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In From the Margins: Forum Reflections Report

A Working Forum for Health, Literacy and Early Childhood Professionals

Vancouver, British Columbia

March 2-3, 2009

By the Adult Working Group, Health and Learning Knowledge Centre (HLKC), in collaboration with the Early Childhood Work Group, HLKC and the Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals Work Group, HLKC

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It is issued by the Health and Learning Knowledge Centre as a basis for further knowledge exchange. The opinions and conclusions expressed in the document are, however, those of the contributing authors and do not necessarily reflect the views of the Health and Learning Knowledge Centre's working groups or members.

The Canadian Council on Learning (CCL) is an independent, non-profit corporation that promotes and supports research to improve all aspects of learning—across the country and across all walks of life. The Health and Learning Knowledge Centre was one of five knowledge centres established in various learning domains by the Canadian Council on Learning. The HLKC coordinated and organized its work according to both the life stages and settings through the work of 14 working groups. The Health and Learning Knowledge Centre was located in the Faculty of Education at the University of Victoria.[1]

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[1] The work of the HLKC terminated in July 2009 when its contract term ended.

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Adult Working Group, HLKC
Early Childhood Working Group, HLKC
Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals Work Group, HLKC [Capacity Building in Health Literacy for Health Professionals, CBHLHP]

I. Introduction

A. Purpose of the Report

This report provides a detailed account and analysis of the results of the forum *In From the Margins: Promising Practices and Possibilities for Health and Learning* held in Richmond, British Columbia, on March 2 and 3, 2009.

The purpose of the report is to build on the momentum and energy of the forum to inform others of the dialogue that took place and the key themes within that dialogue. These kinds of meetings create a great deal of synergy and then people attending the meetings go back home. We wanted to ensure that the synergy that was created at the forum lives on in this report. This report can be a resource to inform other organizations that are interested in working across sectors to address the health of adults and their families from marginalized groups. The report also focuses on how adult education can play a role in the learning of all stakeholders— health care, literacy and early childhood professionals, other service providers, policy makers, academics and adults on the margins and their families.

A companion piece to this report is the document, *In From the Margins: Promising Practices and Possibilities From a Working Forum for Health, Literacy and Early Childhood Professionals.* This document includes more than 30 promising practices submitted and approved by delegates who attended the two-day forum. To obtain an electronic copy of this document, contact Wendy Kraglund-Gauthier at wkraglun@stfx.ca. The document is also available on the Canadian Council on Learning website at: www.ccl-cca.ca/healthandlearning
In addition, a clear language document was prepared on the Social Determinants of Health (SDOH). This document can be found in Appendix C of this report.

B. Rationale for Collaboration among Three HLKC Working Groups

The forum was planned and carried out by three working groups of the Health and Learning Knowledge Centre (HLKC):[2]

- Adult Working Group (AWG)
- Early Childhood Working Group (ECWG)

[2] See Appendix A for a description of the working groups.

- Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals Work Group, HLKC (Capacity Building in Health Literacy for Health Professionals, CBHLHP)

In the course of sharing information at annual HLKC meetings, it became evident that the three HLKC working groups that ultimately lead the forum had much in common. All three groups had conducted consultations with their target groups in order to identify health and learning issues, concerns, gaps, and needs:

- The AWG conducted pan-Canadian consultations with adults with literacy challenges, adults living with HIV/AIDS, immigrants and refugees, adults living in rural and remote areas, and service providers who work with these groups.

- The ECWG's pan-Canadian consultations involved parents (including parents who have children with disabilities), early childhood educators (ECEs), ECE faculty and students, and health professionals.

- The CBHLHP worked on building capacity around health literacy and patient self-management for health professionals. As part of its work, the CBHLHP conducted consultations with health care professionals, patients and others.

All three working groups noted that there were similarities amongst their findings around barriers and gaps with respect to the social determinants of health. All three working groups were interested in moving beyond consultations and reports. All three sought to bring people together to discuss and act on the barriers and gaps they had found in their consultations and to work towards positive change.

The three working groups had not worked together on a project before and most members did not know each other. As the working groups began their work together to develop a concept paper for the forum, they found that there was much common ground across the groups—even through they had different terminologies to work with, differing constituencies, and varied ideas about health and learning. The most common bond across the groups was the importance of working together to address the social determinants of health. As they developed the concept paper for the forum, they saw that common interests around health and learning could be mirrored by bringing different sectors together to talk about how to take action on health and learning.

There would be much to gain from bringing different sectors together. The hope was also that the kind of collaboration that took place at the forum would then be mirrored by providers when they went back to working in the field.

These three HLKC groups saw the strength and value in bringing their collective experience together and in creating greater cross-fertilization.

C. Planning the Forum

The forum was planned by a pan-Canadian steering committee of representatives from the three working groups of the HLKC and led by the Adult Working Group. An advisory committee with members from the HLKC and HLKC working groups, the Adult Learning Knowledge Centre (AdLKC) and the Canadian Council on Learning (CCL) provided advice to the steering committee. Dr. Marina Niks acted as an advisor to the steering committee on the forum concept and design.[3]

The steering committee met regularly, mostly by teleconference, between July 2008 and March 2009. The advisory committee joined the steering committee at key junctures over the course of the planning phase.

i. Initial planning stages: June to September 2008

Representatives from the three working groups spent the summer of 2008 getting to know each other and the work of each other's group. They worked together on a forum concept paper that identified and articulated a common vision for the forum among the three working groups. The concept paper that resulted focused on the idea that issues of health and learning are complex; they overlap across many constituencies, and encompass many social determinants of health.[4]

All three groups heard throughout their consultations that the health of children, adults and families are affected by social barriers and are often dependent on the relationship with health professionals and providers in various settings. The working groups also heard that these health professionals and providers are not always aware of health and learning issues and how to address social barriers. Even when social determinants and health literacy issues are identified, little action is taken. The vision for the forum was that relevant stakeholders (policy makers,

[3] See Appendix B for list of forum steering committee and advisory committee members.
[4] See Appendix C for terms related to the social determinants of health.

members of the target groups, health care and other providers, academics, researchers, and others would come together to plan for action to addresses barriers identified by the three working groups.

The concept paper identified forum objectives, the target audience for the forum, initial ideas about format, and the need for further partnerships to off-set the shortfall in funds needed for the forum.

With the AWG leading the project, each working group contributed in-kind and financial resources; however, in order to ensure a pan-Canadian representation, further funding was needed to sponsor delegates.

The forum concept paper was revised many times as the working groups refined the focus of the forum. One of the major decisions of the steering committee was to narrow the scope of the forum to promising practices related to health and learning. Another decision was to focus on providers and practitioners as the main target group to attend the forum. Initially the steering committee wanted to have members from target populations attending as well. In the end, this was beyond the scope of the project given the resources that would be needed to plan and prepare for members of different communities to participate equitably. By giving the forum a more manageable focus with clear outcomes within the resources that the groups had available, the purposes of the forum became more practical in nature, with the possibility of resource sharing and cross-sectoral networking. The group also felt that the forum could have the most impact by focusing on practitioners and providers as its invited audience.

ii. Planning the forum: September to March 2009

In the fall of 2008, the three working groups officially became the forum steering committee. The steering committee invited an advisory committee to help out with representation from the HLKC and the CCL. They also developed terms of reference. At that time, the Adult Learning Knowledge Centre (AdLKC) also came on board as a partner and a contributing funder.

The steering committee hired Dr. Marina Niks as an advisor to the committee. Dr. Niks' role was to advise on all aspects of the forum, in particular the forum design and process issues relating to delegate selection. The forum organizers recognized that many of the people receiving invitations would need support in order to attend the forum. Potential delegates could also apply for a travel subsidy.

During the fall of 2008, the steering committee secured a forum venue in Richmond, British Columbia. The group finalized the forum goals and outcomes and developed the forum invitation.[5]

One of the key planning tasks of the steering committee was to develop a selection process and a travel subsidy process. The three working groups were each responsible for inviting an equal number of delegates from their own constituencies. There was also room to invite common delegates as well as CCL and AdLKC delegates. Each group selected its own delegates and brought their lists to the steering committee for review.

As part of the invitation and registration procedure, potential delegates were asked to submit a promising practice that they had used successfully to address barriers around health and learning in their work. The rationale for having delegates submit a promising practice was to reinforce the forum's intent to address barriers and further promising practices.

Along with other final details, the Steering Committee made final arrangements for an opening prayer and welcome to the territory from a member of the Musqueam Band Council. As well, the committee made final arrangements for guest speakers, panels, note-takers and catering.

II. Forum Overview

A. Forum Goal

The objective of the forum was to bring together health care, literacy and early childhood professionals, and others to not only identify issues, but also to share and further develop promising practices and possibilities for health and learning.

These promising practices were one major intended outcome to address the many health and learning barriers that marginalized adults and their families face every day.

[5] See Appendix D for the forum invitation.

B. Key Forum Objectives

- To hold a joint forum using the consultation findings from three of the Health and Learning Knowledge Centre's (HLKC) working groups (Adult, Early Childhood, and the Capacity Building in Health Literacy for Health Professionals Work Group) to find common ground for action on issues of health and learning among a wide range of professionals.
- To name and verify common barriers to health, health and learning, and access to quality health care services and information.
- To identify promising practices and emerging practical solutions that focus on addressing the identified barriers to health and learning.
- To compile, publish and disseminate promising practices and practical solutions including online access for health care professionals and other stakeholders through a variety of web portals and sites.

C. Expected Outcomes

- Findings from the three HLKC working groups will be shared among delegates and confirmed.
- Forum delegates will have a better understanding of how adults and their families who are marginalized face multiple barriers in accessing health information and services.
- Forum delegates will have opportunities to recommend emerging solutions and innovative promising practices to overcome barriers in accessing health information and services.
- A wide range of professionals and others will have access to emerging good practices regarding delivery of services to better address the needs of adults and their families who are marginalized.
- Participants will have the opportunity to discuss ways they can sustain and build an ongoing network to continue the sharing of ideas, resources, issues and possibilities.

D. Forum Format

March 2, 2009: Evening dinner and networking session with a panel presentation from members of selected community groups.

March 3, 2009: A mix of small group and large group working sessions to acknowledge and confirm barriers and then move on to action and promising practices; panel presentation from representatives of each of the HLKC working groups.

E. Selection of Forum Delegates[6]

The steering committee worked with the advisory committee to devise an inclusive process for choosing delegates to invite to the forum. The intention of the steering committee was to invite a wide range of delegates from across the country that the three working groups had worked with on their consultations and projects. Attention would be paid to delegates: (a) from both urban and rural locations across Canada, (b) from a range of sectors working in health, (c) with cultural and racial diversity, (d) with promising practices to share, and be (e) leaders who could act as change agents after the forum. At the same time, the forum organizers expected there would be a large contingent of delegates from the Vancouver area. At all times the forum organizers attempted to balance the need to be inclusive with the reality of the financial resources they had for the forum.

The target number of delegates for the forum was 50. The target group was health care, early childhood, literacy and other-community based professionals, and service providers. Other invitees would be people in positions of authority who contribute to policy. Each of the working groups had approximately 15 spots for the forum. Potential delegates were chosen carefully to have the widest representation within each group according to the criteria that had been set. Working groups had to justify their selections to the steering committee as to why the names they put forward would make a contribution to the forum.

Early in the planning process, the steering committee members began developing a chart called "Who are our Service Providers?" The intention was to list all the service providers whose work included health under each of the three working groups. The same names that appeared across the groups were noted. This chart provided the basis for developing a more complex grid to

[6] See Appendix E for a list of forum delegates.

determine who each working group would invite along with delegates that the CCL, AdLKC and other advisory committee members would recommend.

Names of potential delegates were plotted in a grid according to role, region of the country and working group. The grid made it easy to see where the overlaps and the gaps were. The grid became a critical working document for the steering committee to ascertain where they were in reaching their goal of inclusivity as well as sound financial management with respect to delegates.

Based on this selection process, the forum organizers sent invitations to practitioners, providers, academics, and others whom they had worked with, with a proven interest in health and learning and experience working with marginalized adults and their families. Potential participants were asked to submit one promising practice as part of their application. These promising practices were distributed in draft form at the forum. The final document, *In from the Margins": Promising Practices and Possibilities From a Working Forum for Health, Literacy and Early Childhood Professionals,* with over 30 promising practices can be obtained electronically on the Adult Working Group's website at www.stfx.ca/events/bcforum and on the Canadian Council on Learning's website at: www.ccl-cca.ca/healthandlearning

The forum organizers recognized that many of the people receiving invitations would need support in order to attend the forum. Potential delegates could apply for a travel subsidy. The travel subsidy included transportation to and accommodation at the forum. Delegates were asked to cover the costs of their own meals and taxis.

Fifty-five forum delegates came from across British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick and Nova Scotia. There was representation from literacy organizations, HIV/AIDS and immigrant service organizations, early childhood groups, and seniors, health professionals, government members and academics. Delegates represented a range of diverse communities including First Nations, Francophones and "Other Voices." The forum was held in English.

III. Forum Summary[7]

A. Summary of the Evening Session on March 2, 2009

The purpose of the evening session was to set the context for the forum and provide an opportunity for delegates to get to know one another.

i. Welcome and introductions

The evening began with an opening prayer and welcome to the territory from Elder Mary Charles, a member of the Musqueam Band Council. Her prayer was followed with a buffet dinner.

Nadine Valk, forum chair, formally opened the forum and provided delegates with an overview of the activities they could expect over the evening and following day.

Irving Rootman, HLKC, and Kathleen Flanagan, AdLKC, welcomed participants to the forum. Both speakers provided an overview of their respective knowledge centres. They discussed the significance of the forum and what they hoped might be achieved at this gathering.

This welcome was followed by a presentation from Allan Quigley, co-chair of the AWG, who spoke about how the three working groups got together, their consultations, and how the idea for the forum came about. He emphasized the need to move beyond challenges to develop new promising practices across groups and address social determinants of health. He spoke about the need to learn from one another and share knowledge on ways to address health issues with the goal of taking action.

Allan noted he hoped that as a group, forum delegates could build a new network to continue the dialogue through, perhaps, an electronic portal. He indicated that on the following day he would be asking people how they can contribute to this network and introduced the possibility of an ongoing electronic dialogue and resource base.

[7] See Appendix F for the detailed forum agenda.

ii. Ice breaker

The forum chair had delegates organize themselves in groups three times: by location, by role, and by the number of years in their present kind of work. They met as many people as they could in each grouping. The purpose of the activity was to provide an opportunity for delegates to meet each other and set the stage for work across and within sectors the following day.

iii. Panel presentation: What do we need to have good health?

Perspectives from the community

Moderator:	Nadine Valk, Forum Chair
Betsy Alkenbrack:	Instructor, Department of Community Development and Outreach, Capilano University
Barbara Smith:	Other Voices Working Group, HLKC
Angel Sampson:	Manager, Songhees First Nation Early Childhood Education Centre
Baijayanta Mukhopadhyay:	Medical student, McGill University

Each panellist spoke about barriers to health, health information, and health services for the clients they work with. They also addressed what practices are working well to address barriers, and what still needs to be done.

iv. Panellists' presentations

Betsy Alkenbrack works in Downtown Eastside Vancouver in a community organization called WISH, a drop-in centre for women in the sex trade. She indicated that although literacy is an issue for the women she works with, the barriers go well beyond that. She spoke about the stigma, labelling and lack of respect that her client group faces, along with the assumptions that are made when people hear they are from the Downtown Eastside. Betsy indicated that fear of male doctors, lack of resources to get services, and a lack of transportation were also barriers to accessing health services.

One practice that is working well is a women's night at a downtown clinic that includes dinner, crafts, music and health care. Having street nurses is a strategy that is also working well. They do house calls when no one else does. A central theme in the work of WISH is making connections with people, rebuilding feelings of belonging, and knowing there is someone who cares. Papalooza—where the women are encouraged to get pap smears has also been

successful. The focus of their work is also on making connections and strengthening relationships.

Barbara Smith spoke about her work coordinating a Foetal Alcohol Spectrum Disorder (FASD) taskforce which connects seven communities across BC. In this work, they share promising practices from successful initiatives that involve sex workers, their children and those with FASD. Similar to the previous speaker, Barbara noted the main barriers that women in the sex trade experience are stigma and isolation. In her work with FASD, women from the sex trade are hired as coordinators to work in communities to help other women connect with services. She noted the coordinators experienced stigma and isolation in this work and were often not welcome at community meetings. She questioned how to genuinely include these women so that they do not feel excluded or invited out of tokenism. Barbara emphasized the importance of conducting consultations on people's own turf and hiring women from the sex trade.

In terms of promising practices, Barbara talked about the Prostitutes Empowerment Education and Recovery Society (PEERS). PEERS is an organization of sex trade workers *for* sex trade workers that provides support, resources, and programs for past and current sex workers as well as help with housing, training and volunteering opportunities, advocacy and public education.

Barbara spoke about three factors that make PEERS work. First, there is a connection with like-minded people. This is important because trust is critical. Second, finding meaning and having a sense of belonging is important or people may fall back into their old lifestyle. A third piece has to do with altruism—wanting to give back what they got for themselves. Barbara concluded with the comment that we need to figure out how practice can influence policy in a timely fashion.

Angel Sampson is the manager of the Songhees First Nation Early Childhood Education Centre in Victoria, BC. Angel discussed health issues facing First Nations families. One key issue affecting health, in terms of emotional and psychological issues, is the low morale that spreads across generations. Angel also spoke about health concerns such as buildings with mould that cause respiratory problems in children, house overcrowding, lack of money to buy healthy food, and no gyms and indoor places for fitness.

Diabetes is also a problem with First Nations people. Angel herself almost lost a son to diabetes. In her community, nutritionists and dieticians are involved with children and there are workshops in the community on diabetes. At the early childhood education centre, healthy

foods are provided to the children and centre staff act as healthy role models. There is a fitness challenge with staff weighing in every week. Kids notice the difference in their teachers.

Some other steps that the Songhees First Nation has taken include organizing activities with elders, having a natural play space for children, and creating raised bed gardens. Angel noted that the chiefs and band councils must make health a priority; she also stressed the importance of role models and parent involvement in extra-curricular activities. Other promising practices among First Nations on southern Vancouver Island are schools trying to improve outcomes and immersion programs in First Nations' languages.

Baijayanta Mukhopadhyay spoke from his perspective as a medical student. He said that he had more questions than answers. He indicated that he struggled with which perspective to speak from—he coordinated an immigrant and refugee consultation group for HIV/AIDS for the AWG and is an immigrant himself.

His first question related to what health professionals need to learn to remove barriers for marginalized communities. He discussed the value of informal settings for learning and commented that meaning can get diluted in formal systems. He questioned whether this type of learning should happen during the formal education of health professionals or in informal settings. He also questioned the way the medical curriculum is designed and mentioned continuing medical education. He talked about the need for health care professionals to be able to respond to marginalized communities.

He also indicated health care institutions are too often intimidating and overwhelming and that there is not enough training on how the health care system is administered. He spoke about the need to protect the single-tier health system. He suggested that health professionals need to understand how the system actually works if they are to be able to bend the rules when necessary; for example, to be able to serve a person who is living without full status (i.e., landed immigrant or refugee status) in Canada.[8]

Baj indicated that from his perspective, medicine is a social profession but it is set up as a scientific profession. There is a need to bring a humanistic element into medical training. Training in sociology, politics, etc. would make better doctors. He also indicated that Canada

[8] In Canada, "Living without status may mean that an application for status has been made but no decision has been reached. It may mean that an application; or, a number of applications, for some kind of status was made but turned down. Living without status may also mean that no application has been made at all, either due to fear, misinformation, or lack of assistance and resources." It may also mean that someone's sponsorship or work permit relationship has broken down." Retrieved from http://www.ocasi.org/downloads/Status_Questions.pdf.

fails at protecting rights and the ability of people to advocate for themselves. He felt this was a function of a highly bureaucratized system and wondered how doctors should be trained to relinquish their power. He also noted that doctors are trained in evidence-based medicine and that this is just one way to learn. He said that doctors need to approach people as individuals.

As a summary, Baj articulated the following questions:

- Should informal learning be formalized?
- Should we teach people the rules?
- How can doctors relinquish professional power?
- How can they unlearn some of what they have learned?
- How can partnerships be built?

He also noted the formal system cannot do it on its own.

v. Discussion following panel presentation

The panel presentation was followed by a lively discussion and a question-and-answer period. Delegates commented on the presentations and raised their own questions. Many of their comments were related to systems and addressing social determinants of health. One delegate asked which social determinants of health was most manipulable. This questioned shaped the discussion. Barb said to start with adult education, Betsy focused on income, and Baj on building relationships and a social support network. Early education also came up in the discussion as another important social determinant of health.

One point raised was the kinds of assumptions that one might have about people from marginalized groups and their attitudes towards health. One might assume they do not know a lot and are not interested. One person commented that, in fact, the people she encountered knew a lot about health and were deeply concerned. She said that it was important not to bring one's own ignorance and naiveté to the situation. The importance of being able to talk about what makes us feel uncomfortable was raised.

The importance of real inclusion of people in solutions—not doing things without them—was identified along with the need to change structures. One example given was the medical system. In terms of inclusion, delegates gave examples of where this was working. In one case, health services through a medical clinic are controlled by the community who make up the board of directors. The importance of adult education in building awareness and promoting this

kind of inclusion was stressed. The point was made that this kind of control by groups that are affected takes a huge amount of work.

The panel moderator raised some important questions. She emphasized that we have the resources and knowledge and asked "What is our excuse?"

Delegates discussed the determinants of health in terms of which ones could actually be addressed. Delegates said that stigma, poverty, and housing are still big issues. Unless poverty is addressed, people cannot have good food. Comments from delegates suggested that this unequal distribution of resources, with the gap only getting wider, was inexcusable in this nation of plenty. A network of groups can make a difference in terms of approaching politicians as everyone is saying the same thing.

Baj suggested that education is the easiest to manipulate even though it takes a lot of effort. Angel agreed with the importance of education, saying that young people can now get an education that is easily accessible and affordable which helps get away from reliance on social assistance. For example, a family childcare course offered through Camosun College at the Songhees First Nation, has opened up parents' eyes to issues with their kids.

The power of the doctor was discussed. Many people in the groups that delegates work with do not know how to advocate for themselves with doctors. Baj noted that although doctors have been given social power, this must be turned around by reorienting the physician/patient relationship. The doctor should be serving the patient and ordinary citizens should be able to challenge doctors. A system should be built where doctors can take time to listen. Other delegates indicated that there are situations where there has been training for people to speak up for themselves; there are also doctors who do develop relationships with patients. Again, the importance of adult learning in social change was emphasized. One delegate spoke about Patients as Partners, an approach that has specifically been undertaken in BC. She noted that previous to this one-year old program, there had been no mechanism to engage patients and hear their voices.

vi. Session conclusion

Nadine Valk, forum chair, summarized the evening session with some key learnings:

- The health system is an overwhelming system for practitioners as well as patients;

- There is a need to be inclusive: not to plan and decide things for people without including them in the planning;
- It is important to unlearning some things we have already learned, to learn which rules to bend, and to learn to disagree; and
- There are many pockets of hope within this group to build on for the next day's session.

B. Summary of Full-Day Session on March 3, 2009

i. Welcome and introductions

Nadine Valk, forum chair, welcomed people back and outlined the day's schedule. Dr. Irving Rootman, Executive Director of the HLKC introduced His Honour, the Honourable Steven Point, Lieutenant Governor of British Columbia to make the opening address.

ii. Keynote address

His Honour, the Honourable Steven Point, Lieutenant Governor of British Columbia, gave a keynote address on the issue of health and learning. He spoke about barriers to good health in the Aboriginal community and outlined positive strategies that had been used to address and promote good health. He emphasized the need for spiritual health and identified strategies for promoting health that focused on education, mental health, and self-esteem.

His Honour began the address with key phrases about the forum he noticed from the invitation: defining the common ground, creating understanding, and identifying barriers. He began his address with background about his life, describing his family and the community he grew up in, and relating personal stories. He spoke about the community he came from and explained that he was well-aware of health dilemmas and access to health facilities. He said there are many barriers, including what marginalized families such as Aboriginal people have experienced in the past in hospitals—how they have been treated or hurt. He indicated that people will not go back to these hospitals and that he knows Elders who just will not go—they do not want to see a doctor. His Honour said there are cultural barriers that exist and that in both the education and health care system, "we don't understand each other very well."

His Honour spoke about the fact that Aboriginal people have a different world view in that they understand the need for spiritual health. He spoke about the need to have Aboriginal people in

hospitals who understand "our people." He talked about how Aboriginal people lived together collectively in the past—hunting together, crying together, and thinking together. He said that although collective living is a good thing, it is also bad because of collective depression. This depression shows up in ailments such as rashes, migraines, dietary problems, not carrying a foetus full-term, and substance abuse, along with other problems.

Honourable Steven Point described the large school drop-out rates and suicide attempts when he was working in a high school and how, as chief, he got the elders together to figure out what their first priority should be. They unanimously agreed it was the health of their people. They began to look for markers for longer living—whether pregnant women are going full-term, employment conditions, and housing. When his Nation got focused on why they were there, they began to tackle some of the worst problems. Now his reserve has the highest number of people with degrees. He noted the importance of setting goals to tackle problems and finding common ground. He emphasized that we cannot improve physical health until we improve mental health and that people have to feel better about being alive first. Health improves with self-esteem.

His Honour talked about his literacy campaign and the importance of literacy and books. He said it was a simple idea to bring books out to isolated places. The books were well-received by the children in these communities. With his granddaughter, he started up a book series. There are now 500 stories and the fourth series of the book is going out. One strategy is working with Rotarians; they are now sistering with a First Nations community. He is also trying to get a program developed by a Victoria teacher, "Read for the Top," to be implemented around the province.

His Honour noted that a large number of the Aboriginal population has literacy problems. He believes that improving the literacy of the community has a direct impact on economic development and that has a direct impact on lifestyle and health. He talked about the importance of setting goals as a strategy. Improving health reduces costs in health care and the justice system. It is important to understand the importance of reading to children before they get to school. The literacy campaign is working.

The Honourable Steven Point closed by wishing delegates well in their conference.

iii. Welcome from CCL

John Biss, Assistant Director, Strategic Initiatives and Knowledge Exchange, Canadian Council on

Learning, thanked the Lieutenant Governor and brought greetings and welcoming remarks from the Canadian Council on Learning.

iv. Introduction to the day

Anita Ferriss, lead for the Early Childhood Working Group, provided more detail about what the forum hoped to accomplish during the day. She emphasized that the forum is a working session where delegates should move beyond the discussion of challenges to talk about promising practices that address health and health and learning barriers.

Anita also emphasized the importance of connecting and networking and the benefit of having delegates from many different sectors. She also informed delegates that during the day they would be engaged in an action-oriented process. She encouraged people to listen for difference —that this leads to the greatest learning and growth. She asked delegates to think about how they can take things forward, come up with sustainable solutions, and figure out who they can engage with.

v. Roundtable 1 discussion: Knowledge exchange across sectors

Health, health information and health services: Barriers and promising practices

Delegates worked in small cross-sectoral groups to answer the following questions:

1. What are the major barriers that the adults and their families you work with experience around health, health information, and health services?

2. What are the promising practices or successful strategies that you have used in your own work or that you know of to address barriers?

3. What dreams do you have, based on what has been said, for what else needs to happen?

Each group reported back on the three most important points that came out of their conversations.

1. Barriers

Participants identified the barriers that individuals face around health, health information and health services. The main barriers they discussed were:

- poverty
- stigma and discrimination
- culture and power
- low literacy
- silos among disciplines
- sustainability of resources
- health information
- complexity of system
- language
- invisible barriers

This section provides a summary of the detailed conversations across groups.

Poverty

Delegates identified poverty as a systemic barrier to health in general. This includes money for medicine, some services and transportation. Poverty was also discussed within the context of political decision-making where the dominant ideology says that individuals are responsible for their own health. This prevents systems-wide change because marginalized groups are seen as the problem.

Stigma and discrimination

Stigma and discrimination were discussed in terms of the many different forms they take for the marginalized groups that delegates work with. Health care providers were described as often being discriminatory. Delegates described a lack of respect some health care providers had for their clients. There is often a lack of connection between them, and a lack of knowledge about each other. Clients may be diagnosed before they are even spoken to. One delegate commented that there is not enough discussion with respect to trans-gendered sensitivities. One example given described the loss of stabilization of and access to services when people who are HIV-positive are street involved, Aboriginal, or some combination of the three.

The impact of stigma and discrimination leads to loss of trust on the part of clients with whom delegates work. For example, in Native communities, parents may mistrust assessment, screening, and intervention because of lack of trust and fear of labelling—issues which stem from residential schools.

In addition, delegates reported that holistic approaches are not commonly used; while a specific symptom may be addressed, the health of the whole person is not discussed or considered. Individuals want to be trusted and honoured for their health decisions.

Culture and power

Delegates identified issues of culture and power imbalances. A Euro-centric perspective was identified as a key barrier in terms of the relationship between health providers and the individuals they work with. Often providers are from different cultures and hold different world views from members of communities they work with. Care providers see their clients through their own values and beliefs and this can lead to labelling. One example given from the early childhood sector was that early childhood educators may not see parents as knowledgeable about child development; there are layers of knowledge and power imbalances.

The traditional status of doctors was discussed. Often people do not question what they are told by doctors. On the other hand, many doctors do not have the ability to communicate on the same level as their patients.

The perspective of health care professionals may be overly scientific as they are trained in a bio-medical model to the detriment of other models. In addition, delegates indicated that professionalization values academic credentials and undervalues participation.

Low literacy

Low literacy was discussed as an isolating factor. Clients often cannot get the information they need to know for their health. In addition, different people working on literacy are very often working on similar topics but not connecting.

Other barriers include the definitions and jargon around literacy, along with a disconnect between literacy and health. Discussion focused on the type of literacy that doctors and nurses use and how that literacy needs to be different. Another issue is that literacy and plain

language will differ depending on the community involved. These literacies can be highly complex and need to be valued.

Silos among disciplines

Delegates identified silos—where people are not working across disciplines, even though the issues they are working on are interrelated—as a large barrier. One example given was that AIDS programs are not looking at drug issues. One delegate made the point that health should be the responsibility of every ministry.

Another point was that there is resistance to working across disciplines or issues as many people view disciplines as discrete and different, not looking for similarities. The point was also made that silos are not just imposed from above. Sometimes people think of their own work in silos. There is a lack of coordination and cooperation across sectors and among services. These issues, coupled with the great amount of bureaucracy in the system, prevent more coordinated work. These issues, coupled with the great amount of bureaucracy in the health care system, often prevent more coordinated work. In addition, health-care professionals may not be aware of all the supports in a community

Delegates mentioned that there is little interdisciplinary education that goes on within professional arenas such as medical schools where doctors and other health professionals are educated and trained.

Sustainability of resources

The short-term nature of funding for health programs was raised as a barrier in that it often takes longer to develop and pilot programs than what the funding requirements allow for. There is also constant turnover of staff in communities and a lack of funding.

Health information

Often parents get mixed messages about what is healthy for their families because they get different information from different sources. In addition, those who work in unpaid positions, caring for children with special needs, may not know how to sift through information and reject what is misleading or incorrect. The point was made that there is a lot of health information available but there is a lot that is not useable.

Complexity of systems

Delegates identified the complexity of the system of health care as a barrier to those requiring care. Some delegates indicated that the system infrastructure is large. Delegates noted that people who require care often do not know where to start. They may not know what is available and where the services are. Doctor shortages, long wait times for treatment, and quality time restraints were identified as barriers as well. Access to services in rural areas and money for transportation were also identified as challenges.

Often doctors and other health care professionals may also not know the resources in a community.

Language

Language was identified as a barrier to getting services if individuals are not able to speak the language of the organization that provides the services.

Invisible barriers

Delegates identified the Invisible barriers that affect health. One example is that women as caregivers often do not have the time to think of their own health. In addition, mental illness and other ailments such as Seasonal Affective Disorder (SAD) can be undiagnosed or misdiagnosed.

2. Promising practises and successful strategies

Delegates identified programs that focus on education and advocacy along with support systems, partnerships, and relations that focus on the ethics of caring. Delegates' comments indicated the importance of working with people to address immediate needs but also working to address the social determinants of health in the long term. The promising practices discussion focused on the following areas:

- navigating the system
- breaking down silos
- advocacy
- support for parents and families

- health literacy

Many of the promising practices alluded to during these discussion can be found in the companion document to this report, *In from the Margins: Promising Practices and Possibilities*, which can be obtained electronically from the Adult Working Group's website at www.stfx.ca/events/bcforum and on the Canadian Council on Learning's website at: www.ccl-cca.ca/healthlearning .

Navigating the system

During their discussion, one small group identified a successful strategy for helping clients navigate the heath care system. This involves staff and volunteers building a relationship with clients to understand what their goals and needs are, along with where they want to go. Staff and volunteers then help them navigate the system to get where they want to go.

Breaking down silos

Delegates provided examples of where community organizations work together to provide coordinated access to health care and social services.

For example, one community organization in Toronto has a social services committee that organizes 16 agencies at the table to coordinate access to health and social services. The focus is on facilitating social change. In addition, these agencies work to build trust with newcomers, assessing needs before making referrals to other services. This organization uses a case management approach and assessments can occur at multiple entry points. This cooperative and coordinated approach leads to shared learnings among agencies along with a reservoir of learnings and information to enhance social services for individuals who require intensive support.

Other delegates emphasized the need for opportunities to talk across sectors on an ongoing basis rather than just a "one off," after which people go back to their busy lives.

Advocacy

A patient prompt card for at-risk adults was described in one group. Patients use the prompt card in a health care setting to remind them of questions they can use to overcome the power imbalance. Similarly, the importance of building life skills when clients are not in crisis was cited as important. One example of a life skill was training on how to use the nurse line, that is, a telephone help service used in many cities across Canada.

In other cases, programs that help people help others have been successful. People's experience is honoured and they are paid to participate.

Some suggestions were made which indicated that communities should be responsible for health and health services.

The importance of community workers and facilitators from the client's own culture was raised. One example given was the need to fund Aboriginal navigators in hospitals. Another example involved community nurses going to people where they live, bringing the nurses to the people. Involving the support of Elders was another example supporting community health.

Support for parents and families

Delegates also discussed a national employee program, the Special Needs Project, which provides support for parents who have children with special needs. This program uses advisors to check in with parents three times a year. The Special Needs Project also uses parent interviews to gather information to change policies, as well as share ideas and communications through newsletters and a website.

In a program in one health region, parents are asked what kind of support they need as part of the assessment process. One childcare program in a community college uses a form that goes back and forth from the early childhood centre to home to inform parents of the child's development observed at the centre. The parents also track what is happening at home.

Another example of a program offering support for parents and families is the Aboriginal Infant Development Program. In this program there is a special needs support worker who is respectful of culture and provides service choices and options to parents. Another example is the Adult Care Society which serves people who are coming out of the hospital.

Other examples of successful strategies include family literacy programs where relationships are built between parents and the public health nurse, or programs that build hope for women

who have basic life skills. One family program has people meeting together and in one-on-one sessions every week. The program has been in operation for 2 years and has changed lives and generations.

One organization has put together a manual to help immigrant and refugee males parent between two cultures—the Canadian culture and their culture of origin.

Health literacy

Delegates made suggestions for making information more accessible to clients. One of the most important aspects of making information accessible is building a relationship with people and being respectful of their world view and how they use multiple literacies in their own communities. Often people rely on their peers, family, friends, and others they trust for health information. In community consultations, pharmacists were cited often as being helpful in making sure that people could understand the print information that goes with prescriptions. In the same consultations, street nurses were cited as working better than hospitals. Services need to go where people are, as opposed to just people going to institutions.

Another theme across delegates was the need to involve the end users of information in the development of health information products. Integrating culture and language into the information given through videos, popular theatre, and story telling were also identified as important strategies.

3. Dreams delegates have that could make a difference

Small groups identified the following dreams:

- Get the government to think beyond four years
- Every Ministry has a responsibility for health
- Deconstruct power relations
- Invite parental involvement and engagement
- Use an-asset-based model for health promotion
- Implement policy that focuses on long-term thinking
- Build on believing that people can be successful
- Define success in different ways
- Have end users design the system
- Stop the world, fix it, then go again

- Go where people are
- Reward people who work together
- Look for the fastest horses when looking for change agents
- Find a way to share experiences on an ongoing basis
- Find ways to continue sharing across sectors
- Combat the normalization of being at the margins

vi. Lunch and panel presentation

In from the margins: Findings from the three working groups

Moderator: George Eisler, BC Academic Health Council
Hélène Grégoire, Adult Working Group
Donna Michal, Early Childhood Working Group
Lorna Romilly, Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals Work Group

Panellists addressed the following questions:

- How do your findings correspond with conversations at the first roundtable session?
- What are the main characteristics of the promising practices you found or heard about during your work?

Hélène Grégoire

The AWG's purpose has been to advance the health and learning of adults. Its priority groups are adults with literacy challenges, immigrants and refugees, adults living with HIV/AIDS, and adults living in rural and remote regions.

From 2006 to 2008, the group conducted pan-Canadian consultations with community members and service providers from its priority groups. The purpose of the consultations was to develop a knowledge agenda to advance health and learning in Canada, especially for vulnerable and marginalized adults.

Hélène indicated that there was a lot of overlap between what had been discussed at the forum and the AWG's consultations with its priority groups. Poverty, housing, literacy and language were common barriers that consultation participants spoke about. The cost of medication and

health care services not generally covered by provincial health coverage (e.g., dentistry, physiotherapy and counselling) was also identified as a barrier. Discrimination and prejudice were also barriers. Some of this discrimination was race-based (i.e., for immigrants and refugees and for some of the participants who were Aboriginal or racialized and also had literacy challenges) but other types of prejudice and discrimination related to language and stigma. Health care professionals were often misinformed. For example, one HIV-positive participant told the story of a physician putting on gloves to listen to their heart. Similarly, in another case, a dentist was said to have looked in his HIV-positive patient's mouth from two feet away.

Discrimination for the AWG's priority groups was not just in health care, but in society in general. This impacted on access to housing and employment. The lack of recognition of foreign credentials is another form of discrimination. All of this impacts on individuals' mental and physical health, leading to self-esteem and depression issues. Consultation participants felt they were losing the ability to control their own lives. In rural areas, there were transportation issues, lack of access to specialists, and lack of knowledge of where to go to get health information. In addition, seniors whose families have left the area experienced isolation.

Hélène identified the following characteristics of promising practices:

- considers the social determinants of health,
- are based on an ethics of care and non-judgment,
- are based on integrated understanding of health, including spiritual health,
- communicates information using multifaceted media and peer networks (i.e., trusted people),
- are collaborative and coordinated, building on strengths that different agencies bring to the table,
- are community-based, and
- are context-specific.

Donna Michal

During the spring of 2007, the ECWG conducted a pan-Canadian consultation with parents, early childhood educators, ECE faculty and health professionals. This consultation, the *Target Audience Project*, identified health and learning issues and concerns, sources of health information, barriers to accessing information, and information gaps and needs.

Donna reported that the ECWG found that barriers to health included lack of access to health professionals: families use drop in clinics versus family doctors because there are not enough family doctors available. Public health nurses indicated that they need more time to spend with families; they are beset by paperwork and time is precious and limited. There is a need for more assessments for hearing, language, speech, allergies, dieticians, nutritionists and a trained early childhood workforce.

Donna indicated that there is a huge health promotion machine out there with materials and pamphlets that are not easy to access, or may not be relevant to families of varied cultures or those with low literacy skills. How this information gets to the people who can finally use it is a puzzle. Individuals may also not have the skills to find and determine what information is reliable and valid. For example, there are many health materials available on the Internet, yet some of this information may be out-of-date or posted by unreliable sources.

The ECWG learned of information gaps in certain health areas: mental health, learning disabilities and autism, and alternative health. Other barriers were levels of low health literacy, cultural and language differences, and not having tools to understand differences.

Donna identified the following characteristics of promising practices:

- build relationships between health care professionals and parents; services allow for relationships to develop,
- acknowledge the social determinants of health, especially income security,
- use clear messages,
- respect culture,
- based in the community, and
- deal with the emotional aspects of health (for example, how to deal with discrepancies between what we learn from our mothers and what health professionals tell us).

Lorna Romilly

The Capacity Building in Health Literacy for Health Professionals Work Group (CBHLHP) has been working on building capacity around health literacy and patient self-management for health professionals since 2006. The purpose of this project has been to ensure that practicing, as well as future, health professionals have the skills, knowledge, and attitudes to support social and health care agendas that can lead to a more empowered and self-reliant public. Consultations, environmental scans and research were conducted as part of the project.

Lorna noted that health care professionals typically do not recognize literacy as a challenge and frequently do not have the skills to address this issue because their training is limited. There is some professional development but not enough. Health care professionals do not see health literacy as their goal when looking at patient self-management. Providers feel they do not have the time they need. Health care professionals too often overestimate people's literacy as people do not always say directly that they have a problem. They may say, for instance, "I will talk to my wife about that."

There is a need to educate health care professionals. There are attitudinal issues in that health care professionals can feel helpless and often do not see health literacy and patient self-management as their responsibility. Patients recall half of what the doctor tells them at best. People with low literacy are being asked to manage their own illnesses.

Lorna identified the following characteristics of promising practices. As she explained, promising practices:

- develop capacity,
- value pre-existing skills,
- work at several levels,
- are not necessarily new things,
- can be better if supported by the system because they are more likely to be sustainable,
- focus on user-centred processes, and
- will nevertheless, require leadership, support and professional development for health care professionals.

vii. Roundtable 2 discussion: Knowledge mobilization within sectors

How can we use what we heard here today in our own work?

For the second roundtable, delegates worked in their own sectors to discuss the following questions:

1. What have you learned today about the successful work of delegates in other sectors that you could use in your own work to address health-related barriers for adults and the families you work with?

2. How would you tailor some of the promising practices or strategies to your own work?

3. How can the promising practices you heard or know about be used across different client groups?

4. How can the conversation started at the forum be sustained once the forum is over? Who should be involved in the leadership to ensure it continues?

Overall, delegates discussed strategies they had learned about and could use to ensure that people they work with can advocate for their own health with doctors and others. They also spoke about the need for health care professionals to do the learning to be better able to work with diverse clients from marginalized groups. Other strategies of importance that were noted included integrated community approaches that are inter-professional and inter-disciplinary. Participants underlined the importance of listening to the needs of different populations in order to determine how to provide services.

Delegates would like to see ways that they can continue to share and network after the forum, along with ways to reach out to broader networks and advocate with policy makers.

Specific promising practices that delegates said they can use:

1. Academic/Researcher Group

Delegates in this group discussed the importance of research and evaluation to determine whether progress is being made by systems and interventions and to assess if interventions work. They identified the importance of consultations with stakeholders and evaluation of needs. They questioned what the indicators of success were, what is measured, and what the impact is. They discussed capacity development and systematically building knowledge for the future with feedback providing ongoing advice for initiatives. They identified community resilience as a research topic, i.e., how individuals could sustain, educate, and both learn from and refer to each other.

This group identified patient self-management as a purposeful rallying point on health literacy. It is empowering and is an education strategy for which health literacy is important. They identified the importance of a network for research on patient self-management. Other reliable tools identified were the former Canadian Health Network, a website in plain language for

teachers to use with students in plain language, logic models, and evaluation tools from the University of Kansas website.

This group saw the need for a larger vision statement that all could advocate for. They recommended having a declaration on health and learning with a vision and mission statement, role responsibilities, and something to promote. This would instil personal responsibility and build capacity to empower.

The group recommended that dedicated members of stakeholders have access to communication through a network. A core group could coordinate and support this network. Perhaps the Public Health Agency could provide infrastructure as it is adopting health literacy. The Canadian Public Health Agency portal may be able to help with this.

2. Early Childhood Group

This group discussed what they had learned during the forum. Learning included the need to advocate for one's own health or have someone who can advocate on an individual's behalf. They also learned about the domino effect of a lack of trust and the need for community animators and grassroots development. They observed that poverty is an issue for most groups and identified the need to find ways to strategize around poverty. They would like to see a task force struck to undertake this. They were inspired to try "brave things."

They learned about ways that groups are working across different areas in early childhood, the importance of working with others, and sharing power.

This group observed that some funding requires collaboration and recognizes the importance of working together. They cautioned against forced collaboration, noting that it could be disastrous.

Delegates noted the importance of education for early childhood educators around the importance of health, diversity, and social determinants of health versus health services. They also saw the need for including positive, co-constructing goals; inclusion and equity; and diversity and responsibility in early childhood education. This work is based on work in New Zealand through the ELECT project. They recommended using the new textbook by Barb Pimento and Deborah Kernested, *Healthy Foundations for Early Childhood Education,* which focuses on the social determinants of health, critical thinking, and looking at issues from different perspectives.

The group identified the importance of sustainability—sharing within their broader networks and organizing promising practices by sector.
Delegates questioned whether services address the needs of people at the margins.

They identified the principles of promising practices as trust, relationship building, caring, cultural sensitivity, sharing power and collaboration.

3. Literacy Group

Delegates from this group found that concepts were shared readily among the large group and that there was a common language and common values among delegates from across sectors. They saw common values, working from strengths, and working alongside people as vital to change.

Other learnings included that Family Literacy Hubs share spaces and information in Alberta, animating the concept for one-stop shopping for a variety of needs of learners and breaking down silos. There was agreement among the group members that a common partnership was needed across the literacy field.

Delegates were shocked to learn about the lack of community-based training for the medical profession in spite of the increased emphasis on team-building and inter-disciplinary work in health sciences settings. They indicated that pharmacists seem to get different training or practicum on sharing information in community contexts and provide client services with a more helpful and holistic attitude. The group indicated that integrating Aboriginal ways of healing and knowing into medical training would insure that the bio-medical model is not the only source of knowledge.

This group emphasized the need to focus on a coordinated push at the community level and an approach that avoids starting and stopping.

In order to sustain the conversations started at the forum, delegates would like to see a network of networks in Canada to allow for easily retrievable information that is in one place. They would also like to see a sharing of successes and make this available to new audiences. They want to see advocacy efforts to move the agenda forward politically and a way to stay networked and to avoid silos.

Coming out the forum, this group would like to see:

- The tracking of pilot projects that focus on how collaboration rolls out with different partners in a community development focus;
- Ways to connect again face-to face. They wanted to share their learning on collaboration strategies and pull people out of their silos. The focus of any future gathering should be on changes delegates have seen. They wanted to have a more in-depth institute in the future on championing examples of collaboration, and model this collaboration as a promising practice;
- Health literacy goals publicized and formed under one definition: the ability to find, use, act upon, and evaluate information about personal health; figure out if more training is needed to teach these skills to people and whether more people need these skills;
- CCL bring other national organizations and funders that have a stake in literacy together to link with territorial and provincial networks for more centralized sharing, more collaboration and the reduction of barriers. They saw this as a way to share limited resources and showcase best practices; and
- Promising practices promoted with new audiences such as the Canadian Labour Congress, and faculties of education, social work, nursing and medicine (while in training); also promote promising practices with faith communities, early childhood educators, the Canadian Medical Association, and agencies working with people who are street-involved.

5. Providers of Health Services Group

Some delegates in this group said that they learned how to step up to the plate and advocate for others to help themselves. Some people connected with programs and approaches that teach people to ask questions of doctors and to navigate the system.

This group also spoke about the need to educate health care professionals—not just clients and patients. Comments focused on the tendency to focus on individuals rather than putting into place systemic support systems. There needs to be more education around health literacy with health care professionals. However, there is not a common definition of health literacy. Health care professionals need to be literate about their patients. It is not enough for patients to be literate about their health. The question was raised “Who is the learner?” The importance of communicating what people know about health literacy across field was raised.

It was also noted that there was a determination from delegates to come to a common language, to see what health means to different populations, and to take away commitment.

The group suggested different ways to sustain the conversation after the forum. One suggestion was to have national cross-sectoral groups addressing multiple issues with a common theme, for example, literacy. The importance of national leadership for these conversations was highlighted by some people. Delegates indicated that infrastructure and continual learning were also needed. They said learning needs to be in relationship with others —not just from a website.

The group discussed how to get their work recognized as a priority. The suggestion was made that the issues of literacy in a health care environment need to be articulated better so decision makers can hear the message. One take away from the forum was to framing social determinants with literacy messages. Other suggestions were to frame literacy as a patient safety issue using the existing system as incidences of patient accidents can be tracked based on language issues.

Other comments from the group suggested that focusing on literacy was more manageable than poverty. The importance of not letting politicians define literacy was raised as was the importance of the literacy field being in control of the word and pushing a larger agenda.

Delegates raised the issue of the term health literacy and suggested it might have to be called something else. They questioned how to market these issues. They indicated that people who are making decisions around these issues do not have a lived reality of the issues. On the other hand, people with low literacy do not speak up. The idea of having community engagement staff do patient shadowing was suggested.

6. Community Advocates Group

Delegates' learnings in the group focused on the expertise that this group has, certain initiatives that they did not know about, and the whole issue of accountability and how it is carried out. For example, some people learned about the British Columbian initiative where the Premier has made health care a responsibility of all ministries. Others learned about sexual health education reforms in Quebec. Delegates questioned how accountability for mandated health and wellness would be put in place. They wondered what accountability would look like. They identified a need for benchmarks and indicators.

They observed that a very different approach to services is needed for different groups of people; for example, an intensive approach to service is needed to move a person out of homelessness. Immigrants and refugees need a different approach. Groups that are in survival mode need a different approach than those who are already part of the community. They questioned how this plays out on the ground and wondered “where do we go from here?”

They emphasized the need for collaboration on the ground and comments indicated that “health care tends to offload rather than work collaboratively.”

They said that they would do more networking and work with more stakeholders in their own work. They indicated that to validate and strengthen practice, everyone needs to work together across various community issues and services. The pastoral nurse, an intermediary who has the trust of the congregation, was given as an example of a new way to extend help.

They asked what structures in the community they could build on and emphasized the importance of building better relationships to gain trust. They emphasized reaching out to other sectors that are not regularly involved and developing strategies they heard about relevant to their own communities.

This group indicated that information must be available in French and English in order to sustain this conversation after the forum. There should be a formalized structure with a diversity of stakeholders from different social services with everything accessible in French. Advocates need to be able to speak to the government in their own languages, all the while not forgetting their own advocacy language.

The group felt that advocacy was part of its work and that they needed to show their expertise. They thought that more national umbrella organizations needed to be at the table. They indicated that they could participate as partners and contributors in summer health camps that could be organized like travelling road shows.

They concluded with the importance of mobilizing the political will.

7. Policymakers' Group

This group saw health literacy as a policy issue. They questioned what the federal responsibility is, given that health and education are provincial responsibilities. They indicated that a strategy may be to look to other departments that have an interest. Promising practices should be identified along with the evidence base. They asked where policy makers are best placed to support good practices.

A recommendation for policy makers should be to build evaluation dollars into their proposals. If there is a commitment to good work, then evaluation must be built in. Evaluation is often simplistic. It is important to build in the measurement piece and resources for community-based research. A community capacity-building tool with evaluation built in has already been developed by Mary Francis MacLellan-Wright, and supported by the Public Health Agency.[9] This is an accessible tool that is already available.

The group indicated the need for communities of practice and a spectrum of people involved—the need to share tools and ideas. Online social networking tools like Wikis and Twitter™ provide a space for people to have conversations. There is a need for fun and accessible ways of social networking. The groups noted that different sectors are engaged in conversations and have similar experiences. They felt these sectors should sit down together and create space for dialogue. They asked where the opportunities were for these dialogues to take place.

Delegates indicated that there needs to be more action and engagement on the issue of health literacy; right now there is no spot for it even though everyone seems to be on the same wave length around the issues. They reinforced the need to act on the recommendations of the Expert Panel for Health Literacy.

The group also saw the need to engage and include non-traditional health professionals and feed into, and piggyback on, different networks. They commented that building on conferences, developing relationships with other sectors, and sharing knowledge among sectors was needed. They thought it would be helpful to capture what is working across Canada and showcase these initiatives.

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[9] Please see The Community Capacity Building Tool available on the Public Health Agency of Canada's website, Alberta NWT Region, at http://www.phac-aspc.gc.ca/canada/regions/ab-nwt/downloads.html and
MacLellan-Wright, M. F., Anderson, D., Barber, S., Smith, N., Cantin, B., Felix, R., & Raine, K. (2007) The development of measures of community capacity for community-based funding programs in Canada. *Health Promotion International, 22*(4), 299–306. Available at http://heapro.oxfordjournals.org/cgi/reprint/dam024v1

They indicated that alliances need to be created to push forward certain policies. People are afraid to advocate as an individual agency; they worry they will "bite the hand that feeds you." Groups of organizations may have a stronger voice than individuals.

The group also discussed funding mechanisms for projects. Often projects are not long enough to determine effective practices, and pilot projects are limited. They indicated that more time is needed for projects to build on and sustain the work that people are already doing. They advocated for new ways to structure funding for thoughtful programs.

They felt there needs to be more political will to implement and resource pilots, rather than see them as too expensive. They discussed what it would take to leverage the will to do so. They suggested that stories need to be mobilized, bureaucrats need understanding, and there need to be champions from the community. They commented that politicians are gatekeepers. To garner political will, there is a need to know your audience and present with this audience in mind. They noted that inequalities are bad for everyone. Comments included the idea of developing a business case for healthy communities.

The group suggested that each social determinant of each aspect of health be personalized through stories and promising practices for bureaucrats and policy makers. This needs to be explained to other sectors and tied back to an individual story to create meaning. There should be a strategy to address health determinants as this strategy is the missing piece.

viii. Plenary session: Recommendations for change

Moderator: Nadine Valk, Forum Chair

The forum chair asked the delegates what practical recommendations they would make to policy and decision makers based on what they have learned here today. Delegates put forward the following recommendations:

- Develop a long-term vision and make long-term funding commitments.
- Ensure there is an inclusion lens in policies and provide incentives for (or reward) inclusion.
- Build on proven practices that have been evaluated rather than always looking for "innovation."
- Develop a Pan-Canadian Health Literacy strategy that links to other relevant strategies.

- Provide mechanisms for sharing experiences and information and ways for people to contribute their learnings.
- Include more representation from Aboriginal communities and groups in discussions about health policies so they can contribute to the issues being discussed in their own voices.
- Focus on health rather than health services (then it implies all of us).
- Ensure that health is part of every ministry and every department.

xi. Plenary session: How do we sustain this discussion and network in the future?

Moderator: Allan Quigley, Adult Working Group

Delegates were asked what their organizations could do to create a health and learning network for the purposes of information sharing in the future. They were also asked what they would try out and do differently as a result of the forum.

Delegates made the following recommendations:

- Embed a health and learning network in a credible organization where materials can easily be placed on a website (many suggestions were put forth by participants).
- Locate a provincial partnership opportunity where the network could be integrated with other areas of health such as heart health.
- Use their own websites and those of umbrella organizations they work with, as well as conferences and forums to publicize the ideas and information coming out of this forum.

C. Delegates' Commitment Forms

Facilitating this closing session, Allan Quigley explained that this gathering was to ultimately take action. He invited delegates to identify any organizational contributions that might be made now or in the future to help foster an ongoing dialogue on health for those living on the margins. Greg Penney of the Canadian Public Health Agency offered to contribute use of their new CPHA health portal so the outcomes of this forum and other relevant materials might be posted and disseminated.

Following other suggestions, as promised the first day, Allan asked that all delegates be given commitment sheets on which they were asked to identify their own personal commitments for practice change and to add anything they thought their own organization might be able to offer in developing an ongoing discussion. These commitment sheets could be mailed back to delegates if they indicated they wanted them sent to them once they returned home.

This section summarizes the common themes coming out of the commitment forms as analyzed after the forum.

i. Under the heading, "Organizational Commitment: National and Provincial Level":

1. Knowledge exchange and mobilization

One of the main commitments that delegates made at a national level was to share information from the forum and issues related to the forum with other stakeholders they are involved with from across the country. These stakeholders were identified as HIV/AIDS, First Nations communities, literacy organizations and practitioners, early childhood organizations, and other community organizations and provincial ministries.

2. New partnerships

Some delegates also committed to forming new partnerships with other sectors. These new partnership were identified as being with health care professional associations, literacy organizations, and other sectors beyond delegates' own.

3. Taking action

Delegates identified ways in which their organizations would take action. Some of the actions included:

- having sessions at a national conference on the work of the forum,
- championing the need to include health literacy findings and strategies in the development/renewal of HIV/AIDS strategies,
- facilitate events and promote the ideas from the forum in clinical settings and push medical facilities for change, and
- hold a meeting of forum delegates in own regions to make links between health and learning.

4. Creating links

Delegates identified creating links as a key organizational commitment. Creating links included linking up literacy and adult education groups electronically with the forum network, and linking with health researchers and professionals for the inclusion of health literacy in their curriculum and research.

ii. Under the heading, "Personal and Local Level Commitments":

Delegates made personal and local commitments which focused mainly on changes to their practice and doing their work in different ways. They also focused on sharing information from the forum with their own networks.

1. Knowledge exchange and mobilization

Delegates said they would share information they gleaned at the forum with others in their networks.

2. Creating links and partnerships

Delegates plan to invite people they met at the forum to speak at their events, to keep in touch with relevant contacts, and to get involved with those doing health literacy in their communities.

3. Taking action

Delegates identified changes they would make in their own work in terms of values. This focus on values included using the principles discussed at the forum in their work. For example, they intend to share power more, focus on assets rather than deficits, incorporate an ethic of care, use a health and health literacy lens in their work, and be more community-focused.

Delegates also pinpointed practical inclusions to focus on in their work. These inclusions were health literacy, a focus on social determinants of health, the use of plain language, patients interviewing doctors, and support for workers at the margins. Other commitments included using the principles identified at the forum in funding proposals and considering funding a project to build capacity for a stakeholder network.

IV. Evaluation Summary

This section reviews the evaluation feedback and ascertains how well the forum met its objectives and expected outcomes.

A. Evaluation Highlights[10]

i. Overall results of 39 delegates (72% of delegates attending) who completed an evaluation form:

- 100% totally agreed or agreed they learned about the findings of the three HLKC working groups.
- 96% totally agreed or agreed they have a better understanding of the multiple barriers that adults and their families face when accessing health information and health services.
- 97% totally agreed or agreed they have a better understanding of good practices to address the needs of adults and their families who are marginalized.
- 99% totally agreed or agreed they had opportunities to recommend solutions and good practices to overcome barriers.
- 99% totally agreed or agreed they had opportunities to discuss ways to build and sustain an ongoing network.

ii. Evaluation of different aspects of forum organization:

Forum organization

- 76% of delegates indicated it was excellent and 21% said it was good.

Forum content and focus

- 61% of delegates indicated it was excellent and 36% said it was good.

Forum facilitation

- 82% of delegates indicated it was excellent and 12% said it was good.

[10] See Appendix G for evaluation form and charts.

Pre-forum information

- 43% of delegates indicated it was excellent and 36% said it was good.

Forum kit

- 53% of delegates indicated it was excellent and 44% said it was good.

Monday night panel

- 56% of delegates indicated it was excellent and 26% said it was good.

Roundtable 1

- 66% of delegates indicated it was excellent and 31% said it was good.

Tuesday lunch panel

- 60% of delegates indicated it was good and 27% said it was excellent.

Roundtable 2

- 54% of delegates indicated it was excellent and 41% said it was good.

Plenary: Recommendations for decision makers

- 31% of delegates indicated it was good, 26% said it was excellent, and 15% said it was fair.

Plenary: How do we sustain this network?

- 33% of delegates indicated it was good, 26% said it was excellent and 8% said it was fair.

B. Summary of Delegate Comments

Delegate comments have been summarized according to the evaluation questions.

i. What were the main strengths of the forum?

Delegates indicated that the main strengths of the forum were:

- the diversity of sectors,
- participants and their experience,

- the ability to network and have an exchange together—especially in small groups,
- time to discuss topics,
- ability to work on solutions,
- focus on action, and
- the address by His Honour, the Honourable Steven Point, Lieutenant Governor of British Columbia.

ii. What changes should we make another time to improve the forum?

The main areas in which delegates suggested changes for another time included:

- having a broader group of delegates including those from marginalized groups, racialized and ethnic communities, and policy makers,
- having a longer forum—two days instead of one,
- sustaining a conversation in both English and French was raised as an imperative concern that must be dealt with,
- highlighting more concrete examples of promising practices,
- having an action plan, and
- not having a lunch time panel.

iii. Additional comments:

Delegates indicated that the forum represented a great opportunity and they appreciated being able to participate. They reiterated some of the points made in other sections around broadening the delegate base. They thanked organizers for a job well done.

Some comments indicated the difficulty of making change even though there is a desire to and the difficulty of articulating recommendations for policy makers. They also really want to see some results from the forum and follow-up action.

C. Achievement of Forum Outcomes

This section analyzes how well the forum achieved its expected outcomes on the basis of delegate feedback and delegate discussions.

Expected Outcomes

1. **Findings from the three HLKC working groups will be shared among delegates and confirmed.**

Delegates' evaluation feedback showed that this outcome was accomplished very well. In addition, small group discussions among delegates identified similar themes to those of the three working groups.

2. **Forum delegates will have a better understanding of how adults and their families who are marginalized face multiple barriers in accessing health information and services.**

Delegates' evaluation feedback showed that this outcome was accomplished very well. In addition, small group discussions among delegates also indicated their understanding of these barriers.

3. **Forum delegates will have opportunities to recommend emerging solutions and innovative, promising practices to overcome barriers in accessing health information and services.**

Although delegate feedback shows that they felt they had ample opportunity to discuss solutions and promising practices, their feedback also shows that these areas could be strengthened through more practical examples of promising practices in the forum itself. Feedback also included the idea of strengthening the plenary sessions by focusing on recommendations to decision makers and sustaining a network after the forum.

4. **A wide range of professionals and others will have access to emerging good practices regarding delivery of services to better address the needs of adults and their families who are marginalized.**

Although participants indicated that a strength of the forum was the broad cross-sectoral representation and the ability to discuss good practices, they felt that the delegate base should include groups not there—racialized communities, different ethnic groups, policy makers, and members of marginalized communities.

5. **Participants will have the opportunity to discuss ways they can sustain and build an ongoing network to continue the sharing of ideas, resources, issues, and possibilities.**

Delegates rated very highly the opportunity to discuss ways of sustaining an ongoing network. Their comments also show the difficulty of doing so.

V. Reflections and Analysis by the Organizers

This section serves as a reflection and analysis on the key themes arising from the forum through all the components of the forum, starting with the collaborative planning with the three HLKC working groups right through to delegates' commitments and evaluation feedback on the forum.

It is evident that the groundswell of different sectors that work in health, education, or other social services and professions share common concerns about what the barriers and gaps are for marginalized Canadians and how to address them. The participants heartily promote and advocate for cross-sectoral collaboration at both systems and service levels to work towards improving the health and lives of marginalized groups. They also agree that learning needs to be for everyone. Health professionals, together with other service providers and policy makers, have much to learn—it is not just members of marginalized communities that need to do the learning. They also indicated that collaboration is not so easy given competition, scarce resources, and reluctance and resistance to change.

This spirit of collaborative or inter-sectoral work was evident in the beginning stages of the planning of the forum. Three HLKC working groups—each with a very different focus—saw the potential strength and need to bring sectors that work with marginalized Canadians together to share information on promising practices, take them further, and identify ways to sustain the conversation after the forum.

A. Barriers Faced by Marginalized Groups

We saw common agreement on the barriers faced by marginalized groups as a constant theme throughout the forum. The details, experiences, and circumstances differed across these

groups. However, panel presentations, small group discussions, and the keynote address focused on how the health of marginalized Canadians and their families is seriously affected by socio-economic, institutional, and cultural barriers, including access to health and health learning services. These barriers include social determinants of health such as poverty, stigma and discrimination, inadequate and substandard housing, and literacy and language issues.

Uneven power relations, the complexity of the health care system, and the fact that different service providers tend to work in silos all affect the ability of these adults and their families to achieve good health and access health services.

The original findings of the three working groups' consultations with their constituent groups were validated and further expanded through the work and discussion of forum delegates. The difficulty and complexity of addressing social determinants of health was also a key theme.

B. Characteristics of Promising Practices

The forum identified some common characteristics of promising practices that promote improved health for marginalized groups. These characteristics include:

1. Social determinants of health

One key characteristic is the importance of the social context in which health takes place. This includes the socio-economic conditions of people's lives and the importance of addressing the social determinants of health. While providing clear information to individuals and acknowledging individual learning abilities with respect to health services is important, it is critical to address the larger social determinants of health.

2. An integrated understanding of health

Strategies and promising practices need to mirror people's understanding of their health as interconnected in terms of physical, mental, and spiritual dimensions.

3. Ethics of care

The importance of taking time to build relationships and trust between individuals and professionals, listening to concerns, and working in the spirit of inclusion and respect for people

were emphasized in terms of an ethics of care. Taking the time to understand clients' needs and explain diagnoses were important. Sharing power, respect for culture, and respect for the knowledge that people bring to the context are critical.

4. Cross-sectoral collaboration

Organizations and sectors working together to improve access to services and the health of clients was identified as key. This collaboration includes a case management approach and a referral process among different organizations. It also includes opportunities, such as this forum, for different sectors to come together to share knowledge and to plan action on a regular basis.

5. Contextualized, inclusive, and community-based

Promising practices are tailored to particular communities and local situations. They are developed respecting particular contexts and experiences. If they are adapted for other contexts, the particular shape of these new contexts must be considered. The importance of community inclusion, leadership, and engagement are key for any initiatives in which communities will be the recipients or beneficiaries.

6. Capacity building and professional development

Promising practices build capacity for health service providers and for individuals who access health services. This requires support for providers in terms of professional development, and for individuals in terms of being empowered. There must also be sustainable resources built into the system.

7. The importance of research and evaluation

The importance of a rigorous research and evaluation component of promising practices is key to understanding what works, what progress is being made, and the impact of these interventions. Similarly, consultations with stakeholders and evaluation of needs are also essential. Research and evaluation can build knowledge and capacity for the future.

C. The Role of Education in Promoting Social Change

The role of education in promoting social and systemic change for better health and access to health services was emphasized as a key strategy. Education and learning were emphasized for all, not just members of marginalized groups. For example, the need for health care providers to be literate about their patients, and not just patients being literate about their health was a focus. Health providers need to learn to share power with their patients, offer more appropriate services tailored to the specific needs and concerns of the communities they work with, use plain language, examine their own biases, and act as advocates for their patients. In some cases, it may be an issue of unlearning as much as it is an issue of learning. The idea of including these concepts in formal training for doctors and other health care professionals is an important strategy.

Government and other decision makers were also seen as needing to find ways to encourage collaboration across sectors, make health everybody's business, and encourage more long-term funding for sustainable health initiatives appropriate to the communities that need them. At the same time, education was emphasized as a key positive strategy for marginalized groups in contributing to having more control over factors that affect their lives and their health. For example, adult education can help people through peer learning initiatives, skills to take on leadership positions to advocate for social change, and ways to successfully navigate the health care system.

Education can also take other forms including building self-esteem through positive self identity, finishing high school, and improving literacy skills.

D. Delegates' Key Learnings for Changes to Their Own Practice

The main areas that delegates referred to in terms of change to their own practice and work centre around the principles of promising practices articulated throughout the forum. There was special attention to new partnerships, collaboration, networking, and the "ethics of care." There was also an emphasis on moving forward to take action around the ideas discussed at the forum.

E. Creating a Network

There was tremendous interest in a cross-sectoral network that would continue the conversation on issues related to the forum. Some organizations could commit to doing some of this, for example, bringing people together in their own region or sector and including information on their website. The difficulty in making this happen without resources was raised, but the addition of the CPHA portal holds promise for the future.

VI. Summary Comments

The decision of the Adult, Early Childhood, and Health Professional Working Groups of the Health and Learning Knowledge Centre to work together jointly has paid off.

The experience of the members of these groups provided a test case and a microcosm of learning that set the stage for the forum and its success. The members of the working groups did not know each other well, were from different sectors, had not worked together, and initially had different ideas about health and learning. The group worked through an intensive time over several initial months to learn about each other's work, understand what was common among them, and what the common ground was for working together.

To reach this understanding was not always easy. However, the common ground in terms of how to provide a collective space across sectors for developing action especially how to address the social determinants of health for marginalized communities proved stronger than any differences among the three groups. This was coupled by a strong willingness and desire to work together. The first result of this initial work among the groups was a concept paper that everyone could feel proud of. This spirit of working together to find common ground continued through the planning process, execution of the forum, and right up to agreeing on the contents of this report.

Delegates at the forum expressed this same positive energy to work across sectors rather than in silos for the betterment of both the short and long term outcomes of the people they work with: adults, children, families, and communities. The common ground they shared in terms of values, approaches, characteristics of promising practices, and understandings of the need for future action were stronger than any of their differences they had. At the same time, delegates

were frank in terms of individual and institutional barriers that can keep them from working in a more integrated fashion with their colleagues from other sectors.

Delegates positively expressed commitments and action they would take in their work back home, both at an organizational change level and in changes to their practice. They expressed a deep desire for this type of cross-sectoral networking to continue after the forum.

Delegates also showed that being inclusive is a process. They called for more emphasis on including diverse communities should another forum or meeting of this kind be held.

It is the hope of the three working groups that this report will provide the first step to keeping the spirit of the network alive after the forum. This is especially important given the recent closing of the Health and Learning Knowledge Centre. It is also the hope of the group that this report will provide the impetus for further action and opportunities for service providers and others to meet across sectors.

Appendix A: Information about the Three HLKC Working Groups

Adult Working Group (AWG)

The Team

Co-chairs: Dr. Allan Quigley and Dr. Hélène Grégoire
Consultants: Sue Folinsbee and Wendy Kraglund-Gauthier

Our Work

The AWG team has worked together since 2005. The AWG's purpose is to advance the health and learning of adults. Its priority groups are:

- adults with literacy challenges,
- immigrants and refugees,
- adults living with HIV/AIDS, and
- adults living in rural and remote regions.

Since 2005, we have worked with a 22 member advisory committee and partnered with more than 23 organizations across Canada.

In 2006, the AWG produced two major reports, which were updated in 2007: *State of the Field on Health and Learning* and *Environmental Scan on Health and Learning*.

From 2006–2008, the group conducted pan-Canadian consultations with community members and service providers from its priority groups. The purpose of the consultations was to develop a knowledge agenda to advance health and learning in Canada, especially for vulnerable and marginalized adults. We identified themes, gaps and needs related to health and learning as experienced by these four priority groups. Our consultation outcomes point to research priorities concerning the learning needed to improve the health of these groups and necessary policy and practice changes.

Early Childhood Work Group (ECWG)

The Team

Lead: Anita Ferriss, Camosun College
Co-coordinators: Enid Elliot and Donna Michal

Members: Representation from organizations including: Canadian Child Care Federation, Healthy Child Manitoba, Centre for Excellence in Early Childhood Development, Early Childhood Learning Knowledge Centre, Public Health, Human Early Learning Partnership, National Collaborating Centre for Aboriginal Health and Community Health Nurses Association of Canada.

Our Work

The ECWG team has worked together since 2006. The ECWG's purpose is to contribute to the health and learning of young children and their families by insuring that information concerning young children's health is part of the continuum of resources for a healthy community. The ECWG works to promote understanding of the intertwined nature of young children's health and learning within a social development context in order to guide parents, practitioners and policymakers in planning for early childhood.

The ECWG has produced three major reports: *Environmental Scan Update 2007*, *Voices on Health and Learning* and a Lesson in Learning, *Mixed Messages: How to choose among conflicting information to support healthy development in young children.*

During the spring of 2007, the ECWG conducted a pan-Canadian consultation with parents, early childhood educators, ECE faculty and health professionals. This consultation, the Target Audience Project, identified health and learning issues and concerns, sources of health information, barriers to accessing information and information gaps and needs. Our consultation findings will inform applied research concerning the health and learning information needs of young families and contribute to further knowledge exchange efforts of the HLKC.

Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals Work Group (CBHLHP)

The Team

Chair: Dr. George Eisler, CEO, BC Academic Health Council
Consultant/Project Manager: Lorna Romilly

Our Work

Working Group #10 of the Health and Learning Knowledge Centre has been working on building capacity around health literacy and patient self-management for health professionals since 2006. The purpose of this project is to ensure that practicing, as well as future, health professionals have the skills, knowledge and attitudes to support social and health care agendas leading to a more empowered and self-reliant public. Consultations, environmental scans and research resulted in the following:

- A Lesson in Learning for the Canadian Council on Learning: *Patient self-management: Health-literacy skills required. (*Can be found at the CCL website: http://www.ccl-cca.ca/CCL/Reports/LessonsInLearning/LinL20070619_patient_self_management.htm?Style=Print&Language=EN.

And the following which can be found on the BCAHC website at: http://www.bcahc.ca/index.php?option=com_docman&task=cat_view&gid=95&Itemid=65):

- A research project on patient self-management/health literacy examining barriers for health professionals and suggested actions for multi-levels: *Identifying and Addressing Education Needs of Health Care Professionals to Foster Patient Self-Management,*
- *Responsibilities for Health Literacy Across the Continuum of Health Care,*
- *Framework and Indicators for Capacity Building Around Health Literacy in Formal Health Professional Education Programs, and*
- A contact/resource list with national and international resources in health literacy.

Appendix B: Steering Committee and Advisory Committee Members

Steering Committee:

George Eisler	CEO, BC Academic Health Council
Enid Elliot	Co-ordinator, HLKC Early Childhood Work Group #4
Anita Ferriss	Lead, HLKC Early Childhood Work Group #4
Sue Folinsbee	Consultant, HLKC Adult Working Group #6
Hélène Grégoire	Co-Chair, HLKC Adult Working Group #6
Wendy Kraglund-Gauthier	Consultant, HLKC Adult Working Group #6
Donna Michal	Co-ordinator, HLKC Early Childhood Work Group #4
Allan Quigley	Co-Chair, HLKC Adult Working Group #6
Lorna Romilly	Project Manager, Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals Work Group #10

Advisory Committee:

Emma Carter	Manager, HLKC
Kathleen Flanagan	Coordinator, Adult Learning Knowledge Centre (AdLKC)
Irv Rootman	Executive Director, Health and Learning Knowledge Centre
Andrew Stern	Financial Coordinator, HLKC
Barb Smith	HLKC “Other Voices” Working Group
Nadine Valk	Senior Research Analyst, Canadian Council on Learning

Advisor to the Steering Committee:

Marina Niks

Appendix C: Social Determinants of Health

The social determinants of health are the social and physical environments in which people are born, grow up, live, work, and get older, and the systems put in place to deal with illness. They include factors such as poverty, housing, education and social exclusion. These economic and social conditions have an impact on the health of individuals and communities because they determine people's access to the physical, social and personal resources they need to be able to live healthy lives. These environments are themselves shaped by a wider set of forces: economics, social policies, and politics.

Social determinants of health include but are not limited to:

Income and social status

The degree of control people have over their life circumstances (e.g., over what type of job or housing they will accept) has an impact on their stress level and their health. Higher income and social status generally result in more control. For example, people who have more money can make the choice to eat fresh organic produce while those who are poor are likely to be more limited in their choices. They will have to eat what is cheapest and available near them (which may not be the healthiest choice).

Employment/unemployment, working conditions and job security

People who are able to choose the type of work they want to do are healthier and often live longer than those who are in more stressful situations or riskier work and activities. Working in stressful conditions or in an unsafe environment can contribute to poorer health.

Housing

The type of housing people live in has an impact on their health. If they cannot afford adequate housing, people may be exposed to contaminants in the air they breathe, the water they drink, or in the soil or other material around their home. If too many people live in the same home, their place might be too crowded for safe or healthy living. In addition, their neighbourhood might not feel safe for children to play outside and/or their home might be located far from amenities that could contribute to their health (e.g., parks and recreational facilities, grocery stores, etc.). These factors can affect people's physical and psychological well-being.

Education

Education contributes to health by providing people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over the factors that affect their lives. Education increases opportunities for finding a good job and for having a steady income and it usually increases people's job satisfaction and contributes to raising their social status. Literacy is especially important for people to be able to access, understand, and use the information they need to keep healthy.

Conditions for early childhood development

A good start in life has an impact on health that lasts a lifetime. Experiences from the time a baby is conceived to age six have the most important influence of any time in brain development, school readiness, and health in later life. We continue to learn how all the other determinants of health affect all aspects of children's development. For example, a child's development is greatly affected by his/her housing and neighbourhood, family income, parents' education, access to nutritious foods, opportunities for physical recreation, and access to medical and dental care.

Social support network

People who know they can count on their families, friends, and communities tend to have better health. When people feel supported, they are better able to solve problems and cope with life situations. Relationships that show caring and respect can contribute to the prevention of health problems.

Social exclusion

Social exclusion, or being left out, can result from racism, discrimination, stigmatization, and poverty. These processes create stress, which, in turn, affects health. They can also prevent people from participating in education, training, and citizenship activities. In addition, social exclusion prevents people from obtaining adequate employment and from accessing culturally appropriate health care and services.

Health services

Health services contribute to health—particularly those services designed to maintain and promote health, to prevent disease, and to restore health contribute to health. This includes having access to health promotion activities, family doctors, dental care, emergency care, and other types of appropriate services.

The above definitions were adapted from the following sources:

Public Health Agency of Canada. (2001). *What determines health?* Available at: http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants

Raphael, D. (Ed.) (2004). *Social determinants of health: Canadian perspectives*. Toronto, ON: Canadian Scholars Press.

World Health Organization Commission on Social Determinants of Health. (2009). *Key concepts*. Available at: http://www.who.int/social_determinants/final_report/key_concepts/en/index.html

Appendix D: Forum Invitation

CANADIAN COUNCIL ON LEARNING CCL CCA CONSEIL CANADIEN SUR L'APPRENTISSAGE

Health and Learning Knowledge Centre Santé et apprentissage

Adult Learning Knowledge Centre Apprentissage chez les adultes

Invitation

In From the Margins: Promising Practices and Possibilities for Health and Learning

A Working Forum for Health Care, Literacy, and Early Childhood Professionals
March 2–3, 2009

1. Invitation to Participate

The Health and Learning Knowledge Centre (HLKC) with the support of the Adult Learning Knowledge Centre (AdLKC) would like to invite you to participate in a pan-Canadian working forum ***In From the Margins: Promising Practices and Possibilities for Health and Learning.*** The event will start on the evening of March 2, and continue all day on March 3, 2009 at the Best Western Richmond Inn Hotel & Conference Centre in Richmond, BC. Three working groups of the HLKC—Adults, Early Childhood, and the Capacity Building in Health Literacy for Health Professionals Work Group are organizing this forum. People working in health care, literacy, and early childhood across Canada are warmly invited to attend. The language of the forum will be English.

2. Purpose of the Forum

In From the Margins will focus on promising practices and recommendations. The focus will be on identifying and addressing barriers adults and their families face related to the social determinants of health. The three Working Groups of the Health and Learning Knowledge Centre will present findings from their consultations. Together we will share knowledge; document and disseminate innovative, promising practices; and bring forward new health and learning possibilities for those now on the margins.

This invitation has been extended to those individuals whom we have identified as engaged in innovative and promising practices. The working forum will be an opportunity to share and further develop these innovative practices. These practices will be documented for wider dissemination and distribution after the forum.

3. Travel Subsidy

The Knowledge Centres are prepared to provide a travel subsidy to those who require financial assistance. If a travel subsidy is required, please indicate this on your RSVP form and let us know by January 14, 2009 with an estimate of your travel costs. While a subsidy may be available to cover expenses such as travel, accommodation, and airport shuttle, delegates will be expected to cover any additional costs such as meals not provided at the forum and taxis. If these additional expenses would prevent attendance at the event, please let us know.

4. RSVP

Please let us know by January 14, 2009 if you are able to participate in this forum by returning the attached RSVP form. If you have any questions or concerns, please do not hesitate to contact us at bcforum@stfx.ca.

Forum information is also available on our website at www.stfx.ca/events/bcforum, which will be updated as new information emerges.

Appendix E: Delegate List

Betsy	Alkenbrack	Department of Community Development & Outreach Capilano University	balkenbrack@cdo.capilanou.ca
Carolina	Ashe	Literacy Branch BC Ministry of Education	Carolina.Ashe@gov.bc.ca
Jody	Bauche	Victoria Native Friendship Centre	jody.aidp@vnfc.ca
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Appendix F: Forum Agenda

CANADIAN COUNCIL ON LEARNING CCL CCA CONSEIL CANADIEN SUR L'APPRENTISSAGE

Health and Learning Knowledge Centre
Santé et apprentissage

Adult Learning Knowledge Centre
Apprentissage chez les adults

In From the Margins:
Promising Practices and Possibilities for Health and Learning

A Working Forum for Health, Literacy, and Early Childhood Professionals

AGENDA

Monday, March 2

5:30 – 6:30 pm **Registration**

6:00 **Opening Prayer**, Elder Mary Charles, Musqueam Band

6:00 – 6:45 pm **Buffet Dinner**

6:45 – 7:15 pm **Welcome and Opening Remarks**
Nadine Valk, Forum Chair, Canadian Council on Learning (CCL)
Irving Rootman, Health and Learning Knowledge Centre (HLKC), CCL
Kathleen Flanagan, Adult Leaning Knowledge Centre, CCL
B. Allan Quigley, Adult Working Group, HLKC, CCL

7:15 – 7:30 pm. **Who's in the Room**

7:30 – 8:45 pm **Panel Presentation:** *What do we need to have good health? Perspectives from the community*
Moderator: Nadine Valk, Forum Chair
Betsy Alkenbrack, Instructor, Department of Community Development and Outreach, Capilano University
Baijayanta Mukhopadhyay, Medical student**,** McGill University
Angel Sampson, Manager, Songhees First Nation Early Childhood Education Centre
Barbara Smith, Other Voices Working Group, HLKC

8:45 – 9:00 pm **Evening Wrap Up**

AGENDA

Tuesday, March 3

8:00 – 9:00 am **Healthy Breakfast**

9:00 – 9:20 am **Welcome Back**
Nadine Valk, Forum Chair, CCL

9:20 – 9:25 am **Opening Remarks**
His Honour, **the Honourable Steven Point**, Lieutenant Governor of British Columbia

9:25 – 9:30 am **Greetings from Canadian Council on Learning**
John Biss, CCL

9:30 – 9:45 am **Overview of the Day**
Anita Ferriss, Early Childhood Working Group, HLKC, CCL

9:45 – 10:00 am **Networking Break**

10:00 – 10:55 am **Roundtable 1 Discussion: Knowledge Exchange across Sectors**
Health, health information and health services: Barriers and promising practices

10:55 – 11:50 am **Report-backs from Roundtable 1 Discussion**

11:50 – 1:15 pm **Lunch and Panel Presentation:** *In from the margins: Findings from the three working groups*

Moderator: George Eisler, BC Academic Health Council
Hélène Grégoire, Adult Working Group
Donna Michal, Early Childhood Working Group
Lorna Romilly, Health Professional Network

1:15 – 2: 05 pm **Roundtable 2 Discussion: Knowledge Mobilization within Sectors**
How can we use what we heard here today in our own work?

2:05 – 2:40 pm **Report-backs from Roundtable 2 Discussion**

2:40 – 3:00 pm **Networking Break**

3:00 – 3:30 pm **Plenary Session:** *Recommendations for change*
Moderator: Nadine Valk, Forum Chair

3:30 – 4:00 pm **Plenary Session:** *How do we sustain this discussion and network in the future?*
Moderator: B. Allan Quigley, Adult Working Group

4:00 – 4:15 pm **Closing Remarks:** Irving Rootman, HLKC

Appendix G: Forum Evaluation Form and Results

Evaluation Form

Please take a few minutes to fill out this short evaluation questionnaire. The results will help us learn what you thought of this forum and how we can improve various aspects for future similar activities.

A. Please rate your agreement with the following statements:

	Totally Agree	Agree	Not Sure	Do not Agree
I learned about the findings from the three HLKC working groups.	☐	☐	☐	☐
I have a better understanding of the multiple barriers adults and their families face in accessing health information and services.	☐	☐	☐	☐
I learned about good practices to better address the needs of adults and their families who are marginalized.	☐	☐	☐	☐
I had opportunities to recommend solutions and promising practices to overcome barriers.	☐	☐	☐	☐
I had the opportunity to discuss ways we can sustain and build an ongoing network.	☐	☐	☐	☐

Comments:

B. What were the main strengths of the forum?

C. What changes should we make another time to improve the forum?

D. Please rate each of the following aspects of the forum:

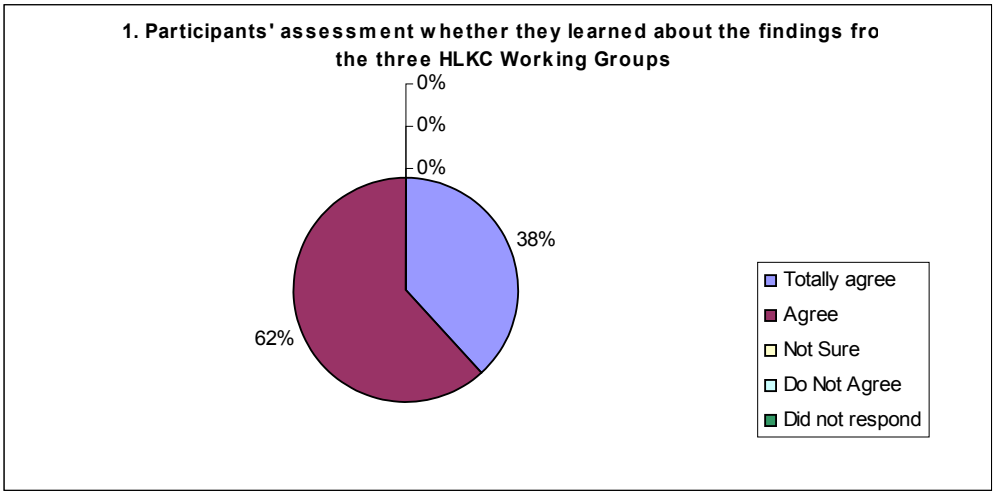
	Excellent	Good	Fair	Poor
Forum organization	☐	☐	☐	☐
Forum facilities	☐	☐	☐	☐
Forum content and focus	☐	☐	☐	☐
Forum facilitation	☐	☐	☐	☐
Pre-forum information	☐	☐	☐	☐
Forum kit	☐	☐	☐	☐
Monday night panel	☐	☐	☐	☐
Roundtable 1	☐	☐	☐	☐
Tuesday lunch panel	☐	☐	☐	☐
Roundtable 2	☐	☐	☐	☐
Plenary: *Recommendations for Decision Makers*	☐	☐	☐	☐
Plenary: *How do we sustain this discussion and network in the future?*	☐	☐	☐	☐

Additional comments:

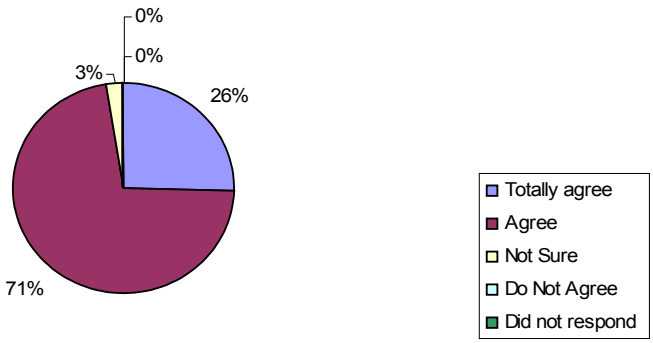
Thank you

Evaluation Results

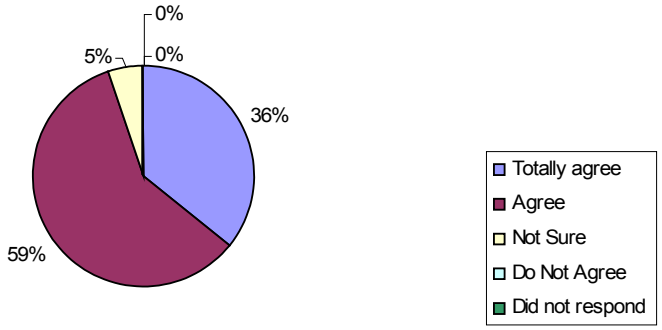
The following figures were constructed from the participants' responses on the Forum Evaluation.



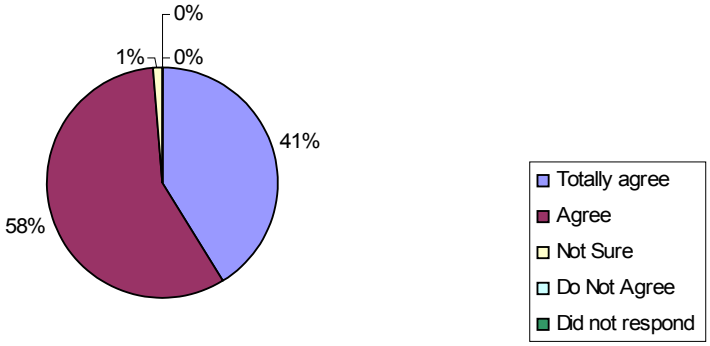
3. Participants' assessment whether they learned about good practices to better address the needs of adults and their families who are marginalized.

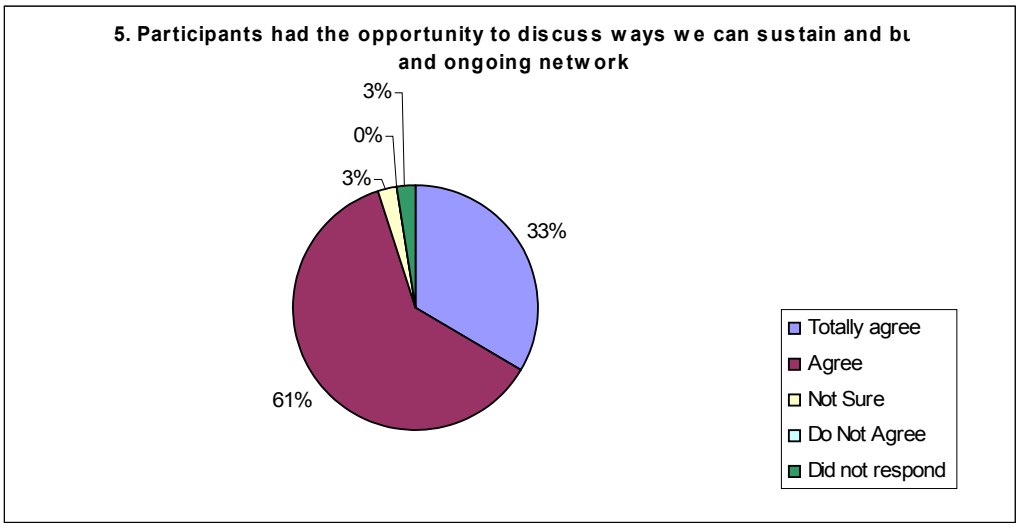


2. Participants' assessment whether they have a better understanding of t multiple barriers adults and their families face in accessing health information and services



4. Participants had opportunities to recommend solutions and promisi practices to overcome barriers




5. Participants had the opportunity to discuss ways we can sustain and bu
and ongoing network
3%
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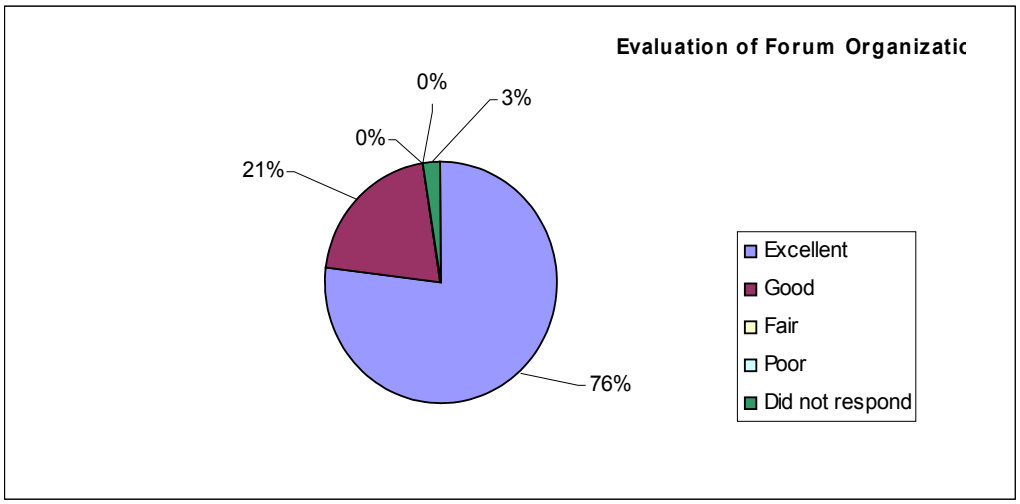
3%
33%
61%
Totally agree
Agree
Not Sure
Do Not Agree
Did not respond


Evaluation of Forum Organizatic
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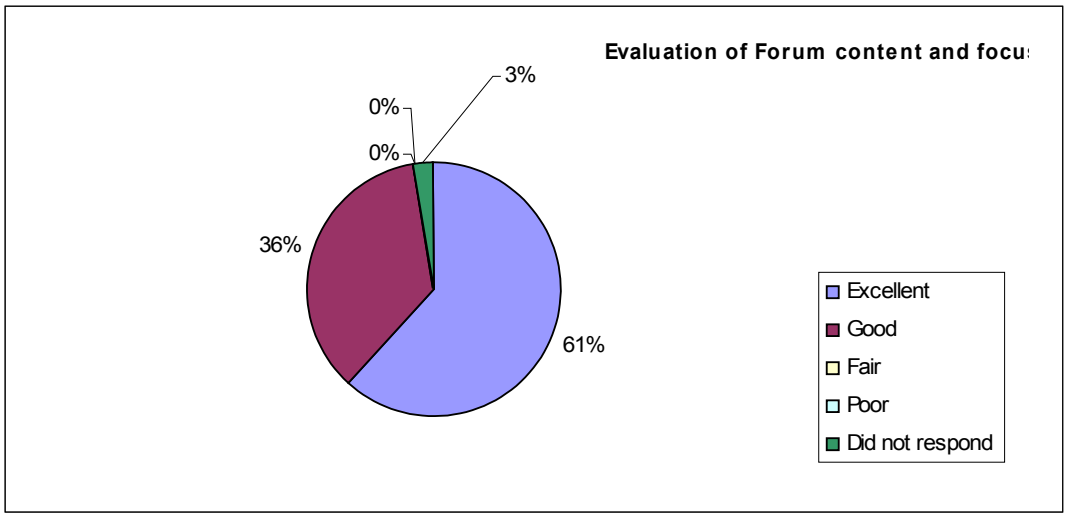
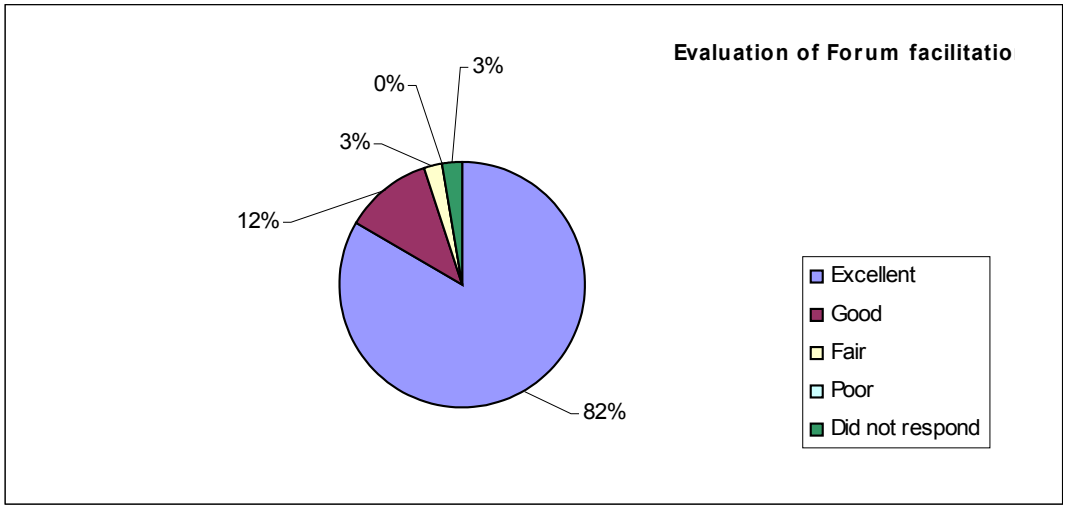
3%
0%
21%
76%
Excellent
Good
Fair
Poor
Did not respond


Evaluation of Forum content and focu
3%
0%
0%
36%
61%
Excellent
Good
Fair
Poor
Did not respond


Evaluation of Forum facilitatio
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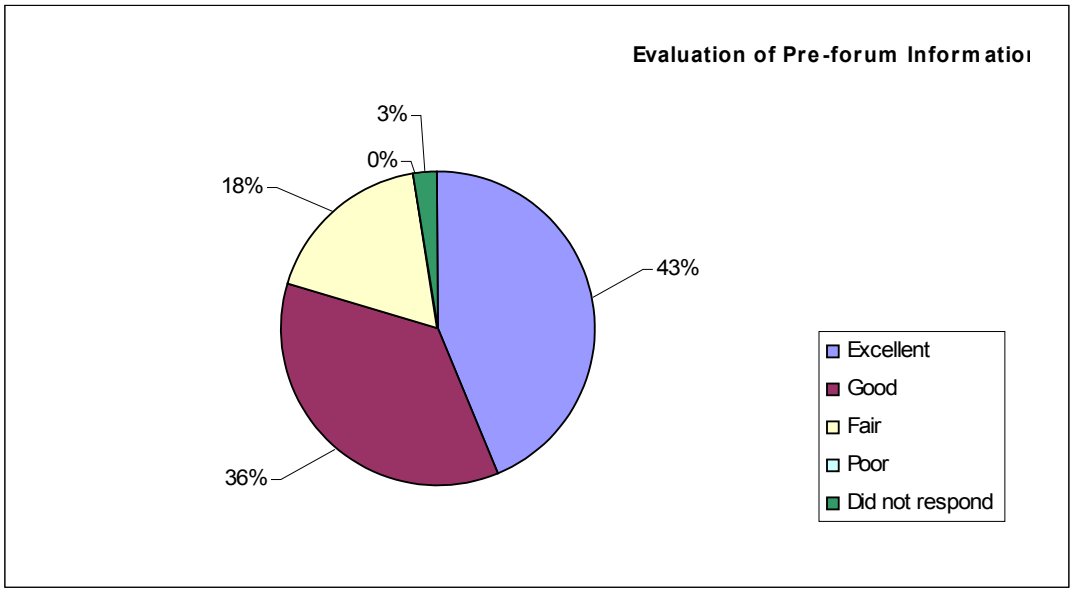
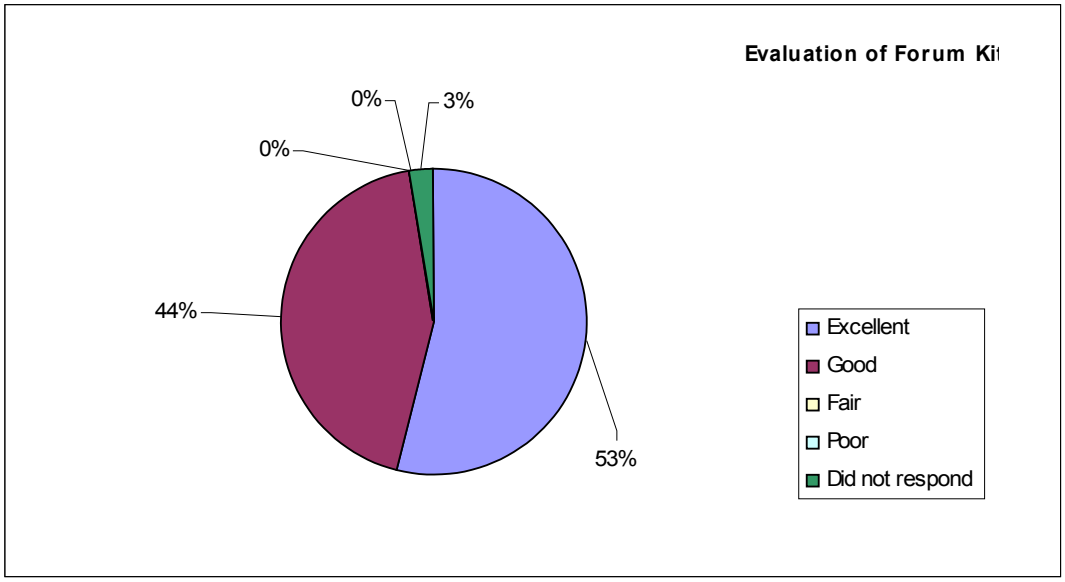
82%
Excellent
Good
Fair
Poor
Did not respond


Evaluation of Pre-forum Informatio
3%
0%
18%
43%
36%
Excellent
Good
Fair
Poor
Did not respond


Evaluation of Forum Ki
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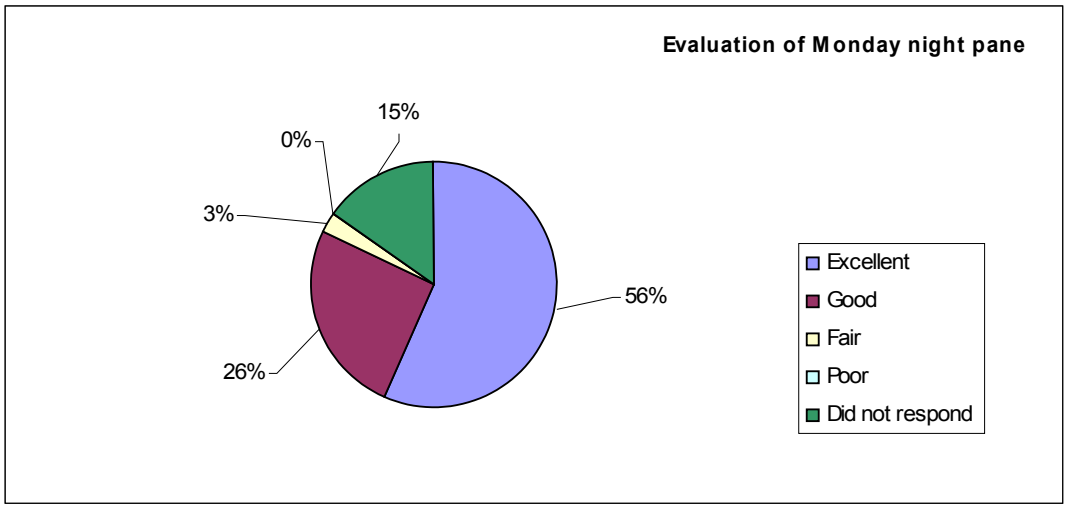
53%
Excellent
Good
Fair
Poor
Did not respond


Evaluation of Monday night pane
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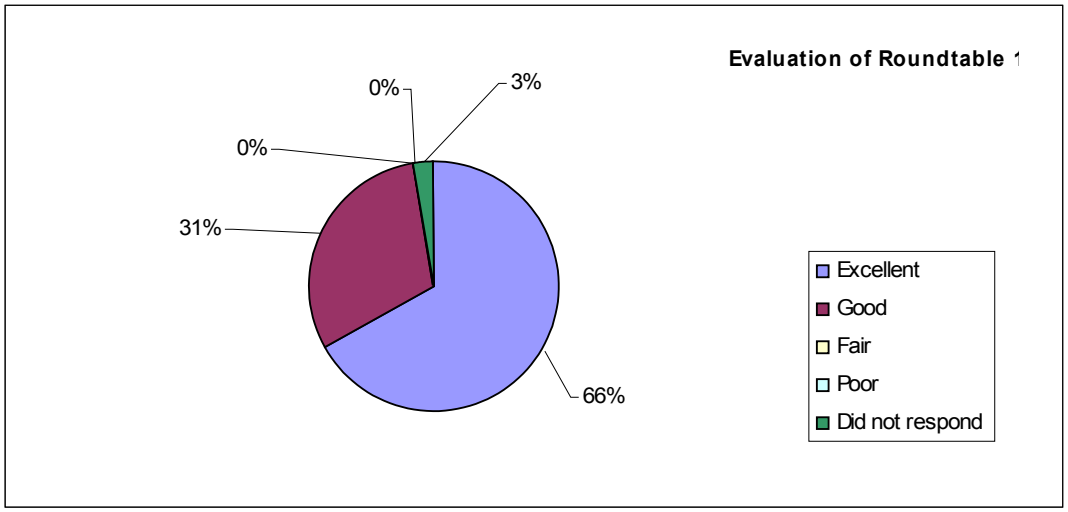
0%
3%
56%
26%
Excellent
Good
Fair
Poor
Did not respond


Evaluation of Roundtable 1
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Excellent
Good
Fair
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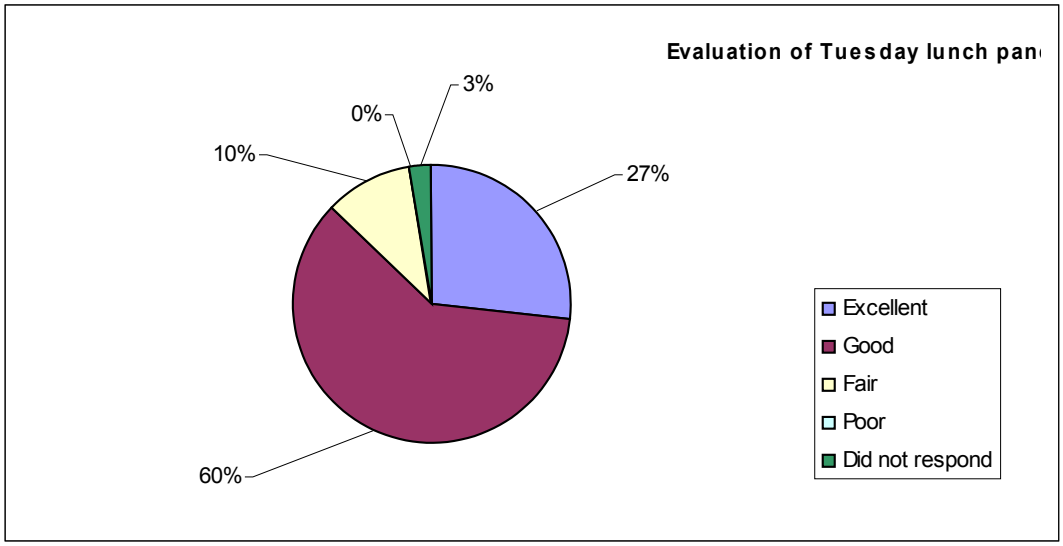
Evaluation of Tuesday lunch pan
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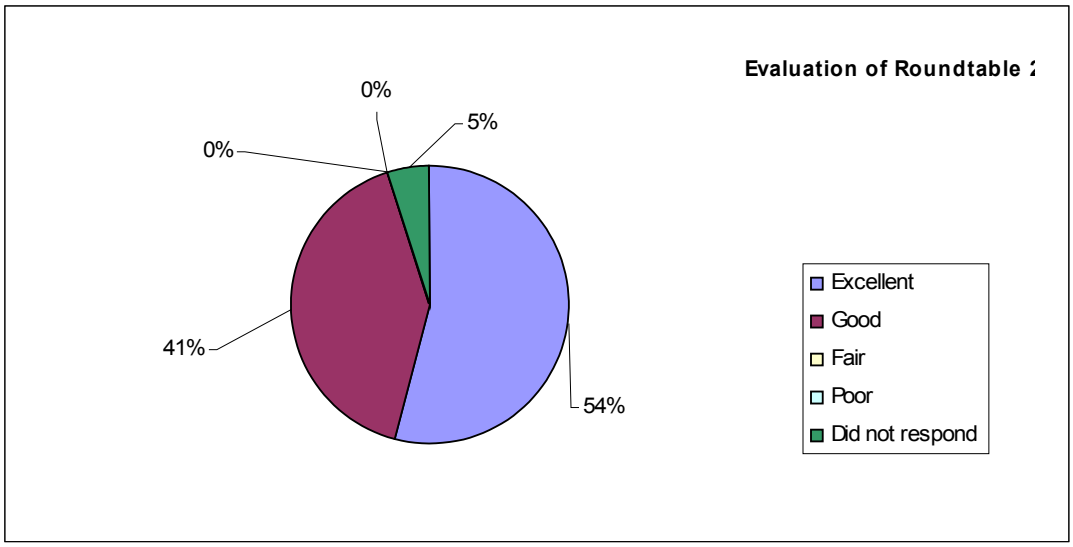
0%
10%
27%
60%
Excellent
Good
Fair
Poor
Did not respond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Poor
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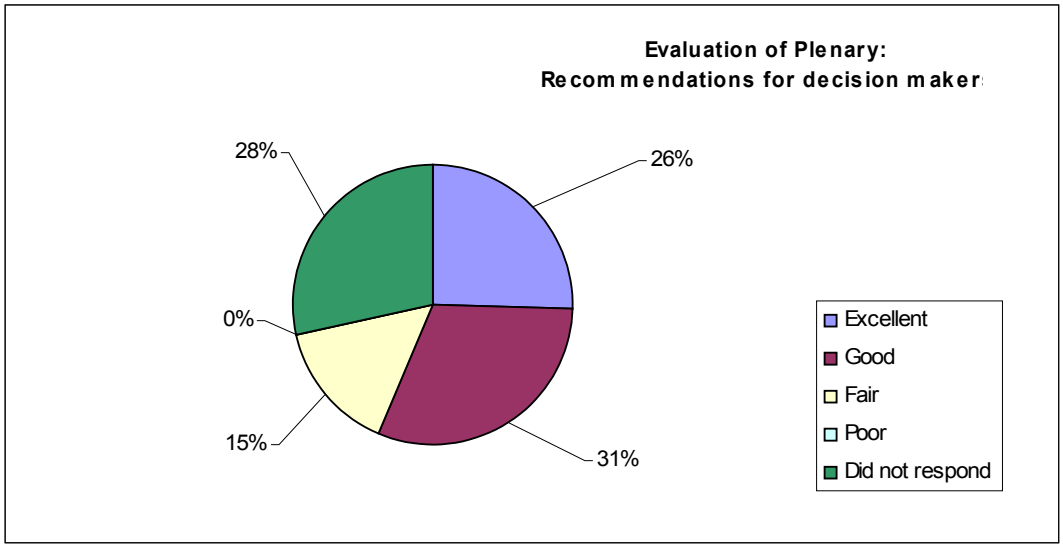
Evaluation of Plenary:
Recommendations for decision maker
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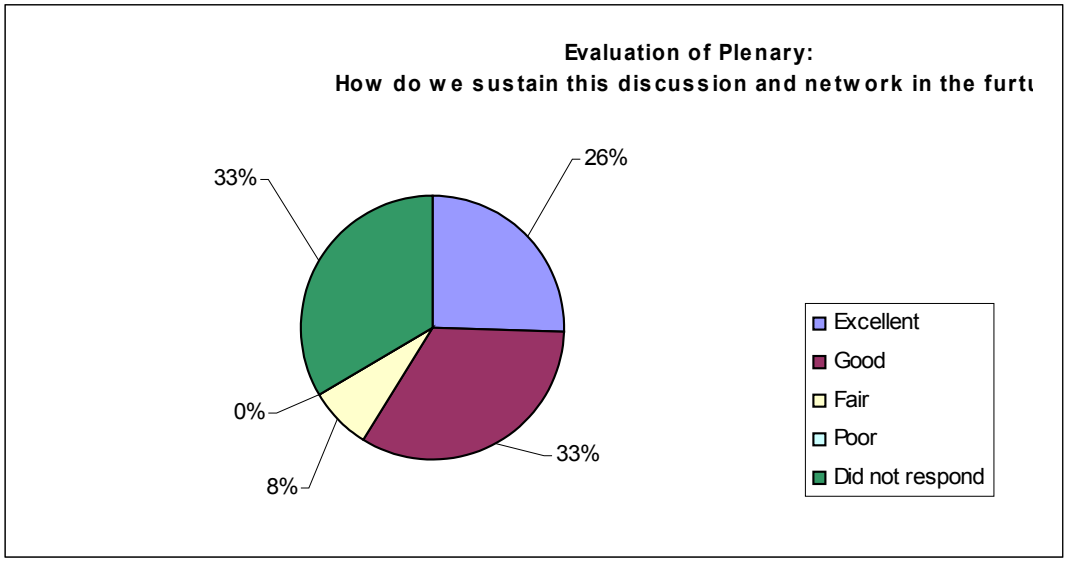
26%
0%
15%
31%
Excellent
Good
Fair
Poor
Did not respond


Evaluation of Plenary:
How do we sustain this discussion and network in the furtu
33%
26%
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8%
33%
Excellent
Good
Fair
Poor
Did not respond