you to the Women's Health Centre in the first place?
(Women who have used the Centre)

Kay:

In February 1995, I was very new to Rockhampton, saw it as a good place to meet women, and a good place to meet other lesbians

The first time I came to the centre was the day after I arrived in Rockhampton, a friend brought me here to a planning day for IWD. I was immediately made to feel as though I was belonging here which was such a big help.

Mary:

I came in March 1992.
I wanted personal answers, soul-searching. I was aware of women's health centres but I was reluctant. I read a newspaper article and started off with the Courage to Speak course and it really opened up my doors and avenues and I have used services for other needs, to journey on further. I've done courses on Aromatherapy, and body health courses, counselling, self-esteem courses, inner child, I was getting answers for the way I was feeling.

Debra:

I came in 1992.
I came to a meeting about women's attitudes to environmental issues - the Women in Environment consultation held in co-operation with the Queensland representative of the National Women's Consultative council. I was invited to attend a meeting at the centre about the importance of healthy environments, healthy lifestye which is very much connected to health. This was my first encounter about this social issue and then I used other services such as attending lunchtime information sessions and menopause groups

Chris:

I came 12 months ago.
I was referred by my general practitioner. The first time I used the phone for counselling and the second time I came in for counselling. I have a woman general practitioner who is open-minded. It is the first time in my life that I have had a women general practitioner. I think I would have come here sooner if men general practitioners had been more open-minded to recommend other services. I am sure that they

all have access to the same information, women are more willing to look at alternative therapies and so forth.

Dianne:

I came in July 1992.
I was told that Cheryl Kernot was visiting. My friend and I were recently widowed and we were in our fifties and had to go on the dole. We came to talk to Cheryl to get the Widow's Pension re-introduced. Cheryl asked the centre to help us and we couldn't have done it without the services of the centre. It has been four years of fighting and we now have had a breakthrough.

Laurel:

I came in 1992.
I was going to a group outside at the time. I was going to the group because I have had a weight problem all of my life. Someone in the group told me about a group happening on eating disorders at the centre when there would be a guest speaker from another community health service.

Ruth

(student) has been at the centre three weeks

Betty

has been a worker for 5 years

Lillian

has been a worker for 11 months and has had previous experience as a student on placement and on the management committee

Andrea

has been a worker for 12 months and has had previous experience as a student on placement and on the management committee.

QUESTION 4: What aspects of the Centre do you particularly like?

(Women who have used the Centre)

Laurel:

Being introduced to natural therapies, to Reiki first and foremost through an initial workshop and wanting to know more about it and having the courage to feel the power coming back - it's O.K. - it's alright to do this for me. I connected with this woman who had had an education and had forgotten about it. I started to read.

IWD - I recall a lunch with women from non-English speaking backgrounds and how delightful it was and we shared foods from different cultures. I remember a video which was made to show to women in remote and rural Queensland what women's health is all about. We were in the lounge room and invited to share our feelings, opinions about women's health. For me doing this was quite something at the time.

The flowers and artwork was where I connected. Workshops, lunchtime sessions. I went to workshop about conflict. I turned up with other women and that was the turning point. It was supposed to go for 8 weeks and those who lasted the distance went for 12 weeks. That is where I reclaimed who I was - I learnt so much - that is where my connection with women's health really started.

There was literature available I didn't have to ask. The flowers, it was comfortable and I connect with it.

Mary:

The trust that is offered to you as a total stranger, you are welcomed to come in and use the centre and the library.

The library is a terrific resource to use. There is always someone there to help, you can drop in. The books are fantastic.

I used to use the centre for when I came into town. We had a property in Alton Downs. I used to come in and sit and feed the youngest, the oldest boys would go out to the sandpit. I used to sit down town and was uncomfortable. I felt more relaxed coming here and the kids felt better, more relaxed. Nothing worse than feeding a baby when you are tense and the sun is blaring down.

Being a house and so homely, the atmosphere. There is nothing clinical about it.

I very much enjoy what the centre has given in the way of pamphlets in the way of describing women's health and women's information. It comes across as lively instead of "headings" and it gives lots of information.

I have found the groups very effective and rewarding and a lot to be gained from them.

Debra:

The centre is multi-faceted and holistic and whatever your needs are at the time you can tap into a lot of these needs - personal needs and an avenue or network as an organisation.

I found the centre a refuge for myself to get input for myself and sustain myself for my activity in the community, inspiration, nurturing and caring and contact with women in general, supportive environment.

The centre is so welcoming.

Reiki sessions I have appreciated personally. My first experience was the "Consumer and Environment Expo". I was one of the organisers and one of the centre workers knew I would be exhausted and offered me a Reiki sessions after it was over as a recovery process. I thought it was marvellous she cared enough.

When I had my hysterectomy, the information was good.

Chris:

Since coming to the centre I have taken part in the Women Growing Stronger course, and met a new set of friends. It helped me realise I wasn't on my own out there with my problems. It was good to get together and support each other and compare notes. If you are depressed you feel that you are the only person that ever had that problem. You find that women of all ages have got the problem. They may be further along the track than you or perhaps they handle their problems a bit differently because of experience or age. To be able to be honest and be able to say - this is how I felt in this situation and feel that your feelings are normal and not alien.

The fact that the sessions hav childcare doesn't effect me personally but it must be wonderful for mums who don't have family or friends to

take care of them. Childcare is expensive and hard to get. It must be wonderful to come and relax.

Dianne:

The access to the photocopier and the service that is provided to the likes of my group which is a lobby group. Having the ladies to help fix the photocopier and having access to equipment.

Kay:

The ethos of the place, the respect stuff that I encounter at women's health that I particularly like. In more tangible terms I very much like the library and the resources - I've gained very much from being able to borrow books. I like it as a referral point. I run across people who need things that women's health can provide. I say go see women's health, the library, go see one of the counsellors.

QUESTION 3: What do you think is meant by the "culture of an organisation"?
(workers)

QUESTION 5: What do you think is meant by the "culture of an organisation"?
(Women who have used the Centre)

Andrea:

The environment, whether the environment is welcoming or not, formal or informal. I guess culture says to me that it is more or less a philosophy or the people who come into the centre or work at the centre are aware and endeavour to follow some of those principles.

Betty:

All of it - philosophy, policies and the activities or behaviour within the organisation.

Lillian:

Unspoken stuff about how the job is done and how workers are treated. If an organisation has a philosophy that is written down, it does not mean that it is adhered to and that people who go in find it there.

Kay:

The part contained in the ethos, philosophy, ethics stuff. It would be the way people would interact, the normal patterns of interaction. The approach taken to things, flowers, pictures that are around - culture of making things beautiful.

Mary:

Setup, the formal rules and regulations.

Debra:

The culture is almost everything - written and stated and the unwritten and unstated. Conscious and sub-conscious.

The underlying philosophy and the actual practice.

QUESTION 6:What in you opinion is the culture of the Women's Health Centre?
(Women who have used the Centre)

QUESTION 4: What in your opinion is the culture of the Women's Health Centre?
(workers)

Lillian:

Are outside influences having an impact. The uncertainty of funding - working in a hostile environment as money may not be here after June next year. Three years ago that was not so much a concern and the organisation was growing and it was very exciting. We were taken by the good fortune to have this place. Maybe more an influence on culture here from outside influences.

A couple of years ago the culture seemed to be much more feminist, much more sure about feminism at that time whereas at the moment the culture seems fragmented, it is moving and possibly being a bit diluted.

At the moment for the last twelve months since I've been working there hasn't necessarily been that equity of value of all women and women's ways of doing things. Because the feminism that was here - there were outbreaks of drama and those things still exist but at that time sisterhood seemed to be more the thing than today.

Who upholds feminism now? I guess it's about how we do business here how we do counselling. The way we have conversations with people about how we do business. Feminism was about guiding all of that, but it was about how we lived our lives as well, how we were as women and how we made connections to other women.

It's shifted from what's important for this place to the individual to what's important to me? Feminism exists - those who believe are very much attached to feminism and those who don't can operate outside of it and we can all exist in this house.

As a student, I had room to move. I was far less confident but that was fine. I have room to move. Other women sparked each other but there was no question that these women were still as opposed as they might have been and they could still accept each other and the work of the house went on. Lately differences of opinion make for more distance between women. Women still believed in this place when they had differences.

Betty:

Woman centred, empowerment of women and respect and acceptance for women who come here.

Women's health is more holistic.

Our approach to hospitality - our commitment is as strong as a few years ago. We value women who come in and what we offer. But something like a personal growth process among staff has not had the focus because we are a changing group and I respond to everyone here. In the early days some of that was really easy. Now it is more serious and not easy to get into certain processes, for example, about cleansing the building. It was easier before and today we think - be more careful. I think who will participate and how do I say it and when do I do this at a time that is appropriate because I am adapting to a changing group of women who are workers.

Andrea:

This organisation - the principles and philosophies are still there and it is up to individual workers whether it is followed or not. Some of the women who come into the centre wouldn't know that it existed. It is not what is written but the acting out of what is written.

We think if we don't push edges we will be seen more favorably for continuation of funding . I don't think that is true - but it is almost like falling back into a conservative position.

I believe that feminism is more subtle within the organisation. I've seen a real change from 4 years ago from when I started on management. I think - are we losing our feminism. It is a different type - maybe more conservative type but it is still there. I need to see that it is there.

We are getting more staff who are reluctant to experiment with what is seen as "fringy" because now funding is "iffy" for women's health centres. The other day when we had a ministerial inquiry about how much money the Centre put into the Lesbian group, I thought "is this going to effect our funding?", and I pulled myself up and I thought - we're falling back into line if we give the politicians what they want to hear, whereas we need to push the edges for acceptance of women.

Every woman regardless of her experience, past experiences, education, knowledge is accepted as being able to contribute and is accepted regardless. Women are seen as people of value regardless of circumstances.

Chris:

It is run for women, by women.

Debra:

The centre has a spiritual feel/awareness, tapping into the universality of life, building on history and contribution women have made to society, feeling that women are reclaiming part of our history.

Women's health centre incorporates ideas of members by having a review of the service in December, asking people what they would like to see in the following year and then staff incorporate these ideas. This is part of the culture.

The hospitality and the culture of the centre is not adhoc.

If you have something to offer it can be put up. I don't know whether anything gets knocked back or not.

Touches that I appreciate are the flowers, the artwork, the oils.

The negative ideas of some people outside about women's health centre puts a lot of pressure on women who use the service.

The design of the meeting room downstairs where there are feminine symbols in the wooden beams of the ceilings reflects the culture.

The outside gardens, particularly the colours of the flowers - green, purple and white.

The down side is conflict can be raised coming from the feminist philosophy. It can become dogma. Sometimes philosophy when being put into practice becomes dogma. We're right and everyone else is wrong leads to conflict and I think unnecessary conflict between people because of other positive aspects of the place such as people being accepted, no hierarchy and being non-judgemental. There are aspects where dogma does come in and is part of the culture. My perceptions are that conflicts arise because of dogma.

It is democratic - not hierarchical, you can come into the house at any entrance. There is no reception area. The seating area reflects the philosophy that we have equal participation. It is a collective not a hierarchy. At meetings chairs are arranged so that they are not structure putting up barriers to equal participation, we do value equal participation.

Encouragement is given to people, giving the feeling that anyone who wants to have a go at these roles in meetings can do so and is encouraged. It is open to general membership.

The conflict healing working group (part of the women's health centre organisation) has been aware that conflict is always there. You can't have an organisation where there is no conflict.

I am aware of tensions between members, management committee and staff not necessarily conflict but observing that there are tensions. Awareness that they are there but not what they are - working in the dark. Not necessarily serious but may involve different personalities which will always be a feature of organisations. Don't know and maybe I don't need to know what the tensions are, whether these tensions should be addressed, are they being addressed? The no-knowing - is that O.K. or should I (as a member) be involved, does something need to be done?

Added to our philosophy is the shared facilitation. In general there is shared leadership. For example, the policy working group meets in different women's homes and the woman whose home it is in facilitates the meeting. The woman who takes the minutes then hosts next time and facilitates.

The windows in downstairs area are low for children and women in wheelchairs. Their needs were considered in the design.

The centre is for women by women. I think we do put this into practice. It is important in the culture. Not a community health centre where there is men and women, It is a different culture and provides an alternative organisation.

The two entrances on the front steps for me represent the womb and the fallopian tubes.

A certain member doesn't like circle dancing and people often highlight her non-acceptance.

Mary:

In reading and talking to different women connected with women's health, I have understood that women using the service can add to committee meetings and the running of the place it doesn't have to be a professional person it can be a lady who uses the services.

The building structure reflects the culture.

There is no right or wrong in saying that we will accept that, but we won't accept that. Listening to what women have to offer. There would have to be rules of don't drown me in your preaching but ladies here are willing to listen.

Broadening our horizons through different things that are offered in the house. Different experiences, cultures not one sort of culture - Tai Chi etc.

It is not one specific feeling in the rooms, it can be Indian, or abstract or native flowers. Over the years I've seen different things from room to room. Not one dimensional. You see different women hang up different things.

Many people outside in the community, jump in with their own concept of what goes on here, rather than open their minds to what goes on.

In saying the word facilitator in groups instead of "I am a social worker". In other health settings their title is always said whereas here it is said "I am a facilitator'.

You walk into women's health centre as a house different to clinical psychiatric health service. I am eager to see what the new community health centre is like. I have had a lot of dealings with community health, you go into a waiting area. Here you walk through and do whatever you like and feel welcome at that. The difference is the house and the structure and the homely feeling, the flowers, the paintings, the seating. It's not a direct manner or clinical feel about it, it is a homely feel.

My first encounter was that there was no hierarchical culture or attitude. Seeing that women had something to offer to each other and to the house and to the community.

At first I wasn't aware of who the workers were or who were women using the house. No hierarchy or attitude that I am a worker. It was that we are all ladies.

I'd notice if the house was gone.

I can remember talking in a group when I was new to the house. The underneath was going to be built. When I said that I didn't like the way they built under houses when it is a straight line, the worker took notice and affirmed that all women can have a say.

I get the overall picture that women here get together and think well what should we do, where should we add to the house, what is needed. Here it is talked about and shared about. I haven't been to meetings but I do feel that I can pick up on the differences here.

The culture comes through the newspaper articles. I don't have to have something wrong with me to come to the centre. Self-help, educational emphasis.

Laurel:

I know that several of the staff have used the downstairs facilities offered by the natural therapists. That has been lovely, if there is a cancellation staff share the time.

Three years ago I came to do voluntary work here, I wanted to give something back. I compiled the menopause kits. I was valued for me. There is something valuable in this house. I said to the administrator at the time about doing Reiki voluntarily and she said write your proposal on a piece of paper and stick it on Marilyn's spike.

The centre is a women's space. You can feel it walking up the steps, the environment, the atmosphere. The upstairs rooms had women's works of art, creativity adorning the walls and it is a house. The house reaches out.

So many staff got sick this winter and that was saying to me that people were stressed. It has become more a business now. Earlier you could walk in at any time and you were welcome. I have removed myself from the house - just earlier this year. This house and the connections have gotten me where I am today. I felt it was inappropriate to drop in.

The value of all women, acceptance, the warmth, tea and coffee and the jars of bikkies, the hospitality make you feel comfortable.

I'll always remember the dance, circle dance. On the second birthday we had a brazier outside and danced, women's rituals, stepping between glass contained candles on the floor and the symbolism of taking women's health into the next year and celebrating.

As a consumer to women's health I see the staff honoring each other. The Monday morning meetings come to mind. Each woman is greeted there isn't this hierarchy - each woman is an integral part of this house.

Things have changed - younger women have started work and they are without the experience. Their journeys have been of a short duration and their wisdom is being developed. The language is different. At first there was a particular venacular used and I had to learn it - I had to read. This has changed - there is much insecurity.

Chris:

The front entrance has two different entrances to the stairway which symbolises to me that is says to people that all ways lead to Rome and there is no set way - all ways contribute.

There is a misconception out in the community that the centre is brainwashing women against men. I think it is a shame that men don't open their minds and realise it is for our general good what the centre does. I'm sure that if they opened a men's referral centre women wouldn't have that attitude.

Non-judgemental atmosphere. There is not a label given as soon as you walk in - not she's this or she's that. Staff are open-minded.

You walk into women's health and it is on a name basis, you do not feel like a client or patient.

Kay:

This organisation has this drop in at any time and you're welcome situation which is a fantastic thing to give to women. It must also put stress on staff as staff then don't have any type of private space where they can let fly if things get a bit much because there are always people dropping in.

There are individual slips about culture. Not the overall what happens, I don't notice that. When people are stressed and pushed, the space which should be given isn't given because someone can't cope with any more and that comes across. But overall there isn't.

I am aware of the importance of Monday morning staff meetings. The message that comes through to me is the value that is placed on being heard, people being informed in a co-operative , consensual way of doing things which I think is reflected in the way that everyone who comes into the house is treated.

I pick up high stress levels at times and the language itself is stress language and there is a sense of rush - too much to achieve and not enough time to achieve it. Sometimes it may be related to having a sick child or it could be related to other changes.

The interactions between members of staff reflect culture.

There isn't a sense in this place of someone in charge and others underneath. If anything at times that's been so obvious that there's some confusion for me in what I've done on Mondays as an unpaid worker. There hasn't been clearcut case of where to go for some things. It's both a strength and sometimes it makes things less clear.

Circle dancing is integral to the Centre.

Dianne:

The fact that there is access to bottomless tea, coffee and bikkies for all comers adds to the friendly atmosphere. There is nothing like friendliness over a cuppa. I think it is great that it is always there.

A lot of people will criticise what they don't understand, people don't understand what happens at the centre.

Negative publicity is quickly picked up and created.

A homely atmosphere.

The atmosphere is friendly. Friendships formed with workers go beyond the centre walls and will go into the future. Staff are genuinely interested in helping women and that will go on for years. The interest is in how we get on.

Kay:

This place empowers women and it is one of the few areas in society where that happens. I feel the frustration and insecurity in the centre and I feel a sense of that. I was in Adelaide when they disempowered the women's health services and I would hate to see that here.

QUESTIONS 5 AND 6:

What are some of the stories which express the culture of the Centre for you?
What are the symbols which express the culture of the Centre for you?
(workers)

Lillian:

How space is decorated, tables have nice cloths. Attention to detail, intentionally having life-affirming things hanging on walls, not negative images. Cleansing space and environment.

Taking language that might be used to put women down and using that like naming of the "High and Mighty" project. Turning the words around. Why not be high and mighty?

The story about the bus trip to Bouldercombe Falls is often told, when one of the women in the over '50s group fell and brok her ankle

The circle is an important symbol of the Centre.

Betty:

Doctors telling women to keep coming here and encouraging them. It is good for women to hear doctors to tell them to keep coming. It makes this place safe for these women. It validates it for them.

Women who have participated in creation of banners in past groups and it is easy to draw on that and extend women's awareness of their own creativity. The women in the "Over Fifty" group know if their banners have been moved and they want to know where they are. There is an identification with here and an ownership.

Morning teas and lunches with volunteers and natural therapists, celebrations on the last days of groups. Women who come and go link around food. The cup of tea has been a powerful symbol.

Language is important. Draw on women's history, some specific language, our history here in the centre. Empowerment, choice, women's wisdom are particular language and introducing the notion of herstory and gossip. This language takes us outside language we usually hear.

The story about staff doing our planning and appraisal week at Emu Park and one of management group saying we were dancing on the beach - it keeps being repeated.

The Women and Environment meeting led onto the women and environment group which led to the Rockhampton Bicycle group which achieved bikeways in the town.

Nags Head is one of our stories. The Media Watch group and Women's Health protested against the Nags Head sign.

Tai Chi on Fridays bring laughter and happy sounds to the house which come up through the floor.

Ruth:

The house is a symbol and contrasts to an office environment.

Many women on the phone inquire and come because they haven't had satisfaction from male doctors.

Andrea:

Sharing food, birthday cake.

QUESTIONS 7 AND 8:

What are the values which for you inform the life of this organisation?
Describe the way in which staff work together and make decisions?
(workers)

Betty:

Part of women's health is that we have placed a value on the workers for example, workers having supervision and celebrations. We do the best we can to include volunteers who give their time. They are workers here too.

Liberating kind of place because of the freedom which everyone has to work in a way which suits her so that her own decisions are respected. Nobody hounding people or following them up in that sense.

The bigger staff group means that sometimes I don't have time to think and I trust the group process. I don't think abdicating responsibility for the group but the group is much bigger. Now not everything happens in the staff meeting - more things may be sorted out between individuals.

Workers remembering that natural healing is here for us too.

Shared decision-making is part of culture. In all sorts of ways we enable women who come here and ourselves as staff to take part in decisions that effect what the centre does and who we are. So that seems to me to be a respect for evolvement - we seem to move with that. Some things for me have been let go to involve new people. So there may not be the fire that you saw at first but that is the way that I understood it that there is an evolution here and I see it expressed in all sorts of ways and to respect that and go with it. Like being part of shaping it and letting it shape me.

Community development and networking are fundamental to the way we work. We bring ourselves to that.

The centre now focusses on issues which meet more women's needs.

The staff group has shaped than individual. Individual can shape the group.

Our understanding of "Peace and Power" needs to be regularly reviewed. We need to work out ways to discuss it and renew our direction.

Andrea:

When I first came I saw workers as being different to women. As twelve months has evolved I realise that workers are women, they have families. Those women, workers and families have the right to care and nurture that we offer women who come through the door.

The decision-making process was a pain in the neck when I first started. As the twelve months has evolved I have realised why it is long and drawn out. The positives include having the opportunity to discuss and compromise then the task which has to be done after the decision has the support of the group and you don't have people sabotaging the decision because by the time the decision is made everyone is in agreement.

In the past people could be challenged within the staff group and people could argue things out and have arguments and when meeting was finished "that was that". It was finished.

The culture before accepted difference with challenge now we accept difference without challenge. Diversity is now accepted without challenge regardless of the impact on the house.

I wonder whether CHASP is going to change the culture of the organisation. There are set standards which, in order to get accreditation, we have to abide by. Part of this culture is to challenge such standards push that edge. In order to get accreditation we need to follow those standards. We will lose some of our culture trying to get accredited by CHASP in order to get funding.

Some of us challenge it, some of us wanted to follow closely the CHASP guidelines because there is accreditation at the end of the line. If those people become formidable in the organisation we will fall into "line".

Not all of the workers are pushing the boundaries.

Women's health says to workers - take time off- yet this organisation is still very productive. I think that is why this organisation is productive because you don't have workers with their eyes hanging out of their head. Most of the time we have energy to put in 100% effort.

Women's choices - their right to choose.

Principles are common knowledge but different people have different interpretations of principles.

I've seen the change in the organisation and at times I am a bit disillusioned with the change and I realise that change is part of life in this organisation. As people get involved in staff positions, providing that women are respected and shown as being equals to me that over-rides these other individual issues. To me the respect and caring of women is the culture.

The staff group can become clouded by person involved rather than addressing the issue.

Our culture is to accept that difference within staff. There are people who don't go to supervision and all sorts of things in this place because we say we have to respect your right to say no, but in time when people say no to more and more things how does that effect this house? That's what I see as the change.

Everyone within staff group would agree with the organisation's principles but individual people would have different perceptions of empowerment because of past experiences.

Lillian:

What we say to women about looking after ourselves we say to each other as workers. If workers are sick or family need them we say yes you must go.

There have always been hoops to jump and we always had to play the game with Queensland Health but we were still able to be subversive and walk in between.

There had been times when I've thought - that's a bit funny - but I'll let it go. Whereas in the past a worker would have challenged it.

Workers are willing to step out and get involved in something new and pass it on to someone else perhaps.

In two years what will differentiate us and Centacare. Hopefully they respect human beings as well. Because we have experimented with spirituality or whatever, that is part of what we offer to women. And for women I've seen that's missing from their lives and that makes me different from workers in other organisations.

The shift is that there was a willingness to open up and have a go. It now seems more "this is my space" and I am not going to step out of that.

Workers' unwillingness to try things they may not understand. If workers step outside of the group they are left to that. It is not until it has had an impact on me that I think I have a place to speak. When it hasn't had an impact on me I let it go and let others respond to it.

Being the same isn't desirable. Rather than risk disharmony I won't question because I am not sure whether the relationship will remain intact.

Collectivism is important part of culture.

Ruth:

I felt quite challenged by the affirmation process but that is experience. I haven't been exposed to these type of things. Where else would this happen?

As an outsider coming in I find it a very nurturing environment. A lot of emphasis is put on process, how people are treated, how women are treated. Women are respected for being themselves. Different to competitive, task-oriented environments like university. You still need to get tasks done and the tasks will be done.

The feminism comes in because positives are seen in people instead of trying to pull each other down.

This is part of culture when we are saying to women but also workers say to one another - take a rest or whatever.

On decision-making I read "Peace and Power" and what I find sometimes in the group is that although everyone has the right and responsibility to put their view forward, I don't see that that always happens because it come back to a one-to-one dialogue and I haven't seen the process described in the book where you go around the group circling asking each member for their opinion. Sometimes it is opened up and other have their say but I haven't seen the process opened up in the book. There is the responsibility of members to put in their point of view as well.

Gossip has been reclaimed and seen here in a positive light. What women have to talk about is valued and within that positive ideas can flow.

QUESTIONS 7,8 AND 9:
(Women who have used the Centre)

Kay:

The ethos is very different. It is very much at community health that this is a professional service and you are stepping in as the client whereas here you are the person who is looking for service or something from here but there is a different feel.

The difference between the Base Hospital and women's health is like two different planets.

Laurel:

(recently been in two hospital and seen number of doctors) Because I've been actively involved with women's health centre I come back again to the learnings. I allow myself to reveal myself and feel comfortable being able to share with hospital staff. It was interesting that these people from traditional medicine were interested in me using natural healing therapies.

Chris:

In other centres the decisions are made in other places. They are so removed from the people who are going to use the services.

Here you can be anonymous. Some women find this can be very helpful because it is confidential. When you go to other clinics you have to give a lot of personal information.

After I had my child, I wasn't well but at Child Health their interest was in my baby not me.

Dianne:

Women's health is more friendly than other places

Debra:

Others have reception desks

Centre doesn't keep cards and this makes a difference

I have used other places for medical services. I use here for preventative things and personal development. Meeting different needs needs different structures.

Mary:

The free flow of women's health is different. There is a vast difference to community health where you go to reception and then to a waiting area. Whereas women's health is opened up. I don't have a nervous anxiety feeling when I walk in to women's health. When you are shown to a waiting area you know that everyone is here for counselling or whatever.

At community health everything is put into your file. One of my children uses counselling over northside and Centacare have files which they keep, sometimes they were on the desk during counselling. Whereas here it can be first name basis until you feel comfortable. I have a big thing about files, what information is being kept, what information is being stored in files.

At community health you can see individual workers who may be open-minded - it is pot luck what counsellor you see.

General comments:

It is important that women's health centre offers another culture different to other services. There is a need for a range of services.

QUESTION 9:
(workers)

Lillian:

At community health there is an understanding that women's problems are located within the woman and here women's problems are seen in a broader context. We have an understanding that some issues effecting women they may not have control over at all.

When I ring community health to make an inquiry they often don't know information and do not seem motivated to find out.

We relate to women as women. We do the thinking through in regards to providing childcare. We endeavour to provide childcare as much as possible.

We sit down for lunch and women sit down with us and chat. There is no attempt to reduce the elitism at community health.

We make connections between the arts and well-being and between dance and movement and well-being. This sets us apart.

Betty:

Women can walk in all of the spaces at women's health. It is an open environment. It is a space which reflects women's interests and perceptions. This is not the case in other agencies.

What makes us different is our understanding of patriarchy and this culture and how women are oppressed in the history of our culture. Bringing this awareness to whatever we are doing.

Andrea:

In community at large it is the norm to announce your qualifications

In Gladstone community health the reception desk is behind bars or glass - some barrier - which makes it impersonal and cold. You sit in the waiting area and I wasn't a client but people look at you as though you are. At women's health centre you could be anyone - it creates an anonymity.

Women's health is about empowering women to resolve their own issues but community health workers create a dependency.

Pam:

Workers don't announce themselves as social workers at women's health.

Additional Comments:

Lillian:

At other places I went to after the first group interview I realised how different the Women's Health Centre was and how glad I was about it. At the last group I think it was only a "slice in time" of my feelings and now I feel more balanced.

Debra:

Questioning of the Women's Health Centre is part of the culture. There is an awareness that there needs to be changes.

Betty:

In think that Lillian was reflecting on changes.

Debra:

The timing of this research is at a time of fearfulness and questions.

Ruth:

Andrea, after the group interview you brought up the idea of revisiting the principles of feminism and organisation and how individual workers apply principles to work.