Facilitator's Guide to Capacity Building

BUILDING CAPACITY AROUND WOMEN'S HEALTH
IN
RURAL AND REMOTE BRITISH COLUMBIA

598 Management Report

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EXECUTIVE SUMMARY

In the spring of 2000, the Women's Health Bureau undertook a project focusing on rural women and rural women's health issues. The project, entitled *The Facilitator's Guide to Capacity Building* – Building Capacity Around Women's Health in Rural and Remote British Columbia, required the development of a user-friendly guide for capacity building that could be used by women residing in rural communities. Although the guide was developed as a resource to be used by rural communities, it was also intended to act as a planning tool for a series of capacity building workshops to be sponsored by the Women's Health Bureau and the Minister's Advisory Council on Women's Health.

The idea to do capacity building workshops around women's health in rural areas of the province arose from the 1999 rural and remote initiative developed by the Women's Health Bureau and the Minster's Advisory Council. The focus of this project was to design an action-oriented instrument for women in rural and remote areas to utilize to improve the health and well-being of women in their communities. The focus was not one of doing research *on women*, but was one of trying to take into account the health needs, interests and experiences of women as defined by rural women themselves, and employ these perspectives into a capacity building session on women's health. The ultimate goal of this project became the development of materials that could be utilized by the Council in their effort to assist women from various rural communities in planning capacity building workshops that would be community-specific to their health needs and interests.

Initially, the objective of this project involved developing a standardized (one-size-fits-all) module for capacity building workshops. Once developed, it was to be utilized by the Advisory Council as a vehicle for setting up capacity building workshops throughout rural BC. However, after considerable reading on capacity building it was concluded that the initial idea of developing a standardized module for the Council to use in rural and remote settings did not coincide with the core definition of capacity building. Capacity building is about community involvement and community effort, it is not about outside experts going into communities and dictating to those residing within the community. The very idea of having Council members go into communities to advise

women on how to develop capacity around health issues specific to their community and their lives was therefore contrary to all the literature. From these discussions arose the concept of developing a *facilitator's guide* that could be used (as a generic resource) by women in rural/remote settings to assist them in developing capacity building skills and thus building capacity around health issues specific to their lives in their communities.

In the end, it was decided that the Council's primary role would be to develop a rapport with women residing in those rural communities where capacity building workshops would eventually take place. This rapport would be developed through a community consultative process. From this process, it would be the rural women themselves who would determine whether or not to move forward with the development of a capacity building workshop for women in their community. If the community decided to move forward, the role of the Women's Health Bureau and the Council would be to assist the community in administrative areas such as financial assistance for bringing in a workshop facilitator, assistance with childcare subsidies, and resources for food and refreshments during the working sessions.

The scope of this project involved three main tasks. These included literature reviews on (a) women's health in the context of rural and remote living situations and (b) capacity building; developing a user-friendly facilitator's guide with the knowledge gained from the literature review; and, developing and managing all aspects of the *first* capacity building workshop to be held under the Council's rural and remote initiative.

The *Facilitator's Guide to Capacity Building* was constructed using information gathered from the literature review. In order to plan for community-specific workshops, a generic questionnaire was also developed. The objective of this questionnaire was twofold: to obtain women's views with respect to community-specific health issues and concerns, and to collect information that will assist the Minister's Advisory Council in advising the Minister with respect to pertinent information about rural women and health.

Tatla Lake, BC became the pilot site for the initial capacity building workshop. Tatla Lake is located approximately three hours west of William's Lake – in the Chilcotin Valley. Members of the Advisory Council's rural and remote subcommittee suggested Tatla Lake as a possible site for this project. It was reported that Tatla Lake was a very

progressive community and therefore the women residing there may very possibly be interested in the concept of capacity building.

One of the most important outcomes from the pilot project in Tatla Lake relates to the critical importance of pre-workshop community consultation processes. Prior to the development of the Tatla Lake workshop there was great debate among members of the Advisory Council as to the necessity of going into each and every community *prior* to having the capacity building workshops. Some members felt strongly that this was not necessary and that it would be too costly from a financial perspective.

Because the target sites for these workshops are rural communities, the cost of traveling to and from can be both expensive and time consuming. However, from the standpoint of those involved in the Tatla Lake project it is unanimous that not only is this necessary, it is critical to developing a successful outcome. Developing a good rapport with the women in Tatla Lake was a key factor in the positive outcomes that resulted. Women in the community came to view the Women's Health Bureau and the Minister's Advisory Council as partners in the project with only one agenda – the development of a workshop that was for the women of Tatla Lake by the women of Tatla Lake. This could not have occurred without the pre-workshop consultation meetings.

Introduction

In the spring of 2000, I undertook this project under the direction of the Women's Health Bureau. The project, entitled *The Facilitator's Guide to Capacity Building* – Building Capacity Around Women's Health in Rural and Remote British Columbia, required me to develop a user-friendly guide for capacity building that could be used by women residing in rural communities. Capacity building is about developing communities through community involvement and community effort. The base of that development comes from the internal strengths of a community's membership. In this specific project, women in rural/remote settings will use the facilitator's guide as a generic resource to assist them in developing capacity building skills and thus building capacity around health issues that are specific to their lives in their communities.

Although the guide was developed as a resource to be used by rural communities, it was also intended to act as a planning tool for a series of capacity building workshops to be sponsored by the Women's Health Bureau (WHB) and the Minister's Advisory Council (MAC) on Women's Health.

The Women's Health Bureau is a division of the BC Ministry of Health and Ministry Responsible for Seniors. The Women's Health Bureau is mandated to promote a health care system that is sensitive to the needs of women by working *within* government and *liaising* with community groups and health care providers.

The Women's Health Bureau works in partnership with the Minister's Advisory Council on Women's Health. MAC was established in 1994 and consists of 15 members who reside in different regions and embody diverse cultural groups and communities

across the province of British Columbia. Representatives of both government and non-government agencies and institutions work with the Council.

The Council's mandate is to advise the Minister of Health on issues relating to the health needs of women, the development of health care policy and the delivery of women's health services. MAC's overall mission is to achieve better health for women living throughout the province of British Columbia.

In October of 1999 MAC identified rural and remote living and women's health as one of the Council's strategic priorities. In accordance with MAC's philosophy of women's health, health is a resource for everyday life. The status of one's health therefore largely determines the quality of one's life. It is now widely recognized and accepted that social, economic, political, environmental and historical forces affect health status. It is in this context that MAC is attempting to better understand the unique challenges of health issues facing women residing in rural and remote locations of the province. It is in this context that MAC is attempting to promote women's health and well-being through the use of capacity building.

Why Focus on Rural Women's Health?

Gender is regarded as a determinant of health because conditions that contribute to health are not equally distributed between men and women. Because women comprise slightly more than half of the population, addressing women's health needs and concerns is not only good practice it is necessary for the provision of efficient and effective health care delivery. Women use the health care system more than men do. Women have a longer life expectancy and experience greater degrees of chronic illness. Although women do have specific health needs with respect to reproductive health, women's health and well-being are far more comprehensive and diverse than simply that of reproductive issues.[1]

The social contexts of women's lives play a major role in influencing women's health status. Women are far more likely than their male counterparts to experience low incomes and poverty, low social status, physical, sexual and/or emotional violence, social isolation, and increased stress that results from working outside of the home while simultaneously maintaining the primary caretaking responsibilities within the home. Although both women and men can be negatively impacted by these factors, women are more inclined to experience these conditions than men, and this is especially so for women residing in geographically isolated parts of the province.[2]

In 1994 the then Minister of Health, Honourable Paul Ramsey, appointed a Northern and Rural Task Force to determine the health needs of remote and rural communities and to identify means of addressing those needs. In essence this was a

[1] British Columbia Ministry of Health and Ministry Responsible for Seniors, Provincial Profile of Women's Health: A Statistical Overview of Health Indicators For Women in British Columbia (1999).
[2] British Columbia Ministry of Health and Ministry Responsible for Seniors, Provincial Profile of Women's Health: A Statistical Overview of Health Indicators For Women in British Columbia (1999).

needs assessment. The Minister of Health was of the opinion that an investigation into the health needs of rural and northern residents was necessary because of disparities in access to health services. Pre-1994 data had clearly indicated that limited access to health services negatively impacted the health status of those residing in geographically remote locations throughout the province of BC. A formal report documenting the issues around health care, and recommendations for addressing some of those concerns resulted from the Task Force's investigatory work. According to the Task Force's findings, women were defined as a population with special needs, "Women's health issues in rural and northern areas of British Columbia were found to be significantly different than women's health issues in urban areas."[3]

The Task Force continues to operate today and it is the Council's intent to discuss with the Task Force any applicable health information resulting from the Council's work with women residing in rural and remote locations.

[3] Report of the Northern and Rural Health Task Force (1995).

Framework

The idea to do capacity building workshops around women's health in rural areas of the province arose from the 1999 rural and remote initiative developed by the Women's Health Bureau and the Minster's Advisory Council. Initially, the scope of this project required me to develop a standardized (one-size fits all) module for capacity building workshops. Once developed, it was to be utilized by the Advisory Council as a vehicle for setting up capacity building workshops throughout rural BC.

Over time the focus of the project evolved. After considerable reading on capacity building I, in conjunction with the Council and the Bureau, concluded that the initial idea of developing a standardized workshop module for the Council to use in rural and remote settings did not coincide with the core definition of capacity building. Capacity building is about community involvement and community effort, it is not about outside experts going into communities and dictating to those residing within the community. The very idea of having Council members going into communities to advise women on how to develop capacity around health issues specific to their communities and their lives was therefore, contrary to all the literature. From these discussions arose the concept of developing a *facilitator's guide* that could be used (as a generic resource) by women in rural/remote settings to assist them in developing capacity building skills that would in turn enhance their ability to build capacity around health issues pertinent to their lives in their communities.

In the end, it was decided that the Council's primary role would be to develop a rapport with women residing in different rural communities. This rapport would be developed through a community consultative process. From this process, it would be the

rural women themselves who would determine whether or not to move forward with the development of a capacity building workshop for women in their community. If the community decided to move forward, the role of the Women's Health Bureau and the Council would be to assist the community in administrative areas such as financial assistance for bringing in a workshop facilitator, assistance with childcare subsidies, and resources for food and refreshments during the working sessions.

The scope of this project involved three main tasks. These included:

1. Literature reviews on two topics:
   (i) women's health in the context of rural and remote living situations; and,
   (ii) capacity building.

2. Developing the facilitator's guide with the knowledge gained from the literature review.

3. Developing and managing all aspects of the *first* capacity building workshop to be held under the Council's rural and remote initiative. Tatla Lake, BC became the pilot site for the initial capacity building workshop.

The *Facilitator's Guide to Capacity Building* was constructed using information gathered from the literature review. Information pertaining to both capacity building and women's health issues from a rural perspective was combined to develop this guide. The *Facilitator's Guide* has five sections in total. The two dominant sections involve those on capacity building and women's health issues. The section dealing with capacity building discusses in detail what capacity building is, how capacity building is done and the benefits of using this format for community development. The section dealing with women's health issues discusses why women's health status is often compromised for women living in rural and remote locations, and gives a detailed outline of the different

issues specifically found to be more problematic for women living in rural and isolated communities.

Other sections of the guide include an outline of the processes involved in developing capacity inventories, a generic exercise workbook for capacity building and women's health, and a women's health questionnaire (sample survey to be used by communities as a planning tool for capacity building workshops).

Methodology

The focus of this project was to design an action-oriented instrument (*Facilitator's Guide*) for women in rural and remote areas to utilize in their efforts to improve the health and well-being of women in their communities. The focus was not one of doing research *on women*, but was one of trying to take into account the health needs, interests and experiences of rural women (as defined by rural women themselves) and employ these perspectives into a capacity building session on women's health. The ultimate goal of this project was to develop the materials that would assist the Council in assisting women from various communities to plan capacity building workshops that would be community-specific to their health needs and interests.

In an effort to better understand and address women's health issues in rural and remote areas, I first had to investigate the issues as they are reported in the literature. This was accomplished through a literature review of which a detailed discussion follows. The literature review encompasses both Canadian and American studies. I have attempted to incorporate and discuss only that material which I found to be pertinent to the Canadian context of rural and remote living.

In analyzing the literature I looked for persistent themes relating to women's health status in relation to rural and remote living conditions. These findings were then incorporated into the *Facilitator's Guide* (See Section 2). The same process was involved in developing the capacity building section of the guide (See Section 1).

To plan for community-specific workshops, I developed a generic questionnaire (See Section 5 of the *Facilitator's Guide*). The Minister's Advisory Council intends to

use this questionnaire as a pre-workshop planning tool. When developing the questionnaire I focused on two key objectives:

1. To obtain women's views with respect to community-specific health issues and concerns; and,

2. To collect information that may help the Rural and Northern Task Force better understand and address the health issues of women living in rural and remote areas.

The Minister's Advisory Council intends to hold several capacity building workshops in various rural/remote locations. Each community will receive a copy of the *Facilitator's Guide*. This resource will assist women in the community to do further community development using capacity building techniques. Each community will also receive a summary report of the information collected from the questionnaires completed by women in their community.

The Women's Health Bureau and the Minister's Advisory Council intend to do a comparison analysis of women's views from the various rural and remote communities participating in this rural and remote project. Upon completion of this project, the Minister's Advisory Council will formally present its findings and corresponding recommendations to the Northern and Rural Health Task Force and the Minister of Health. In turn, the Minister's Advisory Council hopes that, where necessary, policy change relating to women's health in rural and remote BC will be addressed.

Chronology of Events

May 2000

- Project concept discussed between client (WHB) and myself
- Literature review
- Construct and submit 598 proposal

June 2000

June 1-30

- Work on Facilitator draft (ongoing process)

June 10

- Attend MAC meeting in Victoria, BC
- Present facilitator progress report
- Revised concept introduced to all MAC members – project plan altered from development of a generic workshop module, to the new concept of Facilitator's Guide to Capacity Building

June 27-30

- Community Consultation Tatla Lake, BC (pilot site)
- Consulted with 2 different groups of women to discuss concept of capacity building and interest in planning a workshop for Tatla Lake
- Tatla Lake confirmed as pilot site for this project

July 2000

- Continue to work on Facilitator Guide
- Present updates (via electronic mail) of work to MAC and WHB for feedback and revision requests
- Continual communications with Tatla Lake contacts to establish set-up for October, 2000 workshop

August 2000 / September 2000

- Continue to work on Facilitator Guide
- Present updates of work to MAC and WHB for feedback and revision requests
- Continual communications with Tatla Lake contacts to establish set-up for October, 2000 workshop
- Compile all data from survey distributed in, and returned from Tatla Lake
- Write summary report of survey findings for Tatla Lake

October 2000

- October 12 - final draft of Facilitator's Guide completed for Tatla Lake
- October 13 & 14 – Tatla Lake Capacity Building Workshop held

November / December

- November – complete final draft of 598 report
- December – oral defense

Literature Review

The scope of the literature review encompasses two specific subject areas:

1. Women's health in rural and remote settings; and,
2. Capacity building.

Much of the academic literature pertaining to women's health in rural/remote settings was obtained via a computer search. The librarian at the Ministry of Health assisted me in this search. Some articles were present in the library, others were ordered by the librarian on my behalf. Other literature pertaining to women's health was obtained from local government documents, such as that produced by the Rural and Northern Health Task Force, which looks at health issues specific to rural BC. I utilized, substantially, the information presented in one government document produced by Linda Menheer (for the Women's Health Bureau). This document is currently widely used by the health sector, as it is a comprehensive collection of data specific to women in British Columbia. This document is particularly popular for those wishing to discuss and assess women's health from a social determinants perspective.

Members of the Minister's Advisory Council primarily suggested the literature I used to develop the section on capacity building. These sources were located from both the Ministry of Health and the University of Victoria. I relied less on academic studies for this section of the literature review. Since my goal was to develop a user-friendly resource guide, I relied heavily on the information produced by Kretzmann and McKnight since this literature reflected the style I wanted to incorporate into the development of my *facilitator's guide*.

1. WOMEN'S HEALTH IN RURAL AND REMOTE SETTINGS

One of the problems with assessing the health of rural women is the fact that few Canadian studies have focused on this area. Although some of the literature discussed here represents American sources, I have made every effort to incorporate only that literature relevant to the Canadian context of rural/remote living.

According to Fitchen (1991) and Lee (1991), there is no apparent universally accepted definition of the term *rural*. There are however defining differences between Canadian rural and northern settings. Northern settings tend to be more isolated and to have more severe climates (Leipert and Reutter, 1998). Lee (1991) discusses three elements commonly related to the concept of rural – these include occupational, ecological and sociocultural elements. Occupational elements refer to both farm and non-farm occupations (Lee, 1991). In the past, rural areas consisted of predominantly farm employment. Farming was therefore the impetus for many who originally settled in isolated areas of the province. Today this is not necessarily the case. For instance, although the rural area of the Central Cariboo Chilcotin once consisted primarily of resident ranchers, today there is a booming tourist industry developing and although ranching continues to be the dominant occupation, it is no longer the sole form of employment for Chilcotin residents. Ecological elements refer to population density and distance (Lee, 1991). According to Statistics Canada (1987), the census definition of rural is a population of less than 1000, with fewer than 400 people per square kilometer. Finally, Lee's (1991) sociocultural elements refer to those values found to be common among early Canadian immigrants who settled in the northern parts of British Columbia.

These values included right-wing political ideologies, support for the nuclear family, individualism, self-determination and self-reliance (Keating, 1991).

In British Columbia, most remote areas are found in the northern regions. However, similar issues arising as a result of geographical setting mean there are a number of areas in the southern more populated parts of the province that may also be considered remote (MacLeod, Browne & Leipert, 1998). The more remote the area in question, the greater the problems of access to health care. Geographic distance, transportation dilemmas, and a deficient supply of local health care providers negatively impact health care access (Office of Technology Assessment [OTA], 1990).

Lishner et al., (1996) suggest that overall the evidence supports those who argue that rural residents experience serious obstacles in accessing primary health care. Evidence suggests that on average women residing in rural and remote areas were found to:

- have more chronic disease;
- have inferior health status;
- encounter more injuries;
- have reduced life expectancy rates; and,
- view themselves as less healthy than do their urban counterparts (Blondell, Norriss, & Coombs, 1993; Offner, Seekins, & Clark, 1992).

Studies also indicate that women living in rural/remote isolation have:

- fewer employment options and opportunities;
- fewer health benefits; and,
- lower education levels than do urban women (Beck, Jijon & Edwards, 1996).

Women residing in more geographically isolated areas must continually deal with inadequate access to health care resources and ongoing shortages of medical providers (Blondell et al., 1993; Offner et al., 1992). Further barriers to health care include inadequate training on specialized issues facing women, insufficient referrals, limited

transportation options, distance of secondary and tertiary facilities, and a lack of financial resources (Offner et al., 1992).

Specific Issues Influencing Rural Women's Health

When analyzing the literature I looked for persistent themes or issues related to women, rural and remote living conditions and whether or not these factors played a role in negatively impacting women's health status. The following six factors were found to be associated with negatively impacting women's health status:

- violence;
- reproductive health issues;
- poverty;
- mental health services;
- issues of service access; and,
- being from a marginalized group.

The following discussion addresses each of these issues individually.

- **Violence**

Whether we are speaking of rural or urban women, violence is a serious issue that negatively impacts the lives of many Canadian women (Canadian Panel on Violence Against Women, 1993; Canadian Public Health Association, 1994). Nation-wide it is reported that 25% of all Canadian women have experienced some form of violence from either a current or former marital partner (Canadian Panel on Violence Against Women, 1993).

From a provincial perspective, British Columbia has the highest number of recorded acts of violence against women. In 1993, 59% of women in BC reported

experiencing at least one act of violence (physical or sexual) since the age of sixteen (Statistics Canada, 1993). Studies show that in British Columbia:

- one in two women are victims of sexual assault;
- one in three women are victims of wife assault; and,
- one in five women are victims of other types of physical assault (Ministry of Women's Equality, 1998).

Women who are victims of violent attacks are more likely than not to know their assailant – 72% of those found responsible for committing violent incidents against women were either acquainted with the victim or a relative of the victim (Statistics Canada, 1995).

Although both urban and rural women are susceptible to violence, rural women are more vulnerable to such experiences because of geographic isolation. In 1996 the health regions with the highest rates of reported violent crimes per 1000 population included:

- the North West region with 23.3 per 1000,
- the Northern Interior region with 20.6 per 1000; and,
- the Peace Liard region with 19 per 1000 (Menheer, 1999).

Among Aboriginal women, many of whom reside in remote areas, the rate of abuse may be as high as 80% (Canadian Public Health Association, 1994). Factors found to be specifically associated with violence and rural and northern living include:

- isolated living environments;
- seasonal employment of rural men – this often leads to increased alcohol consumption, which in turn can lead to increased levels of violence and abuse for female partners;
- close proximity of hunting weapons;
- lack of privacy and anonymity – lending to the improbability that women experiencing violence will seek assistance;
- the belief that leaving one's partner necessitates leaving one's community;
- fewer social and health supports; and,
- severe climates and geography.

Because these factors are associated with rural living, safely resolving violent situations becomes evermore complicated for women living in remote communities (Fishwick, 1993; Goeckermann, Hamberger, & Barber, 1994). Others point out that rural values emphasizing the male dominant perspective – such as those that define women's responsibilities in terms of home and family – may also contribute to battered rural women *staying* in their abusive relationships (White, Katz, & Scarborough, 1992).

When comparing battered women from urban and non-urban environments, Navin, Stockum, and Campbell-Ruggard (1993) found that rural women experienced:

- increased isolation and financial dependence;
- greater patriarchal family structure and fundamental religious beliefs; and,
- decreased social services – including access to the criminal justice system.

The literature concludes that issues of violence and issues related to violence continue to be inadequately addressed in most rural communities.

- **Reproductive Health**

Reproductive health and family planning services are a vital component in women's health. Reproductive health is one area of women's health where rural women are more negatively impacted in that they face access barriers that urban women do not necessarily encounter (Menheer, 1999). These barriers include access to both services and information. Women ought to be able to access the health care system without having to leave their own health region and this is not always an option when dealing with reproductive health concerns. Access to information and services concerning safe sex, birth control and abortion is vital to reproductive health. The inability to access reproductive health services places vulnerable women (minority women, young single women, women with low incomes and/or women living in rural areas) at risk for

unwanted pregnancy (Menheer, 1999). "If contraceptive care is not confidential, affordable, available when and where it is needed, and provided in a manner that works for all women, it cannot be and is not *effective* contraceptive care" (Hull, 1997).

Teenage pregnancy and access to abortion are both considered problematic when it comes to meeting the health needs of women living in rural/remote parts of British Columbia.

- ***Teenage Pregnancy*** – "teenagers in northern and rural parts of British Columbia are two to three times more likely to become pregnant than teens in the southern metropolitan areas" (Menheer, 1999). 1996/97 statistics indicated rates of pregnancy were highest in the North West and Peace Liard Regions (both showing 66.8 teen pregnancies per 1000 women aged 15 through 19). The Northern Interior ranked fourth highest reporting a rate of 56.6 per 1000 teen pregnancies (Menheer, 1999).

  This is very disconcerting since it often sets in motion a cycle of poverty and dependence on social programs. Furthermore, there is concern over the fact that more often than not birth outcomes are generally not as good for teenage mothers. Babies born to teenage mothers are inclined to have lower birth weights, are more susceptible to illness and have higher rates of Sudden Infant Death Syndrome (Menheer, 1999).

- ***Abortion*** – abortion services in rural and remote areas are not readily accessible. Data from 1996/97 show the urban centres of Vancouver and Burnaby reporting the highest rates of abortions – Vancouver at 23.5 per 1000 and Burnaby with 21.8 per 1000. During the same time period, the East Kootenay and Peace Liard regions reported the lowest abortion rates (Menheer, 1999). Although rates of abortion may be affected to some degree by

philosophical beliefs towards abortion, we do know that women living in some areas have little to no access options within their own regions. For instance, in 1996/97 data showed that only 1% to 6% of the women residing in the South Okanagan, Fraser Valley, South Fraser Valley and Simon Fraser regions were *able* to access abortion services (Menheer, 1999).

In addition, it is important to realize that although some regions have a higher number of women receiving abortions, we cannot assume that this service is readily accessible to *all* women residing in that same region. The geographical magnitude of some regions make travel distances difficult and costly for many women, often resulting in their inability to access abortion services even if those services are offered in their immediate region (Menheer, 1999).

- **Poverty**

When compared to urban areas, rural areas generally have much higher rates of poverty. "By every measure, women are consistently more likely than men to experience poverty and economic insecurity" (Federal/Provincial/Territorial Working Group on Women's Health, 1993). For the purpose of this discussion, living in poverty refers to those Canadians living below Canada's Low Income Cut-Off [LICO] – whereby 70% of a household's income is used to buy clothing, food and shelter (Menheer, 1999).

Some subpopulations of women are at a higher risk of living in poverty than are others. Women more likely to live in poverty include:

- single mothers;
- unattached elderly women;
- women with disabilities; and,
- Aboriginal women (Canadian Advisory Council on the Status of Women, 1995).

According to the National Council of Welfare (1997), in 1995 fifty-seven percent of all single mothers living in Canada were living in poverty. In rural and remote settings, where resources are usually limited, women are particularly vulnerable to living in poverty. Rural communities offer a limited array of occupational options for women. Of these options, some involve excessive risk; e.g., female farmers are especially vulnerable to farm-related accidents and injuries (Bushy, 1990; Wright, 1993). These women may also face an increased risk of agriculturally related cancers; e.g., working with possible cancer causing agents in certain pesticides (Alavanja, et al., 1994). Moreover, women with advanced education often find it difficult to find employment *related* to that education (if any employment at all) in small rural communities (Hunter & Whitson, 1991).

One participatory research project done in Cranbrook British Columbia found that women were consistently facing employment barriers because Cranbrook's economic base included mining, forestry, manufacturing and tourism – leaving few employment opportunities for many of the women living in this area. It is reported that women residing in Cranbrook earn approximately 55% of what their male counterparts earn. Consequently, women are more inclined to experience health related problems such as those resulting from an inability to provide nutritious foods for themselves (Dalton, 2000 – Cranbrook Women's Resource Society).

Whether married or single, Canadian women continue to perform the greater part of the work in the domestic sphere. Household and child-care responsibilities predominantly remain in the hands of women (Canadian Advisory Council on the Status of Women, 1994). Managing these responsibilities are simply compounded in the case of

lone-parent families (83% of which are headed by women). Furthermore, these responsibilities are often carried out in addition to a full day of paid employment (Menheer, 1999). On average, Canadian women do 63.7 hours of unpaid work per week compared with Canadian men who are reported as averaging 31.9 hours per week. This relationship is likely to be the same as or even greater for those working women residing in rural and remote areas of the province because traditional values regarding gender roles are more deeply entrenched in rural community cultures (Leipert & Reutter, 1998). For many women, coping with these combined pressures can be very stressful, resulting in deteriorating health status.

- **Mental Health Services**

When we compare BC's urban and rural populations, we find that rural and northern regions report much higher rates of mental illness. In 1996, data showed that the Cariboo, Coast Garibaldi and North West health regions had the highest rates of hospitalization for mental illness (Menheer, 1999). The lowest rates of hospitalization occurred in the larger urban centres of Burnaby, Vancouver's North Shore and Richmond (Menheer, 1999).

Service availability is a major barrier to many rural and northern women. The use of health and mental health services by rural women is influenced by accessibility to care and transportation is a persistent problem in this respect. Additional issues of mental health include:

- difficulty ensuring patient privacy; and,
- lack of supportive housing and other community-based mental health services (Menheer, 1999).

Women's mental health must be understood and addressed within the broader context of women's lives. For instance, social factors such as violence, sexual abuse, gender discrimination, sex role stereotyping, workplace inequities, multiple roles and responsibilities, poverty and economic uncertainty all contribute to undermining the mental health status of women (Menheer, 1999).

- **Access to Services**

Most British Columbia women are able to access the health care system. There are however, certain groups of women who experience barriers to access. These include marginalized women (Aboriginal women, lesbians, women with disabilities, and senior women) and women who are unable to access specific services because of unavailability and/or geographically-related barriers (Menheer, 1999).

Access to appropriate health care is without a doubt a serious concern for women who live in isolated locations (Northern and Rural Health Task Force, 1995). Commonsense dictates that population density determines both type and amount of health care services available within a given area. Remote and northern areas consist of sparse populations spread across large geographical areas, and for those women residing in such isolated locations, health services either do not exist or they are intermittent and inadequate (Leipert & Reutter, 1998). As well, difficulty in recruiting and retaining health care providers in isolated rural areas continues to remain problematic and the consequences are poorer health systems for women residing in such areas (Northern and Rural Health Task Force, 1995).

Rural community dynamics affect access when it comes to confidential services such as birth control and abortion. Because many rural communities have traditional

cultural values that uphold the male dominant perspective, many women living in northern and remote communities are unable to access services related to reproductive health. Even if such services are available, they may not be highly utilized because lack of privacy in small communities often inhibits women from accessing such services. "In rural areas, women who deviate from the dominant cultural norms in terms of age, sexual orientation, culture, ability, lifestyle and economic status are more visible and consequently, these women often experience discrimination or social ridicule" (Leipert & Reutter, 1998). Such attitudes can create barriers for women. Further barriers to access consist of:

- lack of transportation;
- physical obstacles for women with physical disabilities; and,
- language barriers for immigrant women and women who experience hearing or visual impairment (Leipert & Reutter, 1998).

Finally, Leipert and Reutter (1998) discuss the ability of physician's to *control* women's choices around health care in rural and northern communities. For instance, physicians working in rural and remote districts control access to referrals and modes of care available to local residents. This type of control allows physicians to limit the options of those women wanting to seek alternative types of care or even access to see other physicians should they want a second opinion (Leipert & Reutter, 1998).

- **Marginalized Women**

Certain subgroups of women are particularly vulnerable in isolated settings. These include:

A. lesbian women;
B. women with disabilities;
C. aboriginal women; and,
D. elderly women.

A. Lesbian Women

Lesbian women "have identified fears of homophobia as the central issue in their decision making processes around health care" (Ramsey, 1994; Trippett & Bain, 1993). The fear of being treated negatively is so strong for some lesbians that they consciously choose to present themselves as heterosexual women in health care situations. This can lead to the provision of incomplete and/or inaccurate information, which in turn can lead to negative health outcomes for lesbians because physicians may misdiagnose or improperly treat these women based on false or misleading information (BC Ministry of Health, 1999). For example, a lesbian who is suffering from depression because she is being harassed and discriminated against by others as a result of her sexual preference will go untreated if she chooses not to discuss the situation openly and honestly with her physician. Not treating the depression could have serious consequences, even leading to suicide. In an effort to circumvent disclosure, women who have experienced such discrimination may avoid seeking medical attention altogether, thereby compromising their health and well-being as a consequence (BC Ministry of Health, 1999).

For Aboriginal lesbians, many of who live in rural and remote settings, the social stigma is worse than that faced by non-Aboriginal lesbians. Not only must these women contend with higher levels of poverty, unemployment, and violence, they tend to face extreme ridicule from their own communities if they choose to be open about their sexual orientation (Menheer, 1999). Consequently, as with non-Aboriginal lesbians, Aboriginal lesbians often opt not to disclose their sexual orientation with medical personnel.

"Traditional attitudes about women's roles and threats to guaranteed confidentiality in small communities can contribute to inferior health care for lesbians

leading to inferior health status among lesbian women" (Ramsey, 1994). The health of lesbian women in small rural communities may also be compromised because of the fact that most rural physicians are men (Peloso, 1996). Trippet & Bain (1993) concur, finding that male physicians have been identified as having more negative responses toward lesbian women than their female counterparts who are reported to be more supportive. Leipert & Reutter (1998) report that in isolated areas, the values and priorities of male physicians influence both the practice of female doctors (if there are any) and the attitudes of community nurses.

B. Women With Disabilities

Women with disabilities have unique health care needs that often go unmet. This is especially true for women living in rural and remote communities. Specific issues that need to be addressed include discrimination that results in joblessness, low education achievement, poverty and transportation difficulties (Northern and Rural Health Task Force, 1995). These are compounded in isolated rural and remote settings, because fewer resources are available to dedicate to the special needs of women with disabilities (Leipert & Reutter, 1998). According to Offner et. al., (1992) women with disabilities living in rural or remote settings were found to receive fewer formal or specialized services, travel further in order to obtain health care services, pay a greater proportion of their income on health care services and generally receive poorer quality care than did urban women living with disabilities. BC's Northern and Rural Health Task Force (1995) reported that specialized services such as occupational therapy, speech therapy, diagnostic services, specialized cancer treatments and alcohol and drug addiction treatments are not readily available to rural women. For rural women living with

mobility disabilities, some specialized services are vital to their health and well-being and access is often expensive and time consuming, and consequently not possible for those women of low economic status (Northern and Rural Health Task Force, 1995). Even for those women who have the economic means to afford excess costs, geographical location can be problematic in accessing such specialized services. For instance, harsh winter weathers often cut women off from accessing necessary treatments (Northern and Rural Health Task Force, 1995).

For Aboriginal women living with disabilities, the challenges can be even more difficult because of the extreme isolation of many Aboriginal communities. Aboriginal women with disabilities are also reported to be more susceptible to abuse and violence (Menheer, 1999). Mobility can be especially difficult for Aboriginal women with disabilities because most Aboriginal communities do not accommodate wheelchairs or other means of transportation (Canadian Panel on Violence Against Women, 1993). The consequence for Aboriginal women living with disabilities is often complete isolation, causing these women to live in a state of total dependence on others for assistance (Menheer, 1999).

C. Aboriginal Women

Aboriginal women in Canada continue to rank lowest in health and economic well-being (Statistics Canada, 1995).

From a rural health perspective, the needs of Aboriginal women clearly need to be addressed. Approximately one-third of all Canadian Aboriginal women reside in isolated settings (Canadian Advisory Council on the Status of Women, 1995). As a population, Aboriginal women in British Columbia face:

- higher rates of illiteracy;
- lower levels of academic achievement;
- cultural isolation and discrimination;
- higher incidents of tuberculosis, diabetes and sexually transmitted diseases;
- higher death rates from cancer of the cervix and cirrhosis of the liver;
- higher infant mortality rates;
- higher suicide rates; and,
- a life expectancy of almost eight years less than non-Aboriginal women (Canadian Advisory Council on the Status of Women, 1995; Northern and Rural Health Task Force, 1995).

Health care services are either not available or they are not adequately employed by Aboriginal women. Non-use of existing services by Canadian Aboriginal women is often due to a lack of culturally appropriate care and/or discrimination on the part of health care providers (Sokoloski, 1995).

D. Elderly Women

Whether we are assessing urban or rural environments, elderly women outnumber elderly men – especially among those aged 85 and older (Barnes & Bern-Klug, 1999). This is because women on average live longer than men do (Menheer, 1999). As well, rural areas have much higher rates of poverty than urban areas (Barnes & Bern-Klug, 1999). Combined, these two factors only complicate the health and well-being of elderly women residing in rural and remote communities. There is little doubt that elderly women living in rural and remote areas face barriers to health care access. With age comes more health problems, and geographic isolation prohibits active participation in both primary care services and community-related preventative health services (Barnes, 1997). High levels of poverty among this population limits access to personal transportation and rural areas often do not have adequate public transportation systems to accommodate this marginalized group (Barnes & Bern-Klug, 1999). Although not

defined as an extremely remote location, Cranbrook British Columbia has received criticism from women-serving organizations with respect to transportation matters since it does not have any public transportation system in place. This especially impacts the elderly and the poor — both of which are predominantly women (Dalton, 2000 – Cranbrook Women's Resource Society). Consequently many elderly women live in isolation and loneliness, both of which can lead to negative health outcomes.

An inadequate supply of health care services and providers, geographic distance, poverty and a lack of transportation, all contribute to elderly women experiencing difficulty in accessing and utilizing the health care system (Barnes & Bern-Klug, 1999). This naturally places rural elderly women at risk for inferior health outcomes as compared to their urban counterparts.

2. CAPACITY BUILDING

What Capacity Building Is 'Not'

Capacity building does not mean *weakening* government involvement. It does not mean that governments should abdicate their responsibilities to the people, nor does it mean that government should transfer its responsibilities to non-government organizations (NGO) that are not themselves accountable to those who make use of their services (Eade, 1997).

Capacity building is not a *separate* activity to be done *instead of* supporting or undertaking programs such as health and education (Eade, 1997). Finally, capacity building is not solely concerned with *financial sustainability*. Capacity building should enhance sustainability, but that is not the same as financial self-reliance. We must remember that not all activities can become totally self-funding. There will always be a need for financial assistance for activities such as education and health – two services that no community can operate without funding assistance (Eade, 1997).

What Capacity Building 'Is'

Although there is no one concrete definition for the term capacity building, for the purpose of this project capacity building will be used in accordance with Oxfam's definition. In this context capacity building means…"Strengthening people's capacity to determine their own values and priorities and to organize themselves to act on these" (Eade and Williams, 1995 in Eade 1997).

Most definitions tend to reflect (in some manner) the philosophy of the organization that is utilizing the practice. For instance, Oxfam's definition of capacity

building reflects it's own fundamental belief that, "people have the right to an equitable share in the world's resources, and to be the authors of their own development; and that the denial of such rights is at the heart of poverty and suffering" (Eade, 1997). Oxfam thus views capacity building as an *approach* to development – not as a set of predetermined interventions. However, as Eade (1997) points out, there are basic capacities upon which development depends. These include social, economic, political and practical capacities (Eade, 1997).

Eade discusses four factors related to successful capacity building. Each must be taken into account when entering into capacity building processes. These four factors include:

1. Capacity building can neither be seen nor undertaken in isolation because it is deeply enmeshed in the social, economic and political environment. To not understand this environment is to not recognize who lacks what capacities, why, and why this is significant.

2. Human beings have numerous capacities. These may or may not be recognized by outsiders or by the individual his or herself. To intervene in an effort to assist individuals or community groups without first recognizing the existing capacities is both disrespectful and wasteful. It is wasteful in that it wastes an opportunity to build on valuable existing capacities.

3. Individual capacities and needs and the opportunity to act upon them depend on factors that distinguish human beings from one another and shape social identities, relationships and life experiences. These factors include gender, age, disability, cultural identity and socio-economic status. For capacity building to be both positive and successful, interventions must consider these factors and the manner in which interventions into the community will impact the lives and circumstances of these various individuals or social groups.

4. Although capacity building is about change, it is not 'a one-size fits all' plan for individual or organizational change. Capacity building must therefore be flexible and able to adjust to changing situations while simultaneously maintaining a sense of direction (Eade, 1997).

Some argue that capacity building is simply the newest in a long line of 'fads' that organizers and social planners are now utilizing in an effort to create desired changes. Kretzmann & McKnight (1993) disagree. Compared to the traditional path (performing a needs assessment), Kretzmann & McKnight (1993) view capacity building as more action oriented and therefore as a more positive method for creating change within communities. Kretzmann & McKnight (1993) claim that using the needs assessment approach to create positive change is ineffective because it focuses on the weaknesses and needs of a community and its people, rather than on the community's strengths and assets. For example, "the term's public housing and social welfare invoke imagery of needy, problematic and deficient neighbourhoods populated with needy, problematic and deficient people" (Kretzmann & McKnight, 1993). Although none of us is likely to disagree that such neighbourhoods do in fact have problems, how these problems are addressed, the process, is an important predictor of whether the outcomes will be positive or negative.

From a capacities perspective, it is always recognized that although problems do exist within communities, this is only half of the truth – the other half presents a picture of positive attributes which are present within that community both structurally and individually (Kretzmann & McKnight, 1993).

Another difficulty with concentrating on the needs of a community and its people arises out of the fact that developing solutions while operating from this perspective leads to the likelihood of *deficiency-oriented policies and programs*. When applying this to health policies and programs, such processes may teach people the nature and extent of their problems, with the value of services as the almighty answer to those problems. The

outcome of this is that too often rural and remote (and urban) populations perceive their health status as being dependent upon external forces – such as government and/or local NGO service providers (Kretzmann & McKnight, 1993). Using the needs assessment approach is negative in that it deals with people as though they are clients and *consumers of health* rather than builders of community health services. Those in geographically remote areas tend to view themselves as people with special needs that can only be met by *outsiders*. The result of this is a consumer mentality with no motivation to become producers (Kretzmann & McKnight, 1993).

Powerful communities consist of citizens who are producers (Kretzmann & McKnight, 1993). If the focus remains on individual and structural needs rather than individual and structural assets we are left with a community that views itself and its members as fundamentally deficient – victims who are incapable of taking charge of their own lives and their community's future. This is why Kretzmann & McKnight (1993) reject the needs assessment approach to development in favour of the capacity building approach.

Capacity building leads toward the development of policies and activities based on the capacities, skills, and assets of individuals, organizations and communities. Public funds have become more and more limited resulting in more and more communities realizing that it is simply futile to wait for significant help to arrive from outside of the community (Kretzmann & McKnight, 1993). Development must start from within. Communities that build from within are healthier and more able to sustain themselves because those that participate in building stronger healthier communities also take ownership in maintaining the health and well-being of those communities.

Improving health care services and access to those services in rural and remote areas begins at home. No matter what the situation, where there are people there is an ability to build upon existing resources. People are resources – they simply do not always realize the potential they hold in their very presence. This is the essence of capacity building – focusing on abilities and strengths rather than the needs and weaknesses of a community and its population. The key is to locate all of the available assets and to begin connecting them with one another so that they can multiply their power and effectiveness (Kretzmann & McKnight, 1993). The assets of a community are threefold. They include:

1. Individuals — includes all of the talents and gifts born by each and every individual residing within a community.

2. Citizen Associations — includes informal associations within a community. The capacity of these informal organizations is usually highly underestimated. These associations commonly consist of religious, cultural, athletic and recreational capacities that can be stretched beyond their original purpose and intention and therefore utilized to enhance the well-being of communities.

3. Formal Institutions — includes private businesses and public institutions such as schools, libraries, parks, police and non-profit institutions such as hospitals and social service agencies (Kretzmann & McKnight, 1993).

Clearly it is important to focus on the assets of a community and its citizenry rather than its deficiencies. It is equally important to appreciate that this does not mean that economically poor communities do not need additional external resources. The point is that outside resources will be more effectively utilized when a community and its members are fully mobilized and invested in their community's well-being. We must therefore recognize that although assets are necessary they are not in and of themselves sufficient for creating in-depth change (Kretzmann & McKnight, 1993).

The strongest and most successful communities are those that can identify the gifts of those people within the community that are marginalized. Once the gifts are identified, successful communities are then able to get these people on board with respect to community involvement. Communities that have experienced success in building capacity have two common characteristics:

1. A local group acted as a *connector*. Once capacities are identified, this group connected the people to organizations or informal groups in need of such skill sets.

2. People were mobilized with their existing capacities. Hence, the local group did not begin with the belief that local residents needed to be trained, educated nor treated – they simply started with the belief that all individuals have capacities and the community building task was simply to… (a) identify the capacities, and (b) connect these people with other people, groups and places that could and would utilize these capacities (Kretzmann & McKnight, 1993).

Whether the need be improving health services, health statuses, youth activity or youth participation, the *raw material* for community building is the capacity of its citizens. Living well mentally, economically and spiritually depends upon whether or not capacities can be used, abilities are expressed and gifts given. When individual capacities are utilized people feel valued, powerful and well connected to others within their community. In return, the community will become more powerful because its citizens are contributing to its strength. Strong communities therefore reflect those communities where the capacities of individuals are identified, valued and utilized (Kretzmann & McKnight, 1993).

Finally, Eade and Williams (1994, in Eade 1997) discuss four basic principles for development, which are definitely pertinent to building capacity around health issues for women in rural and remote locations. These principles for development include:

- empowerment;

- risk;
- sustainability; and,
- interdependence.

Empowerment – Women (and men) become empowered by their own efforts and not by what others do for them. When development or new programs are not firmly based on people's own efforts to work for change, the impact may be disempowering (Eade & Williams, 1994 in Eade, 1997).

Risk – Change in never risk-free. Unfortunately, Canadian's — both on an individual and an organizational/institutional level — have become what is commonly referred to as *risk-averse*. People who are risk-averse are fearful of the unknown and thus steer clear of creative and innovative thinking. Capacity building is about change and consequently it is also about taking risks. Women must take risks if they want to create change in their lives and if they want to shape the decisions and processes that affect their lives (Eade & Williams, 1994 in Eade, 1997).

Sustainability - In order to sustain changes, the processes of change must promote equity between men and women and also between women. Change must enhance the ability of women to gain a decent living today and in the future. Sustainability does not simply rely on the individual, but depends upon people's social and economic capacity to endure and overcome pressures on their lives (Eade & Williams, 1994 in Eade, 1997).

Interdependence - No development or change occurs in a vacuum. Impacting the health of women through capacity building will in turn impact the lives and well-being of all others who relate to these women. Therefore, improving health status among women will positively impact not only the lives of the women themselves, but also the lives of their children, their partners, extended family members and ultimately their communities

because healthier women contribute to building healthier communities (Eade & Williams, 1994 in Eade, 1997).

Summary

This literature review is not exhaustive. The information reviewed and discussed did however facilitate me by providing me with the knowledge necessary to construct the *facilitator's guide to capacity building around women's health*.

Reviewing the literature enabled me to more clearly comprehend how rural and remote living can be a factor affecting the health status of rural women. The literature clearly associates rural living and specific factors with decreased health status. Although these factors – violence, reproductive health, poverty, lack of access to mental health services, service access in general and the plight of rural women who are marginalized women – are relevant in impacting the health and well-being of urban women, the literature reviewed here claims that these factors are even more problematic for women residing in geographically isolated areas.

Pilot Project – Tatla Lake, BC

On June 28th 2000 women from the community of Tatla Lake met with myself and a member of the Minister's Advisory Council. Prior to going to Tatla Lake, I established what times would be most appropriate for women in the community to meet to discuss the idea of having a capacity building workshop in their community. As a result of this pre-planning, it was decided that two meeting sessions would occur on the same day. The first meeting was held in mid-afternoon; the second meeting was held in the early evening. These times were deemed to be most appropriate because they would accommodate both working and non-working women. Six women attended the first session and five women attended the latter (this did not include the MAC representative or myself). The purpose of these meetings was twofold:

1. to discuss the concept of capacity building; and,
2. to discuss whether or not the women in the community felt that this was something they wanted for their community.

Once it was decided that this was something that the women living in Tatla wanted and could benefit from, discussion moved to the following specifics:

- selection of an appropriate site to hold the workshop;
- selection of appropriate dates for the community to hold the workshop;
- childcare needs for women with children; and,
- travel costs for women in the surrounding communities.

Women attending the June discussion sessions were asked if they would participate in the survey designed by myself . They were informed of the rationale behind the questionnaire, and that participation was voluntary and anonymous. As well, because Tatla Lake was the pilot site, women were informed that their participation

would assist us with testing the questionnaire. Changes were incorporated after testing the questionnaire in Tatla Lake. These changes included:

- redesigning some of the open-ended questions to reflect a closed format;
- removing certain '*examples'* since these proved to highly bias the responses given by the participants – participants responded to the example instead of the question itself;
- removing several questions entirely because it was apparent from the responses that the questions were not well worded and consequently they were not eliciting the intended information; and,
- adding an ethnic category to section 3.

The final revised version of the questionnaire can be found in Section 5 of the *facilitator's guide*.

Women were also asked for input with respect to distributing the questionnaire in Tatla Lake and outlying communities. The outcome of this discussion — the women attending the June meetings agreed to distribute the questionnaires to other women and to leave some questionnaires in the community's high traffic areas such as the community post office. A total of fifty (50) questionnaires were distributed in Tatla Lake. Each included a stamped addressed envelope to enable women to return the survey at no monetary cost to themselves. As well, it was hoped that this would encourage a high response rate.

Of the 50 questionnaires distributed, 19 were returned to the Bureau – a return rate of 38%. Based on the input of those who participated, I compiled a summary report and all women attending the October workshops received copies of this report.

Workshop participants were informed that the survey findings were not based on scientific research – that the report produced by myself was the result of opinions and views resulting from the experiences of those women who had participated by returning a questionnaire. Although this information did not represent nor reflect the views of all

women in the community, the information was valuable and useful. During the initial stages of the workshop the report was discussed by the facilitator and was useful in bringing to light some of the issues that women residing in the community had reported as relevant. As well, it was found to be a good tool to use as an "ice-breaker" – for getting the women to actively participate in a discussion that was relevant to their immediate lives and community.

The summary of the questionnaire is not included in this paper. The focus of this project was not to perform quantitative analyses of women's views in the community. The focus was one of developing and establishing a process for community-specific capacity building around rural women's health issues and concerns. The idea of the questionnaire was to gather information that would be beneficial in drawing out areas of concern that could then be focused on from a capacity building perspective.

A second advantage of the questionnaire was that it gave women the opportunity to bring to light issues they may have felt uncomfortable bringing forth in a group situation. For instance, some women who participated in the survey discussed their personal feelings about the local nurses sometimes not being very approachable. Another issue was that of addictions and the need for support within the community. Freedom to discuss these matters may have been enhanced by the anonymity of participating in the survey. Once documented, the issues were 'on the table' and thus open for discussion during the workshops if the women so desired.

Finally, it was felt that preparing this report was a means of giving back to the community something tangible and useful for future capacity building workshops around community-specific health concerns.

Outcomes

1. THE PRE-WORKSHOP COMMUNITY CONSULTATION

During the June meetings the following details were discussed and agreed upon:

- The workshop would be held on the weekend of October 13th.
- Two workshops would be held during the same weekend – one during the evening and one during the day. Women could attend one or both days. It was felt that this was the best way to accommodate the needs of all women in the community.
- Workshops would be held in the local non-denominational Church.
- Women from the church would prepare the food for both workshops.
- Childcare subsidies would be available for those women who needed financial assistance in order to attend.
- A workshop facilitator (Cathryn Wellner) would be brought in from Horsefly (a rural sister community). Cathryn's work was well-recognized and respected by many women residing in Tatla Lake and this led to the belief that she would be well received and thus would be a good drawing card for attendance at the workshops.
- The Bureau and the Council would be financially responsible for the costs of food, site rental fees, childcare subsidy costs, and the facilitator's fees.
- Advertising – the facilitator and myself developed a flyer that would be used to advertise the event locally (See Appendix A).
- The facilitator and myself developed a press release to be placed in the William's Lake tribune and the Chilcotin Telegraph (the local Tatla community paper) (see Appendix A).

2. THE WORKSHOPS

The workshops in Tatla Lake were extremely successful. A total of seventy-three (73) women participated in the workshops over the two days. This reached far beyond the expectations of all of those who were involved in the planning processes. Tatla Lake is a small community located in the Chilcotin Valley, which is three hours west of William's Lake. The population in the Chilcotin Valley consists of approximately 400 residents (men and women). When we first visited the community in June, we were advised that getting 30 women to attend (over the course of two days) such an event

would be considered a *success*. Therefore, all those involved felt that the overall participation rate was indicative of success.

The key players involved in the pilot project submitted summaries of the Tatla Lake workshops. The following women submitted reports and comments.

- Rose Soneff - the representative from the Minister's Advisory Council. Rose, a member of the Council's rural and remote subcommittee, worked hand-in hand with myself in planning this workshop. Rose is a resident of William's Lake and consequently she is familiar with Tatla Lake and the surrounding communities in the Cariboo region. Rose provided me with a daily breakdown of events occurring at these workshops. Rose will officially report back to the Council at the next Advisory Council meeting to be held in Vancouver on December 10th and 11th 2000.

- Roma Shaughnessey - the community representative who worked hand-in-hand with myself to plan and prepare for the workshops. Roma is currently the person responsible for all the administrative duties associated with Tatla Lake's nursing station. Roma was my initial contact when I began this project and she was without a doubt the community member who *championed* this project. Without Roma's assistance, hard work and commitment the workshop could not have succeeded to the degree it did.

- Cathryn Wellner - the workshop facilitator. I first met Cathryn on my way back from our initial visit to Tatla Lake. We met in Williams Lake on June 29th to discuss the possibility of her facilitating this event. Cathryn is a professional storyteller and has an extensive background in working with communities. It was at this meeting that her contract was verbally agreed upon. As part of her contract, Cathryn will be providing both the Women's Health Bureau and the Minister's Advisory Council with a formal report on the Tatla Lake workshop/s.

For a detailed look at these summaries please refer to Appendix B.

3. THE WORKSHOP EVALUATIONS

I prepared a two-page evaluation sheet that was used at the Tatla site. This same form will be used at all future capacity building workshops held in conjunction with MAC's rural and remote project (See Appendix C for a sample of feedback from women attending the Tatla Lake workshops).

Feedback by the women participating in the Tatla Lake workshops was positive. Overall, the participants were very satisfied with the process and the outcomes. Many of the women had no prior knowledge about capacity building. There was a real sense among the women that this was a process that not only empowered them as individuals, but also empowered them as a united team. Individually they all had talents and gifts to offer, but when these talents and gifts were united they started to see themselves as a wealth of resources. They came to understand that if their individual resources were *pooled*, they could truly be instrumental in creating positive change for both themselves and their community. The following 'quotes from Roma' sum this up wonderfully:

- "The workshops were an empowering experience for many of the women who for a variety of reasons don't participate in community development projects."
- "I highly recommend this exercise to other communities - there is nothing to lose and so much to be gained."
- "I have gained confidence in myself, and in my community's ability to pursue and achieve the goals that we have talked about and wished for."
- "Capacity building is really an investment that will help a community to grow."

Some suggestions for future workshops included:

- Having a longer period of time for each workshop. To accommodate as many women as possible, the Tatla Lake workshops occurred for four hours on two different days. Women who could only attend one session felt that four hours was not long enough.
- Women who only attended the second day regretted not coming the first day. Although this is hind-sight, the planning committee needs to consider how they can advise women so that future sites can better persuade women to consider both sessions (if two sessions are offered).
- Women really enjoyed having the open-discussion period that occurred during the final hour of the second day. This was so popular that the MAC members attending the workshop suggested that this be incorporated into all future workshops.

Although this feedback must be taken into account for future planning, it is important to remember that each community must organize its workshop/s according to the needs and desires of women residing in that community. For instance, having two workshops on two different days, as was the desire in Tatla Lake, may not even be a factor at another site.

4. FOUR ACTION ITEMS RESULTING FROM THE WORKSHOPS

Four action items resulted from the workshops in Tatla Lake. During the workshop/s each of these items was discussed with some commitment for action.

1) Addictions: Some women brought to light their concern with former addiction issues. They discussed the need for support in order to enable them to continue with their current sober lifestyle. Isolation resulting from living in a rural community was a key stressor in maintaining sobriety.

   The outcome – to build a support group similar to the format of Alcoholics Anonymous. The women do not intend to call their support group by this name.

2) Women's issues: These workshops presented the women of Tatla Lake with an opportunity to meet and talk about issues pertinent to women and women's lives. Such opportunities rarely present themselves in this isolated community and the women felt they would benefit from getting together as a group on a more consistent basis.

   The outcome – the local women plan to have regular meetings/get-togethers to provide support for one another in all areas of women's lives.

3) Seniors: As in urban centres, the population in Tatla Lake is aging. Consequently women are seeking avenues to help keep their older members in the community as long as possible.

The outcome - plans are in place to convert Marie's Place from its current function as a small motel to a care home for the elderly. This will enable older residents to stay within the community for longer periods of time before having to seek long-term medical care in more urbanized centres.

4) Depression. Many women felt that depression was a very real concern due to the isolation experienced by those living in the community.

The outcome – women plan to hold a series of local meetings on the subject. One of the workshop participants was a mental health service provider working in one of the nearby communities. Using her skills as a resource she has offered to give of her time in assisting with the set-up of a support group dealing with these types of issues.

Conclusion

Most of the literature relating to women's health in rural and remote living environments to date is based on quantitative analysis. This provides us with only a partial picture of the experiences of women's health in rural and remote settings. Using qualitative approaches allow for women's own values and perspectives to be heard directly. On this basis, using both forms of analysis in the future will provide more comprehensive and accurate data to inform research, policy, and practice for women's health (Leipert & Reutter, 1998).

Leipert and Reutter (1998) point out that most of the literature focused on health from a rural perspective tends not to be gender-specific. In those studies where gender is considered, women are usually addressed as a small subcategory. Women are not one monolithic group and feminist writers repeatedly point this out. Women from marginalized groups do not perceive their circumstances through the same lens as women from more privileged populations. Few studies focus specifically on subpopulations of rural women and consequently this paints a skewed picture for those attempting to create policy. Policy based on the premise that women as a population are one homogeneous group will not be reflective of the reality of women's lives. For instance, to not look at Aboriginal women as a separate subpopulation is to ignore the reality that differences do exist between groups of women. Aboriginal women represent one subpopulation of women living in vastly remote locations throughout rural Canada.

According to Weinert and Burman (1994), the current literature is lacking in that "targeted, coordinated and in-depth research on various aspects of women's health does not exist in Canada or in the United States." Furthermore, the literature does not

sufficiently recognize the importance of the social determinants of health (Weinert and Burman, 1994). This is particularly important when discussing women's health because women are more likely to be negatively impacted when we look at the social determinants of health. For example, economic status is a social determinant of health and well-being and although women's economic status is generally lower than that of men, rural women have even less access to economic opportunities. Therefore, because the ability of rural women to make an independent living is often highly impacted due to isolation and lack of employment opportunities, so too is it likely that their health status is negatively impacted.

Finally, there is fragmented knowledge around rural women's health because there are numerous disciplines looking at different aspects of women's health without pooling the outcomes of these studies. Although this may result in an increase in the overall knowledge about rural health issues, Leipert & Reutter (1998) argue that coordinated access to this literature remains problematic. In order for positive changes to occur, the information gained from research in this area – regardless of which discipline has collected it – has to be pooled so that future health policy will be based upon comprehensive and not fragmented analysis.

Improving health care services and access to those services in rural and remote areas begins at home. Capacity building is about communities taking action in their own development and this is accomplished by tapping into their wealth of existing individual and organizational resources.

No matter what the situation, where there are people there is an ability to build upon existing resources. People are resources – they simply do not always realize the

potential they hold in their very presence. This is the essence of capacity building – focusing on abilities and strengths rather than the needs and weaknesses of a community and its population. The key is to locate all of the available assets and to begin connecting them with one another so that they can multiply their power and effectiveness (Kretzmann & McKnight, 1993).

Change comes from challenging what is. If rural women want change to take place with respect to women's health issues and health concerns, not only must they have a voice, they must also be willing to take action. Taking action means becoming participants in their own health care. Capacity building is about acting on one's own behalf – individually and collectively. Rural communities and women residing in these communities cannot expect others to service all their health care needs. Using capacity building approaches around women's health issues and concerns will empower women living in small rural and isolated communities to take action on their own behalf. Taking part in capacity building workshops will give women in their communities a voice, an opportunity to be heard and a chance to participate in actively creating change for the betterment of their own health and well-being.

The *Facilitator's Guide to Capacity Building* is a resource guide designed for women residing in rural and remote locations of British Columbia. This document is a valuable tool that can be utilized by rural women to enhance their ability to build capacity around women's health issues and concerns that are specific to their lives and their communities. Once women establish capacity building skills, they can use this guide for all kinds of community development – not simply health issues and concerns.

Developing this Guide has not only led to the development of a user friendly

capacity building resource for women living in rural and remote parts of the province, it has enriched the knowledge base of all those involved in its construction. Myself, the staff at the Women's Health Bureau, members of the Minister's Advisory Council and all those women in Tatla Lake who participated in the pilot project now have a greater understanding of what capacity building is, and more importantly, how to build capacity within their own communities.

Lessons Learned

Much was gained through the process of developing and carrying out the initial workshops held in Tatla Lake. It was recognized that workshop success was highly dependent on two factors. First, it was critical that myself as the project manager connected with someone in the community that was willing to *champion* the event. In Tatla Lake this was Roma Shaughnessey. Roma was a key factor in the successful outcomes. Secondly, all those involved in the pilot project unanimously agree that holding the pre-workshop consultation session with women residing in Tatla Lake was paramount in building the required positive rapport between the community women, the Women's Health Bureau and the Minister's Advisory Council. Once this positive connection was established between the parties involved, it was possible to move forward and build successful capacity building workshops in Tatla Lake. With this new gained knowledge the Council and the Women's Health Bureau can move forward in their efforts to assist rural women in developing capacity building skills that will lead to the development of healthier women and thus healthier communities.

Steps have already been taken to establish the second workshop that is to take place on the northern part of Vancouver Island. Women representing five communities

are set to meet for community consultation on November 29, 2000. It is the Council's intent to hold the North Island workshop early in the New Year (2001). During the December 2000 MAC meeting, further workshop sites will be named by MAC's Rural and Remote subcommittee.

Tatla Lake was but the first step in this rural and remote project. The Minister's Advisory Council, in conjunction with the Women's Health Bureau, intends to hold several capacity building workshops throughout 2001 in various rural/remote communities. When all workshops have been completed, the Bureau and the Minister's Advisory Council plan to do a comparison analysis of women's views from the various participating communities. Upon completion of this project, the Minister's Advisory Council will formally present its findings and any corresponding recommendations to the Northern and Rural Health Task Force who in turn will present their thoughts to the Minister of Health. It is the desire of the Minister's Advisory Council that, where appropriate, policy changes relating to women's health in rural and remote BC will be addressed.

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APPENDIX B

Subject: Success!

Date: Thurs. 19 Oct 2000 23:05:21 –0700

From: Roma Shaughnessy <tatlako@coyote.chilcotin.bc.ca>

To: Heather Hoult <heather.hoult@moh.hnet.bc.ca>,
Rose Soneff <rsoneff@telus.net>,
Anne Speer <anne.speer@moh.hnet.bc.ca>,

Hi Everyone!

I want to thank every one of you for making the capacity building workshop in Tatla Lake such a success! It's hard to believe a week has already gone by - and I am still wired!

I have heard lots of very positive comments from all of the women that attended - "When can we do this again?" was said many times during and after the workshop. I think the workshop was an empowering experience for many of the women who, for a variety of reasons, don't participate in community development projects. The development of the community inventory will identify tools that women can access that will help them to participate and make a difference - assistance with childcare, computer skills, transportation etc. The registration numbers were amazing, and I was so pleased to see women drawn into the group that we usually would never see at such a gathering. I could ramble on and on - I'm still sorting out all the information and feelings that are swirling about in my head from the workshop.

It looks like we will first be focusing our energy on the development of a "senior's care home". There will undoubtedly be lots of support from the community for that.
An inventory "team" will be collating all the information gathered on the community resource map into a database, and I know we will gather more information to add to the inventory. We will distribute that inventory in different formats and areas to make it accessible to as many people as possible.
After that - the sky's the limit!

Well, I must say Heather, I am so glad that you chose Tatla Lake for the first capacity building workshop! When you first contacted me I didn't have the foggiest idea of what capacity building was, but I certainly do now. I highly recommend this exercise to other communities - there's nothing to lose and so much to be gained. It's really an investment that will help a community to grow.

The workshop was over after a few hours on one weekend, but it was really just the beginning of a future full of possibilities for our community. I have gained confidence in myself, and in my community's ability, to pursue and achieve the goals that we have talked about and wished for.

It was my pleasure to help with some of the organizing. Thanks to all of you for sharing your knowledge, wisdom, advice, encouragement, and support. It is very much appreciated.

All the best to you all,
Roma

Subject: Tatla Lake Capacity Building Report

Date: Tue. 17 Oct 2000 19:50:39 -0700

From: Rose Soneff <rsoneff@telus.net>

To: Anne Speer <anne.speer@moh.hnet.bc.ca>,
Effie Henry <effie.henry@moh.hnet.bc.ca>,
Linda Breault <lbro@direct.ca>,
Kelly Finlayson <kfinlayson@telus.net>,
Julie Morrison <Jamorris@netidea.com>,
Rita Bowry <deeva@pris.bc.ca>

CC: Cathryn Wellner <cwellner@grassrootsgroup.com>,
Heather Hoult <heather.hoult@moh.hnet.bc.ca>

I am embedding the report within this email for those who cannot read attachments. I have also added Rita, since she is not formally on this committee, because of her location, and possible involvement in future Rural and Remote workshops. Some of the comments here, were from Cathryn too.

Preamble:

As reported at the breakfast meeting for the Rural and Remote Committee at MAC, Healther Hoult and I went to Tatla in June to accomplish three things:
1) verify a need for a capacity building workshop with local women and possible dates;
2) create a planning group; and,
3) circulate 50 surveys regarding women's health issues in the Tatla area.

- At first, we felt that this step was only necessary in the pilot site (Tatla) but both Heather and I would recommend that this is a crucial step in the success of future workshops creating buy-in and on-site assistance.

- The format of the pre-workshop site visit included background discussions on MAC, followed by a feminist circle discussion - using our MAC stone. Some rural and remote issues were discussed, an explanation of Capacity Building took place, and circulation of the survey and the rationale for doing the survey. Finally we discussed the need for a local planning committee to assist with the future workshop.

- I informed the Cariboo Chilcotin Health Council and the Cariboo Health Services Society about our June visit and our intent to hold a workshop in October 2000. We wanted to ensure that we would not be repeating or overlapping with any of the health authority plans.

- 19 survey results were returned and a comprehensive report was done by Heather. The planning committee, in essence, was one person, and that was Roma Shaughnessy. Roma is the current administrative assistant at the Tatla Lake nursing station.

- During the summer, Heather also worked on a generic facilitator's guide and a workbook that could be left in the community and used in other workshops. Cathryn and I provided some feedback to Heather on the Guide.

- In September Tatla was undergoing a lot of stress as their two nurse practitioners were threatening to leave Tatla Lake because of a lower classification of their position that had been moved from federal to provincial jurisdiction. One nurse has left, and another local RN has been hired and her skills have been upgraded.

- Cathryn Wellner, the workshop facilitator, developed the flyer and the news release with input from Heather Hoult and myself.

- Roma circulated the flyer to all the women in the Tatla area. She also forwarded it to her contacts in Alexis Creek and Anahim Lake for posting in those areas

.

- The news release was published in the Williams Lake Tribune and the Chilcotin Telegraph.

- I invited a female member of the Health Council, Jan Banyard, and the Health Services Society, Cyndi Cassidy, from Wells, to join us. I also invited a woman from Horsefly whom I thought would repeat a similar session in her community. I received two enquiries from Anne Burrill (she presented at MAC) to attend and promote the women's network, and Audrey MacLise, a member of the Provincial Senior's Advisory Council, the Diabetes Association, and the Alzheimer's support group. The latter two had to cancel at the last moment and were unable to attend.

- Roma personally called women in the Tatla area prior to the event when she felt the numbers were still low. As a result, we had <u>36 participants</u> on Friday night and <u>37 Saturday</u>. **Total = 73**

Friday, October 13th (5:00 – 9:00 pm)

5:00 - 5:20, women started arriving. We had 36 women Friday. No First Nations women, 1 woman from Anahim Lake, 1 woman from Nimpo, 1 woman from Puntzi.

5:20 - 5:30, Cathryn told a story about a little brown hen and her ability to overcome obstacles.

5:40 - 5:50, Rose explained how the workshop in Tatla evolved, starting from the MAC's rural and remote committee suggesting the concept of doing capacity building workshops, our hopes to be able to promote this process to the R& R Task Force, my contacts suggesting Tatla as a good pilot site, and finally the June visit and the survey.

5:50 - 6:15, We circled and each woman provided a reason, or anecdote, as to why she wanted to live and stay in a rural and remote area.

6:15 - 6:30, We had posted a map of the Tatla area and of BC. Cathryn had provided small pieces of paper depicting different symbols. She explained that we each had gifts that could help one another, and that the exercise was for women to write down their name, contact number, and resource(s) that they could provide to the community. I provided an example of my nutritional skills and put myself on the map for Williams Lake.

6:30 - 7:20, dinner, during which time people continued to put pieces of paper onto the map and also read the map. The socializing and networking was tremendous.

7:20 - 8:00, I explained that "health" meant more than the absence of disease and that the social determinants of health were just as important. We circled again and each woman told about her slip of paper. It was interesting to note, that many women felt they had little to offer and that other women in the group immediately pointed out their skills and talents, (e.g., open-door policy, great baking skills, gardening expertise). This was an illustration of resources but also an affirmation and acknowledgement of their talents. It was an excellent networking exercise, especially for newcomers to the community. At one point, criticisms started regarding the hospital and Cathryn quickly averted this and suggested action items to be forwarded through Jan Banyard CCCHC, attending the session. It was critical to stay in the solution and not get side-tracked with the negative nor with things that they could not change.

8:00 - 8:10, Cathryn explained the results of the survey and emphasized that these may not necessarily reflect the thoughts of those women attending that evening.

8:10 - 8:50, The next exercise assigned women into four groups to identify an issue they felt was important for local women, discuss the causes (social, environmental, physical), the organizations/or people that could have an impact, and potential actions that could be undertaken. Four threads came out of the first session, each with some commitment for action:

1) addictions (intention to start an AA group),
2) women's issues (plans to have regular meetings, to provide support),
3) seniors (plans for keeping them in the community - some links were made that should move that forward),
4) depression (brainstorming resources and actions to address a widespread problem exacerbated by isolation).

8:50 - 9:10, Each group reported on their issue and planned action.

Questions arose regarding the format for the following day. We stated that it would be similar, and as a result, may have lost many women who decided they may not benefit from the process. Women completed the evaluation form and were provided with a gift for attending. Only one participant requested travel assistance ($10 travel assistance) and no childcare subsidy requests were made.

Saturday, Oct. 14th 10:00am-2:00pm

8:00 am to 9:00, over breakfast, we had discussed problems and format changes. These included…strategies to make women attending for the first time (Saturday), strategies to gain commitment for the action plan. Format changes included increasing the length of the workshop time since it was difficult to start on time at the beginning of the workshop as well as after the meal.

10:00 - 10:15, 37 women attended. No First Nations, 2 different women from Anahim Lake, the same women from Nimpo and Puntzi came.

We followed a similar format the following day. Our intent was to elaborate on the action plan for each issue and have the new women work on another action plan. They introduced themselves, followed by the resource identification and circling again. Representatives from each of group explained what they had done on the issue.

We broke for lunch.

So many of the women came to both sessions that we ended up spending the last hour on Saturday letting them bring up whatever was one their minds – at their request. There are such few times that these women are able to get together and discuss women's issues with one another that they seemed to thoroughly enjoy the moment. This unplanned open-discussion format was very popular and should be incorporated into the future workshops.

We ended with a song from Cathryn, completion of the evaluation and gifts were distributed to all the women. One woman took it upon herself to organize the development of a resource guide from all the completed slips that had been tagged onto the map.

Conclusion:

- The major population missing was that of First Nations women. Anyone who has ever tried hard to integrate the two communities for events such as this has experienced the same frustration, which is always accompanied by that nagging sense of "if only..." We have to keep looking for ways to make it happen.

- One interesting note was the number of women who asked when they could do this again (any time - they have only to get together) and the women who came only on Saturday who said they wished they'd come to both sessions. There's no cut-and-dried solution for that. Some of the women who came Saturday would probably not have come at all had they had to commit to both days initially. On the other hand, having a mixture of women from the first session (who'd already formed a unit) and women who just attended the second session – made Saturday more of a challenge from the facilitator's perspective.

- Since the workshops, I have run into Allison Ruault and extolled the success of the weekend. I informed her that she may be getting Community Grant applications for further sessions elsewhere.

- Paula Kully has already asked me for details regarding the Community Grant funding. Audrey MacLise phoned and I explained that one of the issues was elder care and I had given her name as a resource, so she should expect calls regarding this matter.

Thanks everyone…High hopes for future workshops in the Cariboo.!!!

Rose

Re: Tatla Report

Date: Sun. 22 Oct 2000 11:46:06 –0700

From: Cathryn Wellner <cwellner@grassrootsgroup.com>

To: Rose Soneff <rsoneff@telus.net>,
Anne Speer <anne.speer@moh.hnet.bc.ca>,
Effie Henry <effie.henry@moh.hnet.bc.ca>,
Linda Breault <lbro@direct.ca>,
Kelly Finlayson <kfinlayson@telus.net>,
Julie Morrison <Jamorris@netidea.com>,
Rita Bowry <deeva@pris.bc.ca>

CC: Heather Hoult <heather.hoult@moh.hnet.bc.ca>

You've done your usual thorough and prompt job, Rose, with the report from the Tatla workshops. I'd like to add a few comments to yours:

There's no doubt that Heather's and Rose's advance work played a major role in the success of the capacity building workshop. They not only traveled to Tatla but kept in touch in the intervening months. That created interest and encouraged the local organizers, primarily Roma, to do considerable advance work. By the time we arrived in the community in October, the women were looking forward to participating.

Heather did an excellent job on the guide and was very receptive to **suggestions. Even an inexperienced facilitator would find it an easy workbook to use.**

Rose's thoughts to invite a female member of the Health Council and the Health Services Society, to join us **was a very smart move and should be encouraged for any such future workshops. Including reps from regional health authorities meant that Tatla women now have people they can turn to with health issues that fall within those jurisdictions.**

Roma personally called women in the Tatla area prior to the event when she felt the numbers were still low. As a result, we had 36 participants on Friday night, including ourselves, and 37 the following day, registered.

Receiving a call and an invite from someone well known and respected in the community made a big difference, in part because it reiterated the message that this was to be about local approaches to health.

Rose talked about the four threads (outcomes) coming out of the first session - each with some commitment for action:

It was interesting to note that all four of the threads had a clear link to isolation. While the women articulated their love for the area very clearly, they also acknowledged that geographical and social isolation take a heavy toll on them. The actions they propose show a willingness to find ways to support each other and those in the community whose health is directly affected by isolation-related factors. They can't overcome geography, but they can make things better for each other.

Rose spoke of how many of the women came to both sessions and thus we ended up spending the last hour on Saturday letting the women discuss whatever was one their minds. This unplanned for discussion was very popular.

Being flexible and responsive to the particular group will be important in any of the proposed workshops. Women living in wilderness communities (the term the Tatla woman used) have few opportunities to get together and just talk about things that weigh heavily on their minds.

One thing Rose didn't mention is the wonderful lunch she prepared for the six of us who drove out together.

Thanks!

Cathryn