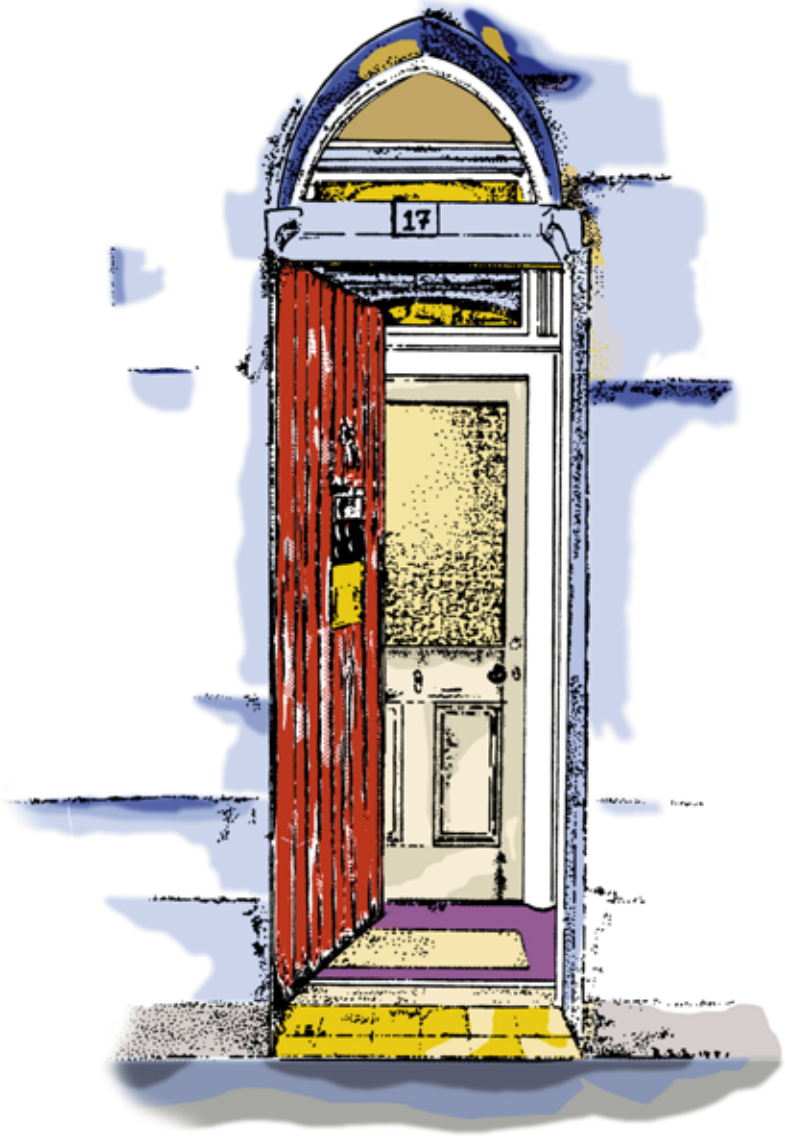
Derry Well Women

At the forefront of womens' health



Strategic Development Plan

2018 - 2021

Contents

I. Foreword

I am delighted to welcome Derry Well Women's Strategic Plan for 2018 to 2021.

This plan builds on the work of this organisation over the past thirty years securing its place as a mature, solid, organisation, recognised for its quality, impact and professionalism in women's community health, Nationally, Regionally and Locally.

When Derry Well Women began almost thirty years ago, the impetus came from a general dissatisfaction with services available at the time in relation to women's health. Since then we have continued to listen to women, provide the services they told us they needed and to evolve as other needs became apparent. Giving women the opportunity first to find their voice and then to make that voice heard has always been at the heart of our approach. Being responsive creates the imperative to evolve and this Strategic Plan sets out the direction that this imperative will take. We recognise that women are experts in their own health and wellbeing, and in so doing we have moved the relationship between Derry Well Women as provider of services and women as recipients, to a different level.

In this Strategic Plan, we make explicit the acknowledgement of women as co-designers and co-producers of health programme and service delivery.

It is founded on the WHO 'Health for All' principles which include Right to Health, the Right to Peace and the Right to Participate. It drives forward the social capital agenda which focuses on mapping the assets of a community rather than its deficits, building positive social investments and creating inclusivity and diversity.

We have witnessed the power of self directed individual change and how change at that level can lead to positive impacts on individuals and communities. This powerful force is located within women themselves, and it is by building on this model of empowerment and participation that Derry Well Women will deliver this Strategic Plan by, for and with women. From client to programme adviser, from adviser to co-producer of their own and their community's wellbeing – this is indeed our Strategic trajectory.

It is founded on strong principles and solid experience and is firmly in line with modern ideas of rights and equality.

I look forward to the implementation of the Strategic Plan over the coming years and the benefits that will be reaped by the community of women who contribute to it.

Carrie Jain

Chairperson
Derry Well Women.

2. About Us

Derry Well Women is a charitable company limited by guarantee company number NI22926. We were first incorporated on 21st July 1989 and registered with the Northern Ireland Charity Commission on 19 January 2015, Charity Number NIC101242.

Derry Well Women's objects are to promote the physical and mental health of women in Derry and surrounding area irrespective of class, race or religion by:-

1. Financing and administering a centre which shall be known as Derry Well Women which will provide premises for a range of services run by and for women.

2. Establishing a health education programme for women in the Derry area.

Our Approach to Service Delivery is:
- Holistic
- Non-judgemental
- Non-Clinical
- Run by women for women
- Pro-active
- Innovative
- In line with what women tell us
- Based on a Social Model of Health Care

From inception, our work has been infused with a commitment to take a holistic approach to women's health and wellbeing. Our core aim is to empower women to help us shape responses to meet their needs, and to work in partnership with them and other agencies to deliver services which are evidenced based and rooted in best practice and address unmet need.

We are advocates for a gender approach to identifying the determinants of women's health and wellbeing, and for the need to devise cross cutting programmes tailored to the characteristics of our catchment area.

The core area we cover has the following characteristics:
- High rates of post-traumatic stress disorder;
- High levels of socio-economic deprivation;
- Generational unemployment and resultant poverty; and
- Border region which faces particular issues of isolation

Some of our programmes also extend into the border region with the Republic of Ireland. As part of our "Other Borders"[1] initiative, particular attention was centred on actions to improve the situation of Older Women, Women living in Poverty, Lone Parents, Travellers and other ethnic minorities. We have also led the development of "Levelling Up"[2], the aims of which were to make a significant contribution to the improvement of the health status of women and reduce health inequalities in the North West of Ireland.

Our approach to service delivery is:
- Holistic
- Non-judgemental
- Non-Clinical
- Run by women for women
- Pro-active
- Innovative
- In line with what women tell us
- Based on a Social Model of Health Care

2.1 Where we started

In 1987, Derry Well Women started as an idea among a group of friends who, having experienced dissatisfaction with the care they received, began to dream about developing a women's health centre.

That dream has materialised over succeeding years. Derry Well Women was:
- the first to provide generic, woman centred free counselling in Derry
- to the fore in the development of community based services for cancer, eating disorders, menopause counselling and support for victims
- first to establish a health programme for LGBT women in Derry
- the first to establish cancer support in Derry and develop a cancer patient charter

We have also created and provided a raft of other support programmes, including pioneering work in areas such as the Well Programme, Confidence to Question, Mindfulness, Journey to Inner Peace and Rolling with the Punches.

[1] *Other Borders:* a Cross Border Health Strategy for Women from the North West, June 2003.

Our innovative approach has been recognised through awards such as The GSK King's Fund Community IMPACT Award for Innovation 2000 & 2010, Partnership working and targeting social need and being one of 6 women's organisations honoured by GSK Employees in the centenary year of women's suffrage.

We have been there for times of change and we have led change.

Where there has, as yet, been no change we remain constant in listening to the stories that woman have to tell, and in advocating for further developments in health and wellbeing to address the reality of women's lived lives.[3]

2.2 Adding Value

We add value because our approach is to:
- be holistic - recognising that wellbeing is determined by a combination of physical, emotional, spiritual, mental, social, political, economic and environmental considerations.
- listen both formally and informally
- offer choices and encourage women to find their own answers.
- promote independence, resilience and self-reliance
- recognise the oppression of women and allow women to explore this and act.
- encourage women to tell us what they think of our services and to become involved as part of the overall healing and growth of women.
- embrace the health for all principles of equality, participation, empowerment and partnerships.
- encourage all women involved in Derry Well Women to take the need for rest, recreation and self-care seriously.
- develop specific and measurable outcomes for services we provide.

There are conditions that only women experience, and circumstances which impact differently on men and women. Furthermore, gender based inequalities in areas such as education, income and employment have a disproportionate impact on the life chances and wellbeing of women. "Women's longer lives are not necessarily healthy lives" .

2.3 Governance/Management Arrangements

Our Board consists of 13 directors, from a variety of professional and community backgrounds relevant to the work of Derry Well Women. The Board meets at least ten times a year. The overall organisational structure and staff levels have been addressed in a way which is both realistic and practical to meet the demands it faces, and taking into consideration the environment in which the organisation must now operate.

The Board is responsible for setting the strategic direction, approving policies and over-seeing their implementation. The Board members attend training including Induction training, Risk Management and Child Protection training. Derry Well Women Ltd has developed a Risk Register and policies and procedures to mitigate risk.

The policies which are currently in operation are listed on our website.
A scheme of delegation is in place and day to day responsibility for the provision of services and management of staff and resources rests with the General Manager, with input from Programme Co-ordinators.

We operate within the code of good governance and within a framework of professional and procedural standards (including; British Association of Counselling & Psychotherapy, PHA standards and CVSNI Minimum Standards

Board Members

Carrie Jain	(Chairperson)
Grainne Mc Laughlin	(Vice Chair)
Sinead Callan	(Treasurer)
Pauline Mc Clenaghan	(Secretary)
Mary Diamond	
Phil Mahon	
Philomena Melaugh	
Joan Noble	
Nuala Doherty	
Paula Barr	
Elizabeth Mc Quaid	
Aine Abbott	
Karen Meehan	

Committee and Staff at 29th AGM with guest speakers Judith Thompson Commissioner for Victims Survivors and Elaine Way CEO WHSCT

Staffing

Derry Well Women is staffed by a range of personnel operating within different roles and responsibilities directly related to delivery within each strand of programme development.

Susan Gibson (Manager)
Ann Mc Donald (Counselling Coordinator)
Patricia Villa
(Social Support Programme Coordinator)

[2] *Levelling Up:* Securing Health Improvement by Promoting Social Inclusion (Derry Well Women & Institute of Public Health, Ireland, 2008).
[3] *Women and Health:* Today's evidence, Tomorrow's Agenda (World Health Organisation, 2009).

Rachel O'Donnell (Creche Coordinator)
Oonagh Butler (Personal Assistant)
Fiona Walker (Finance Administrator)
Patricia Mc Adams (Creche Assistant)

Counsellors

Derry Well Women delivers counselling through twelve counsellors who hold a minimum qualification of a Diploma in Counselling, are registered members of BACP or equivalent and have a minimum of 300 supervised practice hours. All counsellors are accredited or are working towards accreditation. All Counsellors have completed Mental Health First Aid and ASIST training and attend In-house Supervision. In addition to Counselling counsellors also conduct Counselling Assessment Interviews as well as carry out Pre Programme assessments having completed Assessment Training. Counsellors provide one voluntary hour to one hour paid (Fractioned Payment). In return for this arrangement counsellors receive in house supervision and training and the support of the agency in their personal and professional development.

Life Coaches

Our Life Coaches hold a recognised Life Coaching qualification with 150 post qualification supervised hours and a further 150 hours post qualification experience.

Supervisors

In house supervision is provided to counsellors monthly both individually (one hour) and within a group of four (1/2 hour input) to ensure counsellor compliance with BACP supervision requirement.

Our Supervisors are accredited counsellor / psychotherapists with BACP/IACP/ UKCP/ICP/BCP or BPS and have completed a supervision course with a minimum of 80 hours taught input.

Complementary Therapists

Our team of ten sessional Complementary Therapists are members of a professional body registered with

- General Regulatory Council of Complementary Therapies (GRCCT)
- Complementary and Natural Healthcare Council (CNHC)
- Health Professions Council (HPC)

Facilitators/Support Group Facilitators.

All our facilitators hold a recognised Diploma or Qualification in the relevant interventions e.g. CBT, Stress/Anxiety Management Mindfulness and have three years experience of group facilitation. They have a knowledge and understanding of trauma and appropriate interventions. Facilitators also have both ASIST suicide Awareness and Mental Health First Aid training.

Clinicians

All our clinicians hold a recognised and relevant professional qualification and are members of an accrediting body. Our clinicians provide services including a menopause clinic, podiatry clinic, pain management and antenatal clinic.

3. Mission, ethos & conceptual framework

In the spring of 2017 Derry Well Women Board decided to devote several day-long workshops to the elaboration of a new strategic plan for the period 2017-2020. There was a consciousness that significant political, economic and cultural changes were taking place, not just in Northern Ireland where Derry Well Women is based, but also in Ireland, in the UK, in the EU, in the USA and the entire world. In the context of this changing reality Derry Well Women met to reflect on its own context and core purpose.

In a time of significant change there is a temptation to steady the ship and carry on doing what has been tried and tested over the years. Derry Well Women had no reason to do otherwise as its growing programme is meeting the needs of more and more women. There is however a growing awareness emerging within Derry Well Women based on many years' experience of an approach which could be summed up as "involving the programme participants in co-producing relevant health programmes".

The expression "programme participant" is used instead of the traditional "client".[4] A client is:

i. someone who uses the services of a professional person or organisation e.g. a lawyer; or
ii. someone who is being dealt with by social or medical services.

In both these definitions there is an unequal relationship between the client and the professional. The former is in need and requires either help or to be "dealt with"; while the latter is making the needs assessment and giving the help or service.[5]
This process can be expressed as moving from needs to rights and from rights to equality and fits neatly into the social justice approach to community development. In practice this means that Derry Well Women endeavours to encourage the client (programme participant) to become a co-producer of programmes and service delivery in focus groups, needs assessment and expert patient groups. More fundamentally still Derry Well Women aims to support women to develop the skills, knowledge and support to become co-producers of their own health and wellbeing and that of their families and communities.

From client of service provision to co-producer of health programmes to co- producer of wider determinants of personal health and wellbeing - this is a strategic trajectory that fits with important modern ideas of rights, equality and social justice. To have the confidence to formally embed this longstanding approach in the midst of significant change at home and abroad marks out Derry Well Women as an imaginative, determined and rooted organisation.

The Board plans to revisit its mission statement and its core values and restate them in the light of this conceptual framework. It will also have to elaborate the conceptual framework underlying this new direction and embed it in Derry Well Women's guiding principles, philosophy and raison d'être.

3.1 Mission

Derry Well Women's mission is to jointly - identify and work collaboratively to engage with the physical, physiological, social and spiritual health needs and challenges of women of all ages from the North West of Ireland.

We deliver on this mission firstly by providing a wide range of quality services based exclusively on meeting women's needs and valuing their assets, using teams of health and social care professionals in collaboration with staff, volunteers and service users, in a safe, secure and relaxing environment. Secondly, we campaign for and contribute to changes in health care policy and practice. Thirdly, we embrace the Health for All principles of equality, participation, empowerment and partnerships in achieving improved health and well-being for women, and work in partnership with a range of agencies and community bodies.[6]

Specifically, we pursue women's equality and empowerment by involving our programme

[4] *If I use the word patient, or the word client, or the word counsellor, or the word analyst, or the word therapist, I mean those words to be totally inclusive. I don't like the distinctions in our profession. I think they are odious and I just use them interchangeably.* Susie Orbach, BACP Webcast, March 16th 2017.
[5] Oxford Dictionary.
[6] Derry Well Women website. See Chapter 5 of this plan for the extent and quality of the partnership working.

participants in the co-producing of relevant health programmes moving the participant from needs approach to a rights approach. Co-production of health programmes leading to co- production of health and wellbeing is the social justice model which is at the heart of our mission.

3.2 Ethos and Practice.

Core to Derry Well Women's philosophy are three principles:

i. Holistic i.e. Derry Well Women recognised that wellbeing is determined by a combination of physical, emotional, spiritual, mental, social, political, economic and environmental factors;
ii. Women centred i.e. Derry Well Women recognised the oppression of women and that there were conditions that only women experience so women had to be listened to formally and informally and encouraged to find their own solutions; and
iii. Empowerment of women at all ages and stages of life to live healthy, happy and fulfilled lives resilient and with the skills to meet life challenges as well as supporting women to recover, rebuild and sustain their lives following trauma, life changing diagnosis or circumstances.

Derry Well Women's ethos, therefore, places gender and empowerment at the centre of their philosophy and the practice is guided by these three guiding values. Derry Well Women practice seeks to:

- Listen... and treat women in a gentle, friendly and respectful way.
- Support women to take control of their own lives.
- Believe healing is most effective when each person can choose their own method, pace and support systems.
- Offer confidentiality within the boundaries of safeguarding practice.
- Empower women to find their own answers and we are committed to creating the conditions in which women can heal themselves and grow.
- Encourage all women involved in Derry Well Women to take our own needs for rest, recreation, stimulation and care seriously.
- Not create dependence on counsellors or group facilitators.
- Recognise the oppression of women and allow women to explore this and act.
- Encourage women to tell us what they think of our services and to become involved as part of the overall healing and growth of women.
- Embrace the Health for All principles of equality, participation, empowerment and partnership.[7]

3.3 Conceptual framework

When Derry Well Women began almost thirty years ago, the impetus for something new came from a general dissatisfaction with what was available for women's health at that time. Understandably the initial approach was reactive to the needs presented by women but gradually Derry Well Women found its voice and developed its own distinctive and proactive approach.[8]

Derry Well Women's progress has been marked by efforts to define a "Women Centred" approach as an entity in its own right. This approach, evolving from the ethos, allows women to be fully at the heart of the healing process.

Derry Well Women has put gender and empowerment at the core of the therapeutic process. It is built on the premise that it is essential to consider the social and cultural context that contributes to a woman's problems in order to understand that person.

In the belief that gender is central to therapeutic practice, that understanding a woman's problems requires adopting a socio-cultural perspective, and that empowerment of women is paramount to their health and well-being, Derry Well Women recognized that it was essential that therapeutic services be broadened and made more inclusive. Derry Well Women services now meet the needs of specific presenting issues and the wide range of diverse cultures represented by our users.

Now in 2017 a further refinement of the Derry Well Women approach is taking shape. Clearly Derry Well Women will continue meeting the needs of women and giving clients all the support Derry Well Women can command. As a result of its own experience over these years Derry Well Women is attracted to the social justice approach to community development in which the aim is to move the priority from needs to rights and from rights to equality. In practice this means that Derry Well Women endeavours to encourage programme participants to become a co-producer of programmes and service delivery in focus groups, needs assessment and expert patient groups.

[7] Derry Well Women website.
[8] Early influences included Jo Murphy Lawless' "Gender-based Health Work"; Boston Women's Collective "Our Bodies Ourselves"; Susie Orbach's "Towards Emotional Literacy" and "Fat is a Feminist Issue".

From client of service provision to co-producer of health programmes - this is indeed a strategic trajectory and one that is in line with modern ideas of rights and equality.

What is the conceptual framework that underlies this ambitious strategic aim to move from a need to a rights perspective?

In his seminal book, No More throw way people: the Co-production Imperative, Edgar Cahn bewailed the inequality, poverty and oppression of many communities in the USA and set about developing the theory and practice of co-production. Such State programmes for the poor and socially excluded as existed were rolled out on the basis of the State giving to the client with no expectation that the client would or could make a contribution in return. He set out to address the difficulty and problem of getting and sustaining participation from the very people being helped. His concept of co-production signified some kind of parity in the creation of value, a measure of equality between helper and client.

Co-production is based on four core values:

i. Assets. The real wealth of society is its people. Every human being can be a builder and a contributor.
ii. Re-defining work. Work includes whatever it takes to rear healthy children, preserve families, make communities safe and vibrant, care for the frail and vulnerable, redress injustice and make democracy work.
iii. Reciprocity. The impulse is universal. Wherever possible replace one-way acts of largesse in whatever form with two-way transactions. "You need me" becomes "We need each other".
iv. Social capital. Human beings require a social infrastructure as essential as roads, bridges and utilities. Social networks require on-going investments of social capital generated by trust, reciprocity and community engagement.

The main dangers to co-production are: professional monopolization, professional exploitation and professional domination.

The essential element is a social justice perspective.[9]

The idea of co-production is further developed by Cormac Russell in his Asset-Based Community Development approach (ABCD). [10]Russell distinguishes between four forms of helping:

i. Relief: The offering of assistance, especially in the form of food, clothing or money given to those in special need or difficulty.
ii. Rehabilitation: To use a ship building metaphor, rehabilitation puts a person in dry dock for repair. Taking them out of their social context/situation and transplanting them into a therapeutic or convalescent environment.
iii. Advocacy: Action to assure the best possible services for, or intervention in the service system on behalf of, an individual or group is realised.
iv. Community Building: Local people are recognised as the primary architects of a more sustainable future and are enabled to come together to discover, connect and mobilise the assets required to create and realise their shared long term vision. This form of sustainable community development recognises that the more collective agency, ownership, power and control people have over their own lives and communities, the healthier and more prosperous they and their communities will be. Radical inclusion is at its heart. This form of helping is ABCD.

Relief, rehabilitation and advocacy are characterised by ameliorative efforts that flow from a helping professional to a client/patient .ABCD on the other hand is characterised by a form of helping that sees people primarily as producers and makers, not clients, patients or consumers.

An initiative which links co-production directly with health and social care was articulated by Alba Realpe and Louise Wallace in their article "What is Co-production?".[11]They recognise that co-production has historical roots in civil rights and social care in the USA[12] and explicitly reference the work of Edgar Cahn. Cahn showed that co-production challenges the assumption that service users are passive recipients of care and recognises their contribution in the successful delivery of a service. At the same time, it involves the empowerment of front-line staff in their everyday dealings with programme participants.

Realpe and Wallace argue that collaborative co-production requires users to be experts in their own circumstances and capable of making decisions, while professionals must move from being fixers to facilitators. To be truly transformative, co-production requires a relocation of power towards service users. This necessitates new relationships with front-line professionals who need training to be empowered to take on these new roles.

Realpe and Wallace use the term "patient-centred" to describe the relationship between clinicians and patients as a meeting of two experts, each with their respective knowledge and skills. To date there has been far more emphasis on research and practice on elaborating the clinicians' skills in the co-productive consultation than there has been on the skills of the patient.

[9] *No more Throwaway People: the Co-production Imperative*, Edgar Cahn, Essential Books, Second Edition, 2004.
[10] Russell's ideas have been developed in partnership with John McKnight, Professor of Education at North Western University, Chicago, and co-author of *Building Communities from the Inside Out.*
[11] *What is Co-production?* Alba Realpe & Professor Louise M. Wallace, The Health Foundation, Coventry University 2010.
[12] Susie Orbach links the foundation of the Women's Therapy Centre in 1976 to the *movement for social justice which followed the example of the Civil Rights Movement in the USA and the movement to contest the Imperial Invasion of Vietnam.* Susie Orbach, BACP Webcast, March 16th 2017

It is significant that both Edgar Cahn and Cormac Russell reference the work of Paulo Freire as influential in the development of their own ideas and approaches. The whole idea of co-working in education, research, youth work, community development, research, theatre and now health derives in the recent past from the work of Freire, the Brazilian radical educationalist[13]. In his Pedagogy of the Oppressed (first published in English in 1970), which was based on his experience of teaching Brazilian adults to read and write, he describes traditional pedagogy as "the banking model" because it treats the student as an empty vessel to be filled with knowledge. He argued, and the success of his teaching approach confirmed, for a pedagogy that treats the learner as a "co-creator of knowledge".

This dramatic shift in the relationship of teacher to student (from giver/receiver to co-equal colleagues) spilled over into many other disciplines. It hugely influenced the development of action research where the researcher is no longer an external observer but a participant in the study. His ideas lie beneath the contemporary social justice approach to community development where equality in the relationships are paramount. He has influenced the practice of youth work where the youth worker is seen to "walk in the shadow of young people". He has influenced the development of community theatre most notably through the work of his student Augusto Boal and his Theatre of the Oppressed where the audience participates in the production.

And today his ideas are influencing this refinement in Derry Well Women's approach to social justice and equality in the field of women's health where the programme participant becomes a co-producer of health programmes tailored to her specific needs and circumstance

[13] Significantly the UK's National Training Organisation for community development, community workers, youth workers and adult educators (established in 2002) is named PAULO in recognition of Paulo Freire. PAULO is part of the Lifelong Learning UK Sector Skills Council.

4. Strategic Context

In this chapter the Board and staff sketch the strategic context in which Derry Well Women will attempt to meet the needs of women over the next three years.

In the first section a review of the local women's health environment is undertaken including the sex and gender dimensions of health and wellbeing, the working lives of women in Northern Ireland, women's health statistics, women's education and income, barriers to and gaps in services and several policy responses.

The second section examines current issues in the local and global context and attempts to discern trends that will impact on women's health. Care is taken in trying to describe the present and forecast the future developments as the agreed context will influence the planning process and resource allocation over the coming period.

The chapter then records a SWOT exercise by the Board and staff which seeks to stress test the readiness and capacity of Derry Well Women to function and compete in this new world.

4.1 The local health environment

Health and wellbeing is not solely the absence of illness; it is multi-dimensional, covering the physical, psychological and spiritual. Gender is also an important variable in understanding health and wellbeing and health behaviour. [14]The promotion of gender equity has been a long-standing theme within the European Union. The mainstreaming of gender was formalised in the Treaty of Amsterdam.[15]

Whilst some biological differences between men and women may seem to advantage women, these are mostly cancelled out by gender inequalities embodied in the social disadvantage women face in comparison to men, such as lesser access to resources (including unequal pay), heavier workload as women combine a greater share of paid and unpaid work, male violence against women, services and treatments which are not adapted to women's needs, and sex based or multiple discrimination (6). Gender stereotypes also affect all areas of health care.

Sex and Gender Dimensions of Health and Wellbeing

The sex and gender dimensions of health and wellbeing mean that women face a number of specific risks over their lifetime. In addition to this, age, ethnicity, disability, sexual orientation or identity, resources, education, social and marital status, position in the labour market, place of residence, the level of gender equality in society and other attributes influence women's health needs and access to health care services.

The determinants of health and wellbeing need to be viewed in the context of socioeconomic and wider environmental factors. There is a causal link between poverty and health and wellbeing. Poverty, too, is multi-dimensional, and women lag behind men in virtually every indicator. As Dr Margaret Chan of the \World Health Organisation puts it: the obstacles that stand in the way of better health for women are not primarily technical or medical in nature. They are social and political, and the two go together.

The Working Lives of Women In Northern Ireland:[16]

- Women, regardless of age, are less economically active than men
- The economic activity for women whose youngest child was 0-4 was 76% in 2011 compared to 87% for those whose youngest child was 16-18
- In 2011 there were 53,223 day-care places for children aged under 12 in Northern Ireland, reflecting an increase of 13% since 2002.
- 40% of female employees in Northern Ireland work part-time compared to 10% of male employees
- The most common reasons for economic inactivity for women in 2012 was family/home related (35%) whereas for men it was sickness/ disability (42% compared to 22% of women)
- Proportionally, more women in Northern Ireland work in professional occupations than in Britain[17]
- 92% of all female employees aged 16-64 work in the service sector compared to 65% of male employees. 54% of female employees work in public administration, education and health service sectors compared to 26% of males.
- Women still earn less than men · 91% of lone parent households where the lone parent was aged 16-74 were headed by lone mothers in 2011. Just under 20% of these women worked full-time and 33% worked part-time.[18]

[14] European Institute of Women's Health (Dublin, Eurohealth.ie)
[15] Treaty of Amsterdam (1997) cited in Gender Policy (DWO, 2012)
[16] Except where otherwise indicated the statistics in this section are drawn from NISRA (2012) Women in Northern Ireland http://www.nisra.gov.uk/Women in Northern Ireland, September2012final version pdf
[17] NISRA (2012) Census 2011 Key Statistics for Northern Ireland A National Statistics Publication Crown copyright 2012: Tables KS610-12NI
[18] See note 14 Source: Table KSI07NI.

Health

- Life expectancy in our area is the lowest of all health Trust areas in Northern Ireland
- The biggest causes of morbidity and mortality are cancer, cardio-vascular and respiratory disease, mental ill-health, depression, accidents and diabetes
- Highest incidence in Ireland of all cancers combined including the highest rate of breast cancer
- A total of 916 reported incidents of Domestic Violence in the Western Trust Area (Foyle & Limavady: 698, Tyrone: 167 and Fermanagh: 51

Women are almost twice as likely as men to experience depression[19]. Related factors such as violence and self-inflicted injuries have special relevance for women's mental health. Social environment is of critical importance for health and wellbeing. Given their pivotal role in maintaining family cohesion, women faced, and continue to face, challenges as a result of the legacy of the "Troubles" in Northern Ireland. Irrespective of their faith, ethno-political background or location, many women's lives were impacted by the conflict.[20]

"Overall an estimated 53% of individuals who experienced a conflict related event had a mental health disorder at some point in their life with women more likely to have post-traumatic stress disorder". [21]

Women use health care - especially primary care – services more often than men. This is mainly due to reproductive health and child bearing, but also to their social role as primary carers of dependants. Despite this, health care systems are not always women friendly. Differentiated approaches need to be recognised, especially in relation to counselling services.[22]

Education and Income

In Northern Ireland, women tend to leave school better qualified than men. They are more likely to progress to higher education, with around 60% of university enrolment being female. However, women account for less than 30% of those graduating in STEM (Science, Technology, Engineering and Maths) subjects, excluding medicine and health.[23]

This education attainment needs to be set against the relative incomes achieved by women and the impact of the "poverty trap". Women still earn less than men, irrespective of their educational attainments.

The economic position of women and the corresponding impact on their families - especially in deprived areas - will be further compounded by the impending changes to the benefits systems.
The higher the education status of women the more positive the direct impact on the health and mortality of their male partners and families.[24]

Barriers to and Gaps in Services

In the light of circumstances outlined it will be imperative to overcome gender specific barriers which prevent women from accessing services such as child care, work-life balance and affordable transport. It is also imperative that we continue to identify and address gaps in services. A mapping exercise, conducted by Derry Well Women, highlighted a paucity of provision in childcare, post cancer treatment care, counselling, mental health care, carers support, and services for the elderly across the region in areas such as mental health (including eating disorders). It is particularly important to recognise that women will increasingly become receivers of care as well as carers for an ageing population living with long term conditions.

Policy Response

Successive governments in Northern Ireland[25] and the Republic of Ireland[26] have stressed the need for health and social care to address inequalities in health, and target services towards the most disadvantaged in society. Common themes running through the policies include developing maternity services, developing child care services, tackling poverty and social exclusion, reducing child poverty and pre-school education.

Strategic documents[27] for developing health and social care on both sides of the border now acknowledge the wider context and determinants of health and wellbeing. There is a welcome emphasis on self-help programmes, community based services, and the importance of partnership working across the statutory and community and voluntary sectors. There is, however, greater potential to make better use of available gender specific data to better target actions in the design and delivery of care programmes. By taking such an approach, resources would be better deployed, programmes would be more responsive to the specific needs of women and would be tailored more effectively to the specific needs of local communities.

Such an approach is consistent with the strategy of The World Health Assembly[28] which has urged member states to mainstream gender in any planned health action, and specifically to promote the use of sex-disaggregated data and gender analysis.

19 *Women's Mental Health:* an evidence-based review (WHO, 2000).
20 *Women Speaking Across Borders* (Institute of Public Health Ireland, Derry Well Women and Institute for Conflict Research), 2008.
21 *Troubled Consequences:* Report on the mental health impact of Civil Conflict in Northern Ireland, Bamford Centre, 2011.
22 *Women's Health in the EU:* Position Paper, Brussels, June 2010.
23 *Gender Imbalance in Education* (STEM) in Northern Ireland, Seminar held in Belfast in June 2013.
24 Dr R Erikson, Swedish Institute for Social Research, Stockholm University, SE-106-91 (Stockholm Review, 2009).
25 Programme for Government (Northern Ireland, 2011-2015).
26 National Action Plan for Social Inclusion (2007-2016).
27 Transforming Your Care: Improving Northern Ireland's Health and Social Care (2013) and National Women's Strategy, Department of Justice (ROI) 2007.
28 Cited in WHO Gender Policy (2012).

4.2 The wider global context

Although conscious of the "global village" that the world has become, Derry Well Women recorded the relevant events and trends in three different spatial categories:
i. Ireland and Northern Ireland;
ii. United Kingdom; and
iii. European Union and the world.

This allowed for a triple lens focus on those issues that affected more directly the home ground as well as admitting issues that might have a more direct impact elsewhere but which will impact indirectly here. The discussion is summarised in the following grid:

Ireland/Northern Ireland	UK	EU and the world
Politics:	**Politics:**	**Politics:**
· NI Government collapses and elections called. · Elections result in unionist parties taking 40 seats out of a 90-seat Assembly. Talks on forming a power-sharing Executive take place. · Minority Irish Government in disarray over treatment of Garda whistle-blower. · Northern Ireland insulated from EU post-Brexit and peripheralized within UK. · Conservatives make deal with DUP. As part of the deal, the DUP has agreed to support the Tories in any crucial votes in the House of Commons in return for funding including £400m for infrastructure, £200m for improvement of the health service and £150m for ultra-fast broadband in Northern Ireland.	· Following referendum in favour of Brexit (52% to 48%) UK Government triggers Article 50 of the Lisbon Treaty to leave EU. · Scotland (62% to 38%); Northern Ireland (56% to 44%) and London 60% to 40%) voted to remain. · Government losing the war on drugs? · Scottish Parliament vote 69 / 59 in favour of a second referendum on back of Brexit. EU more important to them than UK? · June 8th 2017Conservatives win election with narrow majority called for	· EU prepares for the shock of UK leaving and the rise of populist and right wing parties. · Populist parties with right-wing tendencies prominent in EU election bids. Some evidence that racist discourse becoming normalised. · 673 women's marches took place all over the world protesting against Trump's misogyny. · The Washington march on January 21st was the biggest demonstration in USA since anti-Vietnam protests of sixties and seventies · Security crisis. ISIS inspired attacks in EU. Iraq, Syria, Afghanistan, Libya, and Yemen in turmoil. USA involved in all. Russia active in Syria (and Ukraine). China also active and watchful. North Korea practising missile launches. · Rape has become a standard weapon of war. · Fake news.
Economics:	**Economics:**	**Economics:**
· NI public sector makes up 29.2% of total workforce following Government's voluntary redundancy scheme. · Austerity programmes still in place. · Three out of five children in Galliagh living below the poverty line i.e. household income less than 60% of median UK household income (Barnardos). · Health services HSE deteriorating. · Community sector being squeezed by funding cuts. · Emigration beginning to rise again	· UK Government launches a National Cyber Security Centre to combat cyber theft and interference. · Major Cyber Attack on NHS May 2017 · Health services NHS deteriorating. · Community sector being squeezed by funding cuts. · Austerity programmes still in place. · Divide between richest and poorest growing.	· Purchases on mobile phones predicted to reach 25% of total e-commerce sales by 2017 · Famine in four African countries. · Migrants on the march everywhere. · Divide between richest and poorest growing and economic inequalities increasingly embedded in economic systems.

Ireland/Northern Ireland	UK	EU and the world
Cultural:	**Cultural:**	**Cultural:**
· Ethnic status of Travellers recognised by Irish Government. · Mass unmarked graves found in now defunct Mother & Baby Home in Tuam. Allegations that 796 children had died of infectious diseases and malnutrition and a further 1,000 had been trafficked illegally to USA are being investigated. · Greater participation in cycling, running, yoga, Tai Chi and general improved life-styles in Derry. · Secularism advancing, organised religion on defensive. Individuals seeking spirituality outside churches.	· Obesity (and its relationship to poor nutrition) increasing · "Children who lead inactive lives are likely to grow up to become middle-aged couch potatoes, a study suggests." "Cancer rates will increase six times faster in women than in men over the next 20years"Cancer Research UK · Aging demographics. · Rural isolation worsening. · People are prepared to have sensible conversations about "death". · Some evidence of an increase in racist attacks.	· Racism on the rise.
Health & Social Care	**Health & Social Care**	**Health & Social Care**
Cancer · Radiotherapy Centre and Wellness Centre open in Altnagelvin Hospital. · 70,000 people in Northern Ireland living with cancer- 8,700 diagnosed each year. · Survival rate has doubled. · Three key waiting time targets for cancer patients have been missed in Northern Ireland. · Health and Social Care Environment · Development of GP Federation · Medical School at Magee proposed for 2020 **Bengoa Report.** · "Transforming Health and Social Care in Northern Ireland over the next 10 years" · Health Minister Michelle O'Neill's response to Bengoa stressing the need for co-production **Programme for Government** (Draft/consultation document) · Health and Wellbeing 2026: · Delivering Together (Consultation document) · Children and Young People · "How Early Years influence Mental Health" Susanne Zeedek · WHSCT Infant Mental Health Strategy	· Brexit will lead to the loss of 45million euros from European Commission. to cancer research in UK	· "23% to 50% of all cancers preventable with healthy lifestyle choices." WHO · Clinical trials with immunotherapy treatments showing promise.

Ireland/Northern Ireland	UK	EU and the world
Health & Social Care	**Health & Social Care**	**Health & Social Care**
Women and Alcohol · Alcohol abuse costs Northern Ireland around £900 million a year, including health, policing and justice spending, notwithstanding the impact on people's lives. · Between 1986 and 2008/09 the prevalence of drinking has increased from 64% to 74%, with a greater increase among females (58% to 70%) than males (72% to 79%).	· Irish and UK women 'among worst' for drinking alcohol in pregnancy – · The biggest increase in alcohol-related harm in recent years occurred in the over 50 population	
Sexualisation of Young Women · 86 women victims of sexual trafficking were rescued in Northern Ireland over 2 year period. One third were under 18 . · Premature sexualisation is seen as part of a broader public health issue, and a factor which contributes to other problems such as sexual abuse, and risky sexual behaviour.	· Research has shown that more than a quarter of young people are sexually active before they reach 16. Call data from Childline shows that more than 15 per cent of all calls about peer pressure are related to sex. Some girls spoke of peer pressure, sometimes from other girls, to begin having sex as young as 12 and that they use drugs and alcohol to conquer their inhibitions. · Sexualisation of young girls increasingly taken for granted in our culture.	· A survey carried out in America found that 22% of teen girls have electronically sent or posted images of themselves nude or semi-nude · Worldwide sexual trafficking growing. · Internet bullying and sexual exploitation on the increase. · Gender fluidity increasing.
Womens Right to Choose · Described as a revelation on 25th May 2018 Ireland voted decisively to repeal the 8th Amendment of the Constitution which imposed some of the worlds toughest abortion laws. 66.4% voted yes and 33.6% voted no. The Republic of Ireland's referendum result does not affect Northern Ireland who's abortion laws are more restrictive than the rest of the UK. The Yes Campaign now focuses on Northern Ireland.		
Poverty and Homelessness · In 2015 19,621 persons presented as homeless in Northern Ireland an increase of 759 on the previous year. The largest causes for homelessness were family breakdown, unaffordable housing increase in neighbourhood harassment and domestic violence. 35% of those presenting as homeless were women		

Ireland/Northern Ireland	UK	EU and the world

Conflict-related:

- Strategy for Victims and Survivors. 2009 to 2019
- No mechanism or process for dealing with the legacy of the conflict
- Post-conflict increase in domestic violence.
- Intergenerational impact of conflict into third generations.
- Segregation: 95% of social housing remains segregated on a religious basis; only 7% of young people attend integrated education schools; in Belfast, there are 88 security/segregation barriers (peace walls) and by 2019 some of these walls will have been in existence longer than the Berlin wall.

It has become a cliché to say that we are embarking on a period of rapid and unpredictable change. Derry Well Women recognises that it is going to be a challenge. Already the marked increase in demands for Derry Well Women's services has been noticed is being experienced. When coupled to the increasing complexity of the demand, the challenge becomes more acute. The response begins with a SWOT exercise which will take account of the newly developed conceptual framework described in Chapter I, the strategic context elaborated above in the present chapter and the collaborative partnership working outlined in Chapter 3.

Strengths
- Established Reputation
- Excellent Personnel with varied skill set
- Strong Management
- Good Governance
- Financially sound
- Own premises
- High demand for services
- Needs led programmes, Co-production
- Well established links, contacts and collaborative partnerships
- Evidence of impact of services
- Uniqueness of approach
- Substantial research portfolio
- Openness to Change
- Links to the Kings Fund

Weaknesses
- Risk of inertia complacency
- Continuity of staffing
- Restricted space
- Uncertain economic climate
- Age demographics of directors
- Capacity of current staffing levels to meet increasing demand
- Limited marketing PR
- Reflecting diversity

Opportunities
- Use the lack of direction in Health Service to promote our approach
- Access to free social media to promote organisation
- Competitive tendering
- Partnership working
- Replicate the Derry Well Women Model regionally and globally
- Build on local support
- Expansion of service provision
- Succession Planning

Threats
- Plagiarism of our approach
- Current economic squeeze on community and voluntary sectors
- Work load demands on small team
- No local Government

5. Partnership Working

In this chapter the Board and staff enumerate and categorise the various examples of partnership working in which Derry Well Women are involved. In categorising, Derry Well Women used the matrix of partnership working devised by Himmelman: appendix 2.

i. Networking (NW) i.e. exchanging information for mutual benefit, minimal time commitment and no mutual sharing of resources.
ii. Co-ordination (CD) i.e. exchanging information, moderate time commitments, making access to services and resources more user-friendly and no mutual sharing of resources.
iii. Co-operation (CP) i.e. exchanging information and sharing resources to achieve a common purpose, substantial time commitments, high levels of trust, sharing resources and risks responsibilities and rewards.
iv. Collaboration (CL) i.e. exchanging information, sharing resources, enhancing the capacity of the partner, extensive time commitments, high levels of trust, full sharing of resources, risk, responsibilities and rewards.

Himmelman himself warns that these definitions are developmental and that, therefore, when moving to the next stage the previous stage is included within it. None is "better" than another. It is a question rather whether one is more appropriate than another. Note that the final stage of this process after collaboration is merger, which of course is no longer partnership.

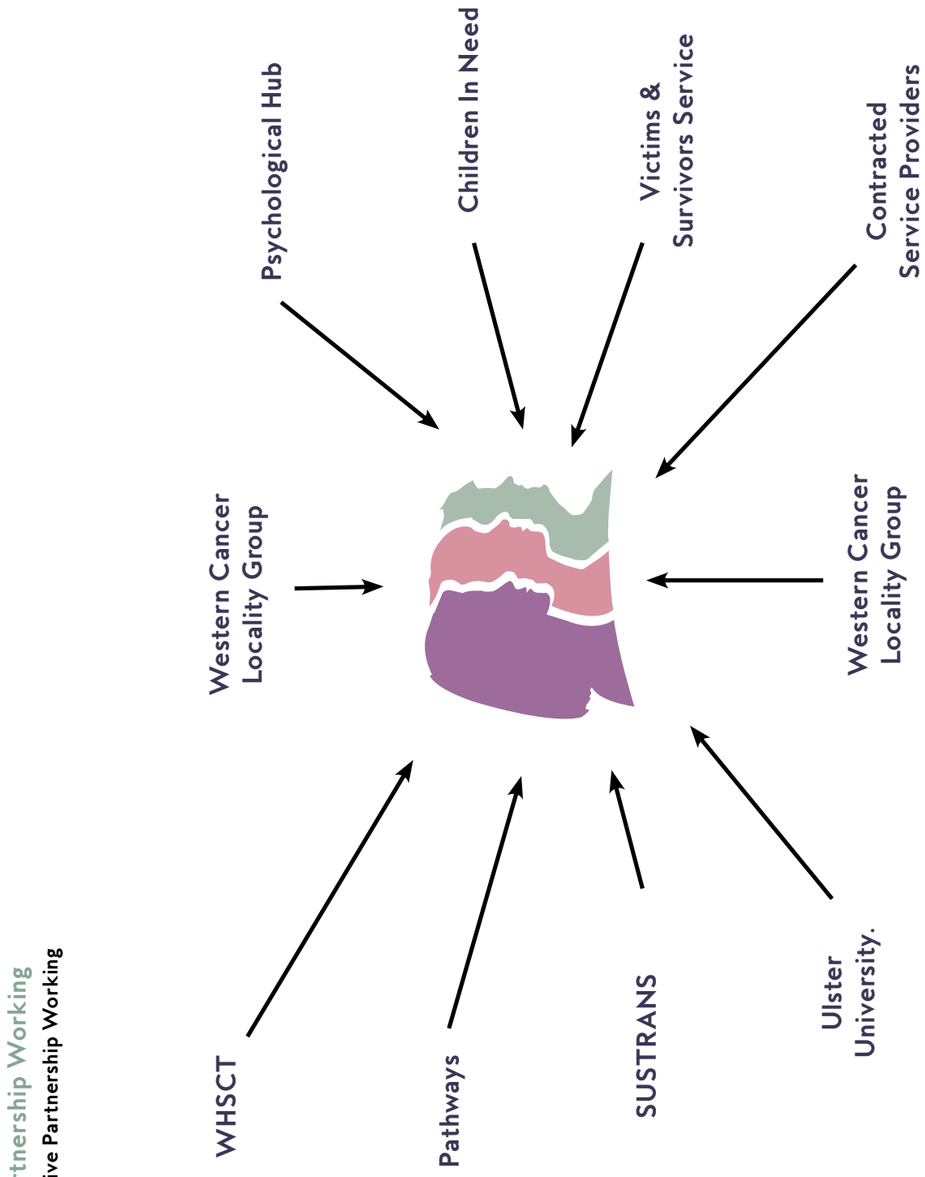
In engaging in partnership working Derry Well Women does not rush in but asks rigorous questions of itself and of the potential partner. Will partnership working get Derry Well Women to where it needs to be in order to meet the needs Derry Well Women wants to meet? Will it dissipate energy instead of consolidating energy? Will it add value? Will it undermine Derry Well Women's practice and values? Derry Well Women engages only when satisfied that the partnership working will be of mutual benefit and based on shared values.

The current list and categorising of partnership workings are: The current list and categorising of partnership workings are:

Organisation	Partnership working	NW	CD	CP	CL
WHSCT	Contract to deliver women's health services.				✔
PATHWAYS	Funder				✔
Western Cancer Locality Group	Derry Well Women co-chairs with WHSCT this inter-agency group to signpost patients to community-based services.				✔
Emotional Health & Suicide Prevention Strategic Implementation Group	Derry Well Women co-chairs this group with the PHA to implement protect life strategy.			✔	
GSK Impact Awards Network	Derry Well Women is member of regional and national network for Community Health Impact Winners to share practice gain leadership skills and influence policy. Participation on Cascading Leadership Programme.			✔	
Action Cancer	Derry Well Women partner in service to relatives of people living with cancer.			✔	
Primary Care Organisations	Formal referrals to Derry Well Women from GPs ,Social Workers, CPNs, Health Visitors Memory Assessment Clinic Altnagelvin,	✔			
Community & Voluntary Sector and Primary Care	Partners in programme delivery include Diabetes UK, British Red Cross, Alzheimer's Society, Verbal Arts Centre, LifeStart, Citizens' Advice.			✔	

Organisation	Partnership working	NW	CD	CP	CL
Community and Voluntary Organisations	Inward and onward referral by Derry Well Women services in partnership with C&V sector, Probation Officers, RNIB, Victims Support, WAVE, Aisling Centre, Pat Finucane Centre, Women's Aid, HURT, Koram Centre and CRUISE. Foyle Hospice Derry Women's Centre		✔		
Victims & Survivors Service	Funder.				✔
VSS Practitioners Working Group	Derry Well Women active member of the Group by contract.			✔	
Psychological Hub	Formal referral arrangement with financial support to refer clients with mild to moderate depression and anxiety.				✔
Foyle Hospice Compassionate Communities	Derry Well Women sits on Advisory Board and share practice and co-hosted Carer's Conference			✔	
WHSCT Patient Client Council	Derry Well Women is represented on the group.	✔			
North West Regional College	Partnership arrangement including Open College Network for delivery of community-based programmes.				✔
North West Community Network.	Member.	✔			
BBC Children in Need	Funder.				✔
SUSTRANS	Derry Well Women in partnership including Derry and Strabane Council supports the delivery of funded cycling training programme (for mental health and wellbeing).				✔
NICVA	Member.	✔			
Contracted Service Providers	Derry Well Women engages a multi-disciplinary team of counsellors, GPs, Pharmacists, Community Psychiatric Nurses, therapists and educationalists to deliver holistic care programmes.				✔
FWIN	Member	✔			
BACP	Member.	✔			
MENCAP	Placement provision, supervision, training, shared practice.			✔	
DESTINED	Placement provision.		✔		
Ulster University & WHSCT	Breaking ground research projects in partnership with WHSCT and Ulster University into needs of Carers and the effects of anti-depressants				✔

This exercise reveals a significant amount and variety of partnership working with a preponderance at the high end of collaboration. Derry Well Women engages thirteen organisations in collaborative partnership working. This paints a picture of an organisation grounded and embedded in the local community and statutory sectors with advanced partnership arrangements. See Diagram I



Collaborative Partnership Working

Diagram I: Collaborative Partnership Working

6. Strategic Aims & Objectives

Having reflected on its mission, ethos and the conceptual framework underlying its work and having considered the strategic context of rapid and unpredictable change, the Board of Derry Well Women agreed five strategic aims for the period 2017-2020:

i. To continue to provide women with a women-centred health service which will improve the health and wellbeing of women, families and community and recognises the changing needs of women's health.
ii. To promote social inclusion, to address health inequalities and improve health by meeting the specific health needs of women generally and specifically marginalised groups of women including women victims of the conflict.
iii. To further refine the conceptual framework and embed the theory and practice of co-producing in the work of Derry Well Women.
iv. To continue to build and maintain a strategic complex of collaborative partnerships.
v. To capture and share the learning from the work of Derry Well Women with women's health projects at home and abroad especially in post-conflict societies.

They are set out here in grid format showing related objectives and expected impacts.

Strategic aims	Strategic objectives	Impacts
I. To continue to provide women with a women-centred health service which will improve the health and wellbeing of women, families and community and recognises the changing needs of women's health.	I.I To develop and deliver training programmes which embody the Derry Well Women Model of women's health, working particularly addressing the five main causes of morbidity/mortality in women. I.2 To extend activity age band to include 16 – 18 year olds. I.3 To maintain and enhance the current solid financial situation by strategic and *ad hoc* unrestricted fund-raising. I.4 To review the current staffing levels in the light of the new strategic aims and seek to recruit where deemed necessary to equip Derry Well Women to achieve all aims.	Impacts will include: I. Derry Well Women will build on its current solid financial situation to maximise and optimise its reach. 2 Derry Well Women will have the necessary human resources to extend its reach and establish itself as the leading women's health organisation in Northern Ireland. 3 Derry Well Women will build a cohort of trained women advocating the Derry Well Women model and bringing it into communities.
2. To promote social inclusion, to address health inequalities and improve health by meeting the specific health needs of women generally and specifically marginalised groups of women including women victims of the conflict.	2.I With Social Justice at the heart of Derry Well Women's theory and practice of Co-production, identify eight cohorts of socially excluded people and establish mutually beneficial working relations with each. 2.2 As part of building collaborative partnerships, include four organisations and agencies which may not have a women's health focus but which do have a strategic focus on social exclusion and/or conflicted related issues.	Impacts will include: I. Derry Well Women will become the leading organisation in the field of women's health and social exclusion and their interaction. 2. Derry Well Women will build mutually beneficial partnerships with leading social exclusion and conflict related organisations. 3. Derry Well Women will capture and share the learning in conferences and journals from its own practice of the interrelationship between poverty, political conflict and women's health.
3. To further refine the conceptual framework and embed the theory and practice of co-producing in the work of Derry Well Women.	3.1 Research the concept further and produce a position paper matching the experience of Co-production globally to the work of Derry Well Women. 3.2 Identify in the work programme opportunities for introducing the practice of Co-production. 3.3 Source training of key staff and key programme participants who are tasked with the implementation of Co-production to improve their skills, knowledge and capacity to participate. 3.4 Review and extend the implementation of Co-production to its full embedding in the work of Derry Well Women.	Impacts will include: I. Derry Well Women will have a rigorous and evidence-based conceptual framework which underpins its values and practice. 2. The quality of Derry Well Women's work will be enhanced by the inclusion of programme participants in the production of tailored health programmes. 3. The theory and practice of Co-production will enhance the unity of purpose and experience of Board, staff and participants. 4. The work of Derry Well Women will be easily understood, appreciated and admired by a global audience familiar with the values that underlie the conceptual framework.
4. To continue to build and maintain a strategic complex of collaborative partnerships.	4.1 Critically review and analyse current health-focussed partnerships with a view to the sustainability of their mutual benefit. 4.2 From among a wide cohort of projects, agencies and departments itemise the benefits of building new partnerships in order of priority and compile a list of not less than eight. 4.3 Target one engagement every three months and assess the mutual value and the means of moving from a networking to a co-ordinating, co-operating or collaborating relationship.	Impacts will include: I. Derry Well Women will cultivate and nurture robust alliances of mutual benefit which will strengthen its position in the face of competitive and gate-keeping rivals. 2. Derry Well Women will optimise its sphere of influence and respect by strategically increasing its cohort of supportive partnerships.
5. To capture and share the learning from the work of Derry Well Women with women's health projects at home and abroad especially in post-conflict societies.	5.1 Appoint an external evaluator expert in both women's health and evaluation techniques to devise an evaluation model and mechanism that will capture both the quantitative and qualitative impact. 5.2 To extend the reach of Derry Well Women by creating a platform to take the lead in developing a feminist approach to women's health. 5.3 Complete the process of telling Derry Well Women's story in book form by stitching the conceptual analysis into the history of work undertaken and by describing and analysing the trajectory of past, present and future development. 5.4 As part of capturing and sharing the learning, research the interrelationship between political violence and poverty as they impact on women, family and community health and incorporate it into the learning and practice.[29] 5.5 Board to receive quarterly reports from the evaluator on the progress of her evaluation of the capturing and sharing of the learning. 5.6 Derry Well Women will consider changing its name to Well Women NI.	Impacts will include: I. Derry Well Women's work will be recognised at home and abroad for its expertise in the interrelationship between women's health and political conflict (an UNO priority). 2. The international exchange of theory and practice will enhance the expertise and standing of Derry Well Women in Northern Ireland and throughout Europe and the world. 3. Well Women NI will be well placed to attract Government and European funding, sponsorship and respect.

29 A good starting point might be *Poverty & Conflict in Ireland: an international review*, Professors Hillyard, Roulston and Tomlinson, Combat Poverty Agency, Dublin 2005.

7. Monitoring & Evaluation

Our primary purpose in evaluating and monitoring the programmes we offer will be to ensure that Derry Well Women is positively contributing to women's lifelong self- healing and personal growth and to demonstrate to our stakeholders the effectiveness of our programmes in achieving predicted outcomes.

To this end we will adopt an evidence based approach to practice that incorporates a series of scientifically recognised and robust internal evaluation methodologies capable of producing clear evidence that desired outcomes are being achieved.

We will ensure that the efficacy of all programmes is measured with each delivery, through the use of a scientifically credible health impact tool appropriate to the specific type of intervention and to the stage at which it is delivered.

On the first day of the health improvement intervention, we will ask participants to complete the appropriate health impact tool. The baseline scores will be tallied and recorded. This process will be repeated on the final day of the health improvement intervention. All collated data will be analysed. This process will ensure that we are informed of the impact of each programme as well as ensuring our service delivery standards are maintained at consistently high levels. It will also highlight areas for review.

Conscious of our role as being in the forefront of women's health in the North West and aware that the theory and practice of co-production in women's health programmes which Derry Well Women is embedding in its core practice requires an impact in the community in which the women and their families live and work, an evaluation priority will be capturing the outcome and impact of the health interventions in their local communities. Although challenging, this will become part of the strategic evaluation during 2017-2020.

Validating Interventions:

We will validate our programmes both formally and informally. This combined approach will enables us to ensure that what we do resonates with policy, and remains relevant to the needs of service users.

Performance against target volumes is important, but the achievement of quantitative targets does not tell the whole story.

We will, therefore, ensure that our programmes have a relevance to women's lives, their needs and communities, and add value in terms of positive outcomes.

Derry Well Women become the leading expert on women's health in Northern Ireland on the basis of its evidence based research and publications.

Evidence based practice will underpin everything we do.

7.1 Psychometric tests

As part of our work, we will use psychometric testing of programme participants before and after participation in programmes. These will include Rosenberg Self Esteem Scale, Becks Depression Inventory, Ways of Coping (Brief Cope), Self-Assessment and Lifestyle Inventory (SALI) and General Health Questionnaire.

The results will indicate statistically significant changes in relation to, self-esteem symptoms of anxiety and depression, uptake of positive behaviours and lifestyles, and reduced reliance on medication by women who have completed our health and well being programmes.

We will also implement a Self-Assessment & Lifestyle Inventory developed by Derry Well Women which will measure health improvement across six dimensions of wellbeing (physical, mental, emotional, spiritual, behaviour / lifestyle and reliance on services).

7.2 CoreNet

In Counselling Derry Well Women will use Corenet which measures:

1. Wellbeing
2. Problems
3. Functioning
4. Risk

A 34 item questionnaire CORE-OM will tap into a 'core of clients' distress in a wide range of psychological therapies.

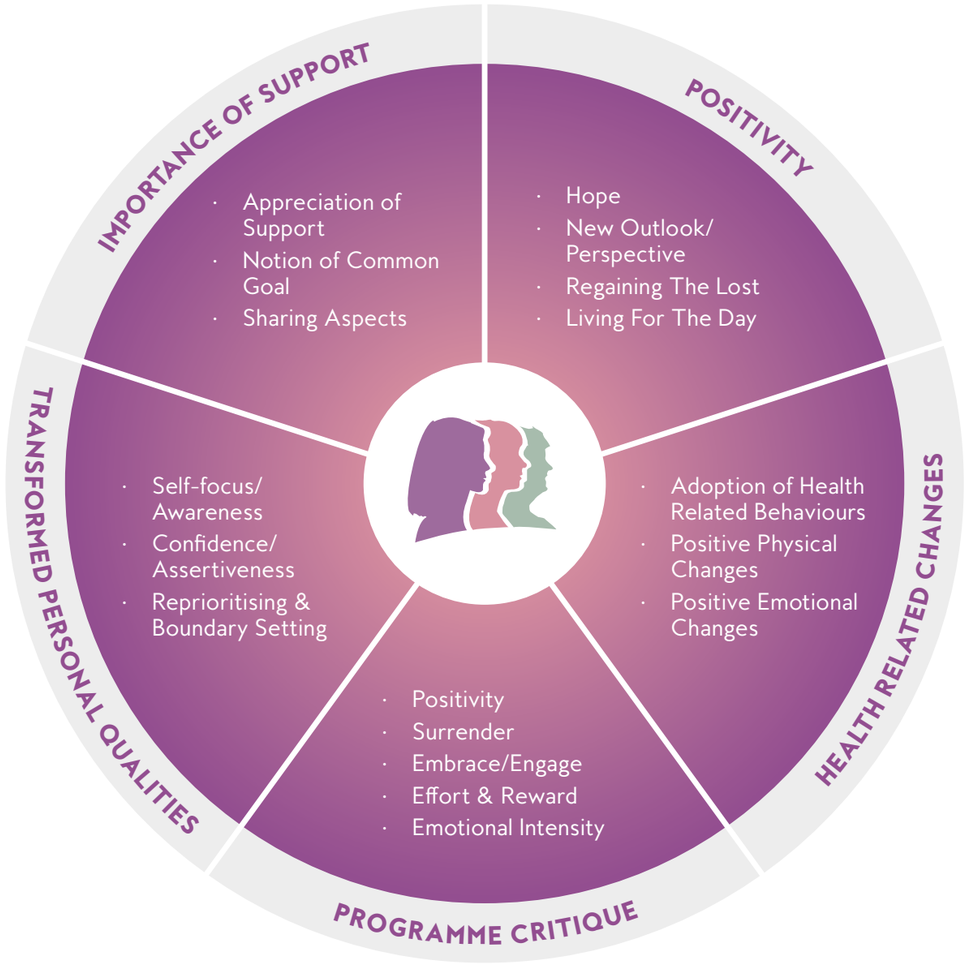
The questions will address subjective well-being, commonly experienced problems or symptoms, life and social functioning and risk to self and others. The aim is to achieve a reliable and clinical change across the score of all 4 areas. Through this approach we will measure improvement across all dimensions of health and wellbeing.

7.3 Measure Yourself Medical Outcome Profile (MYMOP)

In the provision of complementary therapies Derry Well Women will use MYMOP a tool for measuring what women want "to come out of the treatment/therapy".

Developed by Dr Charlotte Patterson MYMOP evaluates complementary therapies and does so in partnership with the client with their choice of symptom, level of severity and score 0= as good as it can be to 6= as bad as it can be setting the baseline.

Derry Well Women is committed to embedding evidence based evaluation processes in order to measure the outcomes (added value) of what we do. We are also committed to developing a partnership between those who deliver programmes and women who participate in them. In doing so, we will place emphasis on rigorous outcome evaluation, including the empowering nature of self-evaluation of participants in programmes, case studies, testimonials etc.



7.4 Outcome-led evaluation

Derry Well Women is rooted in the local community and will seek to evaluate not only the distance travelled by individual participants but also the impact of their health interventions in the wider community. We understand "outcome" to mean the use made by participants of the outputs (e.g. a specific health programme) and "impact" to mean the changes that result in the condition of the community from a series of outcomes.[30]

Impact in the wider community is important to Derry Well Women. We will employ tried and trusted methods of outcomes and impact evaluation methodologies in focus groups with participants such as Most Significant Change, Nominal Group Technique, Outcomes Matrix, and Richter Scale Measurement. Through this approach we will be able to demonstrate a number of positive outcomes.

Outcomes

- Measureable improvements in quality of services provided;
- Measureable, enhanced quality of life, embracing factors such as positivity, hope, new outlooks or perspectives;
- Measureable health related improvements and adoption of positive health related behaviours;
- Measureable physical improvements; measureable emotional improvement;
- Improved resilience, including the adoption of coping strategies;
- Transformative personal qualities, such as self-awareness and focus, increased confidence and assertiveness and self-control;
- Reduced reliance on health and social services;
- Women who use our services set personal goals and make positive life choices, which do include a move to paid employment and further education;
- Measureable improvements in the quality of life in the communities where the participants live.

30 OECD DAC: Glossary of Evaluation Terms, 1995

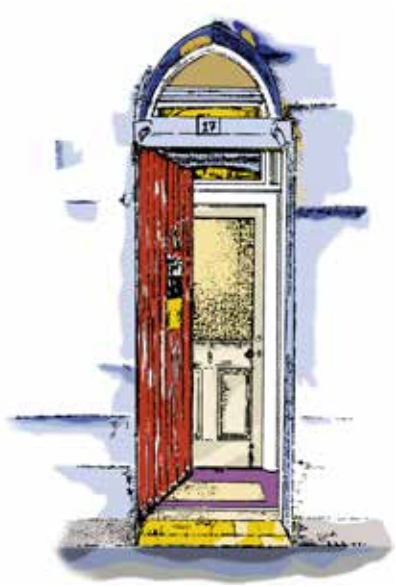
8. Appendices

APPENDIX I

PARTNERSHIPS FOR CHANGE

Definition	Networking	Co-ordination (CD	Co-operation (CP)	Collaboration (CL)
	Exchanging information for mutual benefit	Exchanging information for mutual benefit and altering activities to achieve a common purpose	Exchanging information for mutual benefit, altering activities and sharing resources to achieve a common purpose	Exchanging information for mutual benefit, altering activities, sharing resources and enhancing the capacity of another to achieve a common purpose
Relationship	**Informal**	**Formal**	**Formal**	**Formal**
Characteristics	Minimal time commitments, limited levels of trust and no necessity to share turf; information exchange is the primary focus	Moderate time commitments, moderate levels of trust, and no necessity to share turf: making access to services or resources more user-friendly is primary focus	Substantial time commitments, high levels of trust, and significant access to each other's turf: sharing of resources to achieve a common purpose is the primary focus	Extensive time commitments, very high levels of trust and extensive areas of common turf; enhancing each other's capacity to achieve a common purpose is the primary focus
Resources	**No mutal sharing of resources necessary**	**No or minimal mutal sharing of resources**	**Moderate to extensive mutal sharing of resources and some sharing of risks, responsible and rewards**	**Full sharing of resources, and full sharing of risks, responsibilities and rewards.**

In using this chart, please keep in mind that these definitions are developmental and, there, when moving to the next strategy, the previous strategy is included within it. None is "better" than another is; rather, each may be more or less appropriate. The final stage of this process after collaboration is merger, which is no longer a partnership.



Derry Well Women
17 Queen Street
Derry BT48 7EQ

Tel: (0)28 7136 0777
Fax: (0)28 7137 0103
Email: info@derrywellwoman.org

www.derrywellwoman.org