

Gender, diversity, and quality assurance in health care institutions

Halime Celik, MSc^{1,2}, Ineke Klinge, PhD¹, and Frans C.B. van Wijmen, PhD JD²

Department of Health Sciences, Section Gender studies in Health and Health Care¹, and Section Health Law², Care and Public Health Research Institute (CAPHRI), Maastricht University, Maastricht, The Netherlands.

Introduction

The Dutch patient population is becoming increasingly diverse in terms of sex/gender, age, ethnicity, disability, and social economic status (SES). Therefore, health services should become tailored to accommodate diversity. A previous study showed that gender and diversity issues were hardly recognized and received little attention in hospitals¹. To establish a solid health service, it is essential that gender and diversity issues are mainstreamed in quality assurance and become a structural part of it^{2,3}.

Objective

This study is the first part of a research project entitled ‘Mainstreaming gender and diversity in quality assurance of health care institutions’. This study aims to raise awareness of gender and diversity issues by offering a programme of diversity competence to health quality assurance managers and/or other strategic actors of selected health care institutions.

Materials and Methods

We have developed a programme for diversity competence consisting of four modules: 1. theoretical background, 2. relevance for health services 3. mainstreaming approach, and 4. implementation strategy, with respect to quality instruments⁴. Three institutions (hospital, nursing home, and institute for mental health) fulfilling our inclusion criteria have been recruited to participate. From each institute, 8 to 12 health quality assurance managers and/or other strategic actors will join the program. The diversity competence programme is tailored to the specific situation of each institute. Finally, two measurement instruments have been developed: one to measure changes in diversity awareness of the participants (‘diversity thermometer

II'), and a second one to measure the effects of the diversity competence programme on the quality assurance of the institute ('diversity thermometer I').

Preliminary Results

The programme for diversity competence has started in two institutions: the hospital and the institute for mental health. Baseline data with respect to diversity thermometer II have been collected from the participants of these institutions. These data have been analysed using a modified Deming cycle, consisting of the following stages: Unawareness-(some) Awareness-Plan-Do-Check-Act (figure 1). This cycle serves to identify in which stage the institutions are in considering gender and diversity issues.

Hospital: The majority of the participants indicate that they are in the (some) Awareness-stage for all gender and diversity issues and point out that they pay sufficient attention to these issues except for ethnicity. However, none of them is in the active stage of the Deming cycle (Plan-Do-Check-Act).

Institute for mental health: The majority of the participants point out that they are in the Do-stage with respect to sex, in the (some) Awareness-stage for ethnicity, and in the Plan-stage for age, disability and SES. According to the participants, age and disability receive sufficient attention, sex and SES should receive more attention, and ethnicity considerably more.

Conclusions

The majority of the participants of both institutions indicate that they are at least aware of gender and diversity issues. This awareness, however, has not resulted in taking these issues systematically into account. Therefore, our diversity competence programme, which has the potential to stimulate the participants to complete the Deming cycle by mainstreaming gender and diversity, is well in place.

Bibliography

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Acknowledgements

The authors thank the participants and are grateful to Nico van Oosten, MSc (TransAct) for his contribution to the present study. Grant information: this study is funded by the Netherlands Organisation for Health Research and Development (ZonMw).

Correspondence to: Halime Celik, Department of Care Sciences, Maastricht University, P.O. Box 616, 6200 MD Maastricht, The Netherlands. E-mail: h.celik@zw.unimaas.nl

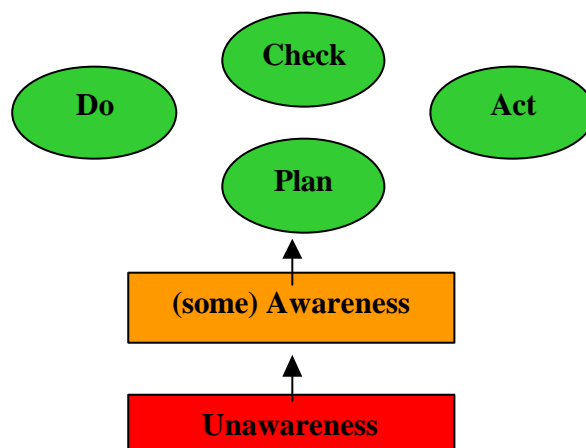


Figure 1 Modified Deming cycle