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ADULT HEALTH AND LEARNING IN CANADA

REFLECTIONS ON A FOUR-YEAR PROJECT CONDUCTED UNDER THE AUSPICES OF THE HEALTH AND LEARNING KNOWLEDGE CENTRE AND THE CANADIAN COUNCIL ON LEARNING

2005–2009

The Adult Working Group
Health and Learning Knowledge Centre

ACKNOWLEDGEMENTS

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I. INTRODUCTION, ACKNOWLEDGEMENTS, AND INTENT

The Adult Working Group arose out of the establishment of the Canadian Council on Learning (CCL) and, in turn, the Health and Literacy Knowledge network which followed. By way of brief background, the Canada Council on Learning (CCL) was established in 2004 under the federal Liberal government with funding from Human Resources and Social Development Canada. This arose out of a series of nationwide consultations on innovation whereby participating Canadians agreed that lifelong learning is required if Canada is to be a leader in innovation, skills, and learning. The events that followed the creation of the CCL included the establishment of five Knowledge Centres across Canada: The Work and Learning Knowledge Centre, the Early Childhood Learning Knowledge Centre, the Adult Learning Knowledge Centre, the Aboriginal Learning Knowledge Centre, and the Health and Learning Knowledge Centre.

This is the final report of the Adult Working Group—a group of four individuals assisted by an international advisory committee, a highly supportive staff at the Health and Learning Knowledge Centre, the financial staff at St, Francis Xavier University, the Canadian Council on Learning, and allied HLKC Working Groups; but, above all, we were assisted by health and adult education practitioners and those whom they worked with across Canada. Without the funding support, the advisory assistance and the generous help of those communities who participated in this important work, this project would not have been possible.

The intent of this report is to reflect on what we learned—not only in terms of the outcomes, but what we learned about the four-year process itself. Reflections on what went well and what we might have done differently may, we hope, be instructive to others who might undertake a similar project into the future.

Background to the Health and Learning Knowledge Centre

Each Knowledge Centre has its own story but, in the case of the Health and Learning Knowledge Centre, the story for the Adult Working Group began in 2004 with a number of stakeholders—particularly health and adult educators working in a wide range of policy and practice across Canada. They met at the University of Victoria and, later, in Vancouver on three separate occasions to develop a proposal to submit to the CCL. In a highly collaborative manner, this proposal envisioned a Health and Learning Knowledge Centre and asked to have it established at the University of Victoria. Dr. Budd Hall, Dr. Irv Rootman, Dr. Joan Wharf-Higgins, and Doug McCall were among those who took the organizing leadership for this proposal.

Among those invited to those early consultation meetings was Dr. Allan Quigley, then at St. Francis Xavier University, Antigonish, Nova Scotia. The proposal to establish the Health and Learning Knowledge Centre at the University of Victoria was ultimately put forward to the CCL with indications of support from a wide number of health, educational, and community institutions. The proposal was accepted by the CCL and the HLKC was established at the University of Victoria in 2004–2005.

To deliver its wide mandate, the HLKC established a number of working committees which would then focus on various segments and issues of health and learning across the lifespan.

These Working Groups would focus on life stages from early childhood through the school-years, to adulthood, to seniors' learning and their health. The work of the HLKC would also be conducted with the help of an Expert Panel and working committees which would concentrate on, for instance, the health professions and scientific issues of health knowledge and learning. Each Working Group, panel and committee had a separate focus but all worked under the wider mission of the Health and Learning Knowledge Centre.

The founding mandate of the Adult Working Group—similar to all of the Working Groups—was to "define a Knowledge Agenda for the Canadian Council on Learning (CCL) and the HLKC and propose that agenda to CCL and other research organizations." This mission was to be accomplished with attention to three central themes:

- Health literacy (with a priority on access, equity, and achieving basic health literacy for all);
- Developing and sustaining healthy communities of life-long and life-wide learning;
- Strengthening the capacity of communities, practitioners and public agencies/systems to implement intertwined health and learning strategies in comprehensive, sustainable, effective ways.

It was also understood that each Working Group would address these four primary functions of the CCL by making recommendations as well as preparing, facilitating, implementing, and reflecting on small or large-scale activities in these areas. These four functions were to include:

- research;
- data/monitoring/reporting;
- knowledge transfer; and
- dissemination/communications

Each Working Group was to consult with a CCL senior staff person responsible for these four functions.

Establishing the Adult Working Group

In 2005, Dr. Quigley was invited to chair one of the several Working Committees—the Adult Working Group (AWG). Allan's first concern was that this Chair position required more than one person. He asked if he could perhaps co-chair this with someone else and Dr. Budd Hall, then the HLKC Director, put out an invitation through the Canadian Association for the Study of Adult Education listserv. Dr. Hélène Grégoire was one who responded. She was invited to co-chair the committee with Allan. In turn, they asked Sue Folinsbee and Wendy Kraglund-Gauthier to be the other two members of the Adult Working Group since both had high levels of expertise and experience in this area.

But even before the Adult Working Group got underway, Budd Hall and Allan Quigley discussed what the actual focus might be for this new working committee. After all, there are many adults in Canada and health and learning is a massive topic. Who to focus on? With the mandate of the HLKC in mind, it was their concern that certain marginalized groups in Canada would probably have a very different story to tell about health and learning than would the

mainstream. If recommendations for a research agenda and the other activities outlined in the mandate were to be addressed, Hall and Quigley asked about the health and learning of those adults in Canada who often live at the margins of society. They asked: "How universal is Canada's universal health care system when we think of those not in the mainstream?" They posed the questions: "How do Canadians with limited literacy and language skills learn about and maintain their health? How do those with minimal access to health facilities in remote areas learn about and maintain their health? How do those living with HIV/AIDS maintain and learn about their health? It is relatively easy to ascertain the needs and concerns of those Canada's mainstream, but what are the unique barriers and challenges of those who are too often at the margins of our society? What recommendations would they have for further research, policy, and practice?"

Initially, Hall and Quigley thought that the Adult Working Group might focus on the input of five groups in Canada: Aboriginal adults, adults with low literacy skills, adult refugees and immigrants, adults living in rural and remote regions of Canada, and those living with HIV/AIDS. However, since the Aboriginal Learning Knowledge Centre already existed, and since there was no desire to overlap with the work of that CCL-sponsored Knowledge Centre, Allan talked with a board member involved with the Aboriginal Learning Knowledge Centre and it was agreed that the Adult Working Group (AWG) would not directly seek to focus on Aboriginal experiences with learning and health as a target group; instead, the Adult Working Group would try to liaise and communicate with that Centre where Aboriginal health issues might arise.

Early in the founding of the Adult Working Group, we sought the help of 21 international adult learning experts. With their input and extensive assistance from the HLKC, our four-person team set out to develop a plan and set of objectives for the coming three years. The funding from the HLKC ranged from $60,000 to $90,000 annually as we conducted an environmental scan on health and learning in Canada and developed a State of the Field report, then launched a series of consultations with Canadians in our four priority groups.

With a literature and research background as our foundation, we then planned and conducted pan-Canadian consultations with marginalized Canadians concerning their health and learning. Consultations occurred in British Columbia, Alberta, Saskatchewan, Ontario, Nova Scotia, and the Northwest Territories. As noted, the groups we consulted with through the four year period included:

1. Adults with low literacy skills;
2. Adult immigrants and refugees;
3. Adults living with HIV/AIDS; and
4. Adults living in remote and rural regions of Canada.

The full consultation report was submitted in June 2008, and a national capstone forum to discuss the findings and bring adult and health practitioners and researchers together was held in Vancouver in February 2009.

Purpose and Intent of this Report

Consistent with the mandate of each Group to "prepare, facilitate, implement *and reflect* on small or large-scale activities in these areas," this report constitutes the final report of our multi-faceted project and is intended to summarize, reflect upon, and make both process and future research recommendations arising from the four-years of work the Adult Working Group.

Reflecting on the Establishment Phase

The establishment of the HLKC and our Adult Working Group was an exciting time. We felt strongly that learning—particularly adult learning—was being largely neglected in the "medicalized" and highly institutionalized world of health and medicine. Adult education and learning, as we were interested in exploring, seemed to need to play a stronger role in the health of Canadian adults. We were in agreement that the voices of so many of the marginalized in Canada were not heard at the policy and, often, at the practice level and believed that adults can "learn their way forward" given the tools to do so. We were willing to take on something of an advocacy role in our work to try to bring the voices of those we sought to engage with to the research, policy and practice decision-makers of the future. The CCL and HLKC gave us, and many like us, the opportunity to make space for others to speak.

Reflecting on this early phase and decisions made, the four target groups chosen for our work were highly appropriate for what we were working to achieve, but the liaison with the Aboriginal Learning Knowledge Centre did not prove to be particularly successful. We did not see much on Aboriginal health and learning arise from either Centre through time. Looking back, our group might have sought to have the voice of Aboriginal adults more clearly articulated from among those whom we met with. Perhaps a sub-group could have been developed on a Pan-Canadian level.

Secondly, dissemination of our Groups' reports and findings was an ongoing frustration throughout the duration of our mandate. For reasons ranging from a lack of HLKC and CCL human resources to poor communication between the sponsoring agencies, it was very difficult in the first years to get reports and findings disseminated. The groups across Canada which we had worked so closely with had expectations that their stories and recommendations would be heard. However, towards the end of our project, this was addressed and most of our reports can be found on the CCL website, the National Adult Literacy Database (NALD) website and the Canadian Public Health Association (CPHA) web portal. Our work also appears in journal articles and conference proceedings (see Appendix A: Dissemination Activities of the AWG).

Third, the mandate of the HLC was never to engage in large research studies; rather, to propose a research agenda for the CCL and other agencies. Since the CCL mandate was not renewed after 2010, and since the HLKC has since been closed, one wonders if the many proposals and reports submitted, not only those from our Working Group but the reports and recommendations from all five Knowledge Centres, will ever be acted upon? Looking back, perhaps various Working Groups might have been given more authority to initiate actual research, and do so in close concert with the CCL and with or through various research

institutions, rather than send in proposals to the CCL for a “future agenda.” If there is evidence that such a “future agenda” is being acted upon in any systematic way, now that the mandate of the CCL and HLKC is over, none on the Adult Working Group have been apprised of it. By not encouraging systematic research, even with the strength of the Pan-Canadian consultations voices reported here and elsewhere, the informal methods of choosing participants and the “location of convenience” selection criteria used by the Adult Working Group does not allow the outcomes to be considered systematic nor can it be claimed to be “generalizeable research.” Since research was not the mandate of the Working Groups, we have necessarily cautioned against generalizing the results across contexts. Looking back, is this the best way to have ended four years of work?

Nevertheless, while generalizations cannot be made from the consultation outcomes, the outcomes do provide a good deal of illustrative insight into areas of adult health and learning—further areas that call out to be explored through systematic research. We can only hope this may be achieved into the future.

Finally, despite its limitations, it is clear that a four year life span for a major pan-Canadian activity of this nation-wide nature was too short. So much more could have been accomplished. Yet, knowledge was exchanged; practitioners, policy-makers, and researchers brought new ideas and concepts forward; many shared best practices in ways that had never occurred before in Canada; networks were created that continue and the dissemination of outcomes that arose from our Working Group and others have already outlived the life of our immediate Knowledge Centre hosts. Much has been achieved.

It needs to be emphasized, in closing this section, that the Adult Working Group team worked remarkably well together; the supports from HLKC were exceptional; and individuals from the CCL went far out of their way to ultimately help disseminate this Group’s outcome findings.

II. YEAR TWO: DEVELOPING THE *ENVIRONMENTAL SCAN* AND THE *STATE OF THE FIELD REVIEW ON HEALTH AND ADULT LEARNING*

In order to determine an appropriate and relevant focus for our consultation process, the Adult Working Group team undertook a comprehensive environmental scan and state of the field review. The resulting two documents serve to inform stakeholders of the work being done in the field of health and learning across Canada. Specifically, the purpose of the *Environmental Scan* was to identify current knowledge initiatives and knowledge dissemination vehicles related to health and adult learning. The purpose of the *State of the Field Review on Health and Adult Learning* was to make generalizations about the existing literature—both practitioner-based and academic—related to the health and learning of adults. Also, in the analysis of this literature, we identified gaps and made recommendations with respect to promising lines of inquiry for the future.

Design of the *Environmental Scan* and the *State of the Field Review*

Before commencing the community consultations, the Adult Working Group felt it was necessary to have a cogent plan and an informed perspective of the state of the health and learning issues of Canadian adults. In addition to informing the work of the CCL and other key stakeholders in the fields of health and learning, we believed strongly that the process of compiling the data would serve to inform the planning and delivery of the consultations in Year Three and Four. Year Two was dedicated to the research and compilation of these key documents, starting with the *Environmental Scan* and then moving on to the *State of the Field Review on Health and Adult Learning*.

The *Environmental Scan*

The *Environmental Scan* focused on the three central themes of the HLKC and the five priority areas of the Adult Working Group. It included the settings (i.e., workplace, community, health care, and families) of the Adult Working Group and aligned with the research priorities of the CCL. The scan also included an appendix of important recommendations for the future and other information generated by participants before, during, and after the HLKC Vancouver Consultation in June 2005. This information includes potential themes and topics that could be investigated by the HLKC, existing research and knowledge organizations that appear to be building relations between health and learning, and reports that could be published on a national basis, etc. While this information is important for future planning, it did not belong in the official scan of current knowledge initiatives and knowledge transfer vehicles. In the original planning and funding model, the *Environmental Scan* was to be updated yearly; however, this did not happen. After the first scan was completed in 2006, the Adult Working Group was able to complete one additional update in 2007 before its funding was discontinued.

The audience for the *Environmental Scan* was purposively broad to encompass a number of stakeholders working at various health and adult learning policy and programming levels. As such, the intended audience includes researchers, academics, practitioners, decision- makers,

and others with a high interest in adult learning and health. The intent was that the information contained in the scan would serve to inform, among other things, everyday practice, strategic planning, proposal writing for programs and funding, and policy initiatives.

The scan completed by the Adult Working Group was an updated revision and expansion of a preliminary concept document prepared by Allan Quigley and Budd Hall, with input from the initial advisory committee for the HLKC's June 2005 consultation. Once the Adult Working Group's Advisory Committee, and, in particular, the Adult Working Group Co-chairs had vetted the proposed categories of information and search locations, Folinsbee and Kraglund-Gauthier assumed primary responsibility of compiling information.

Folinsbee and Kraglund-Gauthier conducted numerous Internet searches, starting with well-known national organizations, databases, and websites related to health and to adult learning, and specifically related to the five Adult Working Group priorities. These searches led to other Internet links and other sources of information. Members of the Adult Working Group also contributed links and information for the scan. Many references included in the *Scan* are national in scope and relevant to the broad Canadian context; furthermore, many of the national links include other links to provincial/territorial and local projects. Significant provincial/territorial or local sources were also included where they contributed to the national picture, or where there was an absence of information on a topic at the national level.

The Adult Working Group made every effort to include research-in-practice websites and networks in the scan to include the work of practitioners. In addition, useful references that added to the body of knowledge in Canada from the United States, the United Kingdom, and Australia were also included. International references that seemed to connect strongly to national work are also in the scan. In order to maintain a national focus, references to local research projects on health and learning were not included, though they may appear as embedded content on listed websites. Using the five Adult Working Group priorities, information was organized according to categories including the following:

- Websites, databases, and portals
- Listings of organizations and agencies that analyze and link data and broker knowledge
- Educative and training programs
- Provincial and territorial government resources and planned research funding programs
- Inventories of research or researchers and related journals
- Forums (i.e., conferences, workshops, and institutes; discussion lists; and listservs)

The *State of the Field Review on Health and Adult Learning*

In the 2005–2006 fiscal year, the Adult Working Group conducted a comprehensive review of the existing literature and state of the field related to adults and health and learning. In the resulting report and its 2006–2007 update, the Adult Working Group provided generalizations about the state of the field and reports on knowledge gaps related to the health and learning of adults in its five priority groups. We also identified gaps in this literature and made

recommendations with respect to promising lines of inquiry for the future. Similar to the *Environmental Scan*, the *State of the Field Review* was meant to be useful and accessible to practitioners, researchers, academics, and policy-makers involved in the health and learning of Canadian adults.

Guided by the expertise of the entire Adult Working Group membership, in its search criteria the research team included national references relevant to a broad Canadian context, and provincial, territorial, and local sources that also contributed to building a national perspective. Also included was international literature deemed to have influence in Canada. To maintain the focus on accessibility, the team excluded those works assessed as extensively technical or medical. Excluded were conference proceedings that tended to appear in publications; materials identified to be too location-specific, including many provincial and territorial reports; and practical materials related to teaching and learning. Theses and dissertations on health and learning were generally excluded because of the difficulty in gaining access to in-house publications, but those which re-occurred in references and those identified by the Adult Working Group were included. Again using the five Adult Working Group priorities, over 1,660 references were organized according to categories including the following:

- Canadian government and government-related reports
- International social literature on health, including government and organizations
- Theories of health and learning
- Capacity-building
- Health promotion and learning, teaching, and Research-in-Practice
- Indicators of change (practice- and policy-based)

Summary of Findings

In the analysis of the *Environmental Scan's* content, the Adult Working Group identified a separation between the fields of adult learning and health. While each field had its own terminology, research agendas, and methods of dissemination, there were very few intersections and sharing between the fields was minimal. Furthermore, few organizations and research agendas explicitly linked health and learning together—this, despite the presence of federally-funded opportunities for health initiatives. As well, the Adult Working Group identified disparities among the five priority groups in terms of knowledge initiatives and vehicles for knowledge dissemination. Immigrants and refugees and adults living in rural and remote areas of Canada appear to be especially under-represented in health and learning policy and programming.

The *State of the Field Review on Health and Adult Learning* revealed several trends in the literature reviewed. First, there was no shortage of literature and government reports that focused on knowledge or provided both technical and general information about health, health care, and health-related issues generally, and for specific communities in particular. There was also much literature that described the health of Canadians and the health status of communities and regions of Canada. The Adult Working Group found a rich knowledge base describing and reporting on the social determinants of health, inequalities within health, how

these inequalities may be addressed, and how the health of Canadians improved. At the same time, there was a strong research base on indicators for health-related topics and measurement tools that assessed health and recommended ways to access health care. In contrast, there were few linkages between adult learning and education as a field, and what role learning and education this might play in improving the health of Canadians. A few citations in the international literature did make these connections and may be helpful in the Canadian context.

The international literature cited seemed to focus on community involvement that includes community participation and moves health-related issues to community-based participatory research, participatory education and action, and community capacity-building. However, there was scant Canadian literature in this area. Community capacity-building is a critical area connecting health and learning and needs to be further explored as a vehicle for community empowerment whether through participatory research, research-in-practice or research related to other community capacity related interventions. Given the role that adult learning might have in improving health, the emerging areas in the literature were ones that were collective such as community-based participatory education and community capacity-building.

Dissemination of the Reports

After a detailed process of member-checking with the Adult Working Group's Advisory Committee, the reports were submitted to the CCL's Health and Learning Knowledge Centre for posting to their website. As well, we summarized the findings of the *Environmental Scan* and this summary was translated to French and also posted on the CCL website. As noted earlier, despite the CCL's closure in 2009, all website materials are still available. In addition, both reports have been posted to the Canadian Public Health Association's (CPHA) web portal and to the National Adult Learning Database (NALD) website. Also, as funding permitted and opportunities emerged, the Adult Working Group has been team presenting the findings from these reports at meetings and conferences and in publications (See Appendix A).

Reflections on the Literature Background Stage of the Project

The process of examining and compiling the literature and content materials for the *Environment Scan* and the *State of the Field Review on Health and Adult Learning* was time-consuming, yet affirming. The resulting documents are a testament to the ongoing work that has been done in Canada concerning the health and learning of adults.

It was also strikingly apparent that there are significant gaps among researchers, policy-makers, practitioners, and learners. We in the Adult Working Group questioned our own actions, debating whether the laborious task of compiling the *Environmental Scan* and the *State of the Field Review* was an important contribution to the body of knowledge, or whether it was merely another "academic exercise" that would make little impact. A significant amount of the data included in the reports relates to "counts and amounts" studies; the voices of experience of adult learners were missing. These gaps and boundaries only served to strengthen our

resolve to undertake consultations with adults in the marginalized groups discussed earlier, together with key stakeholders involved in their health and adult learning across Canada.

III. YEARS THREE AND FOUR: CONSULTATIONS

Once informed by the results of the *Environmental Scan* and the *State of the Field Review on Health and Adult Learning*, the Adult Working Group team planned and facilitated community consultations to identify themes, gaps, and needs related to health and learning as experienced by the four priority groups identified in our original planning in 2006. Ultimately, our goal was to bring about a greater understanding of the relationship between health and learning and in initiatives to improve the health status of those groups across Canada. In the Adult Working Group's consultation plan, particular attention was paid to issues of gender and racialization across the identified range of priority areas and we

Using project funds from HLKC and welcome additional funds from the National Collaborating Centre for Determinants of Health (NCC-DH), based at St. Francis Xavier University in Antigonish, Nova Scotia, we were able to make a concerted effort to engage in direct discussion with marginalized adults in the identified groups who could be directly helped through an effective knowledge exchange and translation with respect to health and learning. In Year Three (2006–2007), we focused on the health and learning of adults with low levels of literacy skills and adult immigrants and refugees. In Year Four (2007–2008), we focused on the health and learning of adults affected by HIV/AIDS and adults living in rural and remote regions.

Developing a Model for Consultations

The plan for the consultations was developed by the Adult Working Group with input from its national Advisory Committee as part of its planning work in 2005–2006. The Adult Working Group hired Lindsay Angelow, a health promotion student who worked out of Access Alliance Multicultural Community Health Centre in Toronto, to help develop the consultation plan. The methodology developed was based on the successful experience of Access Alliance in conducting other similar consultations with the immigrant and refugee communities it serves. The process was adapted slightly to meet the needs of the Adult Working Group consultations.

Contacting Community Groups and Participants

Communities were chosen for the consultations based on the population's ability to represent a wide range of views. The Adult Working Group worked with local organizations and consultants to organize and conduct consultations. The tasks of our local partners included identifying and securing participants for the consultations, making all the logistical arrangements for the consultations, co-facilitating the consultations, reviewing consultation reports for accuracy, and disseminating consultation outcomes at the local level. In all cases, we worked with a local contact person or organization to organize the consultations. Our goal was to attract the widest

range of participants in these priority areas to the consultations by advertising them widely in the communities where the consultations were to be held.

Recruiting Participants for Consultations

Our local partners used their established networks to advertise the consultations in print and by word-of-mouth and direct referral. We wanted providers to participate in the consultations because of the useful information they would provide related to their experiences around health and learning in terms of the community members and students they worked with. At the same time, we wanted the voice of community members to be predominant. In all cases but two, providers made up one third or less of the entire group of participants in a consultation. We wanted providers to participate in the consultations because of the useful information they could provide related to their experiences around health and learning in terms of the community members they worked with. In total, we met with 218 community members and 76 service providers across Canada.

Consultation Participants

The chart that follows outlines the participation in our consultations.

Priority Groups and Locations	Community Members	Service Providers
Adults with Low Literacy Skills	**74**	**21**
Vancouver	*22 (11 not in programs)*	*3*
Regina	*12 (2 not in programs)*	*5*
Toronto	*21*	*7*
Nova Scotia	*19 (1 not in program)*	*6*
Adult Immigrants and Refugees	**64**	**21**
Vancouver	*17*	*4*
Regina	*18*	*7*
Toronto	*15*	*5*
Montréal	*14*	*5*
Adults Living in Rural and Remote Regions	**41**	**17**
Fort Liard	*6*	*3*
Seaforth	*13*	*7*
Inverness	*22*	*7*
Adults Living with HIV/AIDS	**39**	**17**
Edmonton	*13*	*7*
Montréal	*16*	*3*
Truro	*7*	*7*
Totals	**218**	**76**

Structure of the Consultations

In each consultation, the plan was for both providers and community members or students to be together for introductions and a review of the consent practices. They were then supposed

to split into two groups—community members and providers—for the majority of the consultation discussions, coming back together at the end to report back and for further discussion. Consultations conformed to the original plan, except for slight variations. In Montréal, by the participants' choice, the split was along English-French language lines. In Vancouver and Toronto, a deviation from the original format occurred to address participants' schedules and to ensure greater participation in the consultations. In these cases consultations with providers and community members were held separately and the two groups did not come together. Each consultation was approximately 3 to 4 hours long, including a hot meal.

As part of the process, community members were asked to complete a one-page anonymous background information sheet. Participants indicated details such as their gender, age range, employment status and level of education, country of origin (if applicable) and time in Canada (if applicable). An honorarium of $40 was made available to each community member, along with reimbursements for travel and childcare to compensate for their time and out-of-pocket costs. Providers' expenses for parking and public transit were also reimbursed if requested.

Participants were asked to respond to various probing questions in the following categories:

- what health means
- how community members keep in good health
- how they learn about health and get information they need
- their experiences with the healthcare system
- who should learn what
- what else needs to be done

Consultation Feedback

People participated in a short, oral evaluation of the consultation—what they liked about it as well as how it could be improved at the end of each meeting. In all cases, participants gave positive feedback on the consultations. They said they felt respected and heard. They indicated that they welcomed the chance to talk about the issues related to health and in many cases would like to have more opportunities to do so. They also made suggestions on how the consultations could be improved. Their suggestions included changes around logistics and timing and having more participants involved.

The Adult Working Group prepared detailed reports on the consultations in each community for a total of five separate reports (see Appendix A, as well as the CCL, NALD, and CPHA websites). Each report was provided to the local partners and facilitators for review and feedback before being finalized. The final report was sent to local partners so they could distribute the report to consultation participants.

Year Three: Consultations with Adults with Low Literacy and Immigrants and Refugees

The concept for how to create a model for the consultations was discussed earlier, but implementing the model had its own challenges, as now discussed.

Consultation Plan

Our group discussion model for the consultations with adults with low literacy skills and refugees and immigrants turned out to be essentially the model we used in the following year with adults living with HIV/AIDS and adults in rural and remote areas. As discussed earlier, how we went about the consultations was developed by the Adult Working Group with input from our national Advisory Committee as part of its planning work in 2005–2006. A large part of our decision-making was based on the successful experience of the Toronto Access Alliance in conducting other similar consultations.

Working with Local Partners

Our goal was to attract the widest range of participants in these priority areas by advertising the consultations widely in the communities where the consultations were to be held. Our local partners used their established networks to advertise the consultations widely to immigrant and refugee organizations and to those organizations that serve adults with literacy challenges.

In Vancouver and Regina, our contact persons were knowledgeable and worked in both priority areas. Our partners in Vancouver and Regina liaised and did outreach with organizations well known for their service and program delivery to immigrants and refugees and adults with literacy challenges. In Regina, a wide range of community organizations and some government departments were invited to attend. Similarly, in Vancouver a wide range of community organizations serving immigrants and refugees were invited to participate along with students and providers from the largest deliverer of adult basic education in Vancouver. In Toronto, we worked with three separate local partners to organize consultations with literacy providers, students, and the immigrant and refugee community.

For the consultations on literacy challenges, we worked with the lead Toronto literacy network to bring providers together. In addition, we worked with the student association that represented literacy students from across the city for the student consultation. We worked with one immigrant and refugee organization in Toronto with a variety of locations in Toronto's west end. In Montréal, our contact person worked in the area of health and immigrant and refugee communities. He conducted outreach to a variety of organizations in the Montréal area serving immigrants and refugees. In Nova Scotia, we worked with the Nova Scotia Community College, largest deliverer of adult basic education in the province, to canvass adult students and literacy providers in three areas of the province.

Consultation Overview

Consultations with adults with low literacy skills and adults who were refugees and immigrants were held in Vancouver, Regina, Toronto, Montréal, and in three communities in Nova Scotia through video conferencing. In all cases except Nova Scotia and Montréal, there were separate consultations with both adults with literacy challenges and with immigrants and refugees. In Montréal, the focus was solely on immigrants and refugees and providers who work with them while in Nova Scotia, the focus was solely on adults with literacy challenges along with practitioners who work with them.

Communities chosen in this first year of consultations were selected based on the population's ability to represent a wide range of views and also, if the AWG had the ability to contact local practitioners to help with the organization of the consultations. The urban centres of Vancouver, Regina, Toronto, and Montréal were selected for their immigrant and refugee consultations based on the large population of immigrants and refugees in these centres. Montréal was specifically chosen to include the voice of immigrant and refugees in Quebec. In Vancouver, Toronto and Montréal, the majority of providers working with immigrants and refugees were immigrants themselves.

By contrast, consultations with adults with literacy challenges were held in the same urban centres to be as efficient and cost-effective as possible within the scope of the project. Nova Scotia was chosen as a consultation site for adults with literacy challenges to include the voices of a more rural population within the Maritime region and because it was a priority area for adults with literacy challenges.

Vancouver consultations: In Vancouver, there was a session with literacy students, a session with adults with literacy challenges not in programs, and one with providers. There were two sessions with immigrants and refugees. One followed the original format with providers and community members in the same consultation. There was also an additional session with immigrants and refugees. This session was conducted in Farsi by a local program facilitator who worked with Afghani women. In Vancouver, the local consultant suggested that there would be greater participation if consultations were held where people attend classes or drop-in centres rather than expecting people to travel to a different location.

Regina consultations: In Regina, there were two consultations, one with adults with literacy challenges which included a number of Aboriginal adults, and one with immigrants and refugees. Both consultations followed the original format.

Toronto consultations: In Toronto, there was a separate consultation with literacy providers, and another with adult students in literacy programs. The group was divided this way because the timing did not work for providers and students to attend together. The consultation with immigrants and refugees followed the original format with providers and community members in the same consultation. The consultation was held in the evening. The community members

and providers were connected to the same community-based organization serving immigrants and refugees.

Nova Scotia consultation: The consultation in Nova Scotia was unique in that it made use of video conferencing. The Adult Working Group's partnership with the Truro campus of the Nova Scotia Community College (NSCC) made it possible for students from the NSCC's Adult Learning Programs on the Truro, Cumberland, and Lunenburg campuses to "meet" live. With Truro as the host site, participants at the other two "remote" campuses connected to the consultation via real-time high-speed video feed. All students were able to see and hear each other as questions were posed and responses were generated. The note-taker was positioned in the Truro location with a view of the main video screen, which simultaneously displayed all three locations. Meanwhile, the small group of teachers and a campus counsellor met separately with an Adult Working Group facilitator and a second note-taker.

Montréal consultation: As noted, in Montréal, participants wished to split into groups along language lines as opposed to community member/provider groups. Participants indicated that they saw themselves as community members first. All providers were immigrants themselves with the exception of one person.

Reflections on Year Three: The First Consultation Phase with Adults with Low Literacy and Immigrants and Refugees

The group discussion model which was developed was refined through several consultation sessions, but the overall format stayed the same. We learned that having the practitioners and participants together to begin, then separated for the more detailed discussion worked extremely well. The two groups typically had very different viewpoints, experiences, and recommendations. The nature and sequence of the questions did not vary, even if the discussions were different in every case. It was not always easy, however, to record the conversations—typically with hand notes by a recording person in the room. Conversations often went fast, people talked over each other and interrupted one another and it was not always clear who said what. Yet voice-recognition technology or tape recording would not have necessarily improved the recording accuracy or quality. As the Adult Working Group got increasingly more comfortable with the format, the group interview process became more and more effective as time went by.

The outcomes of the first year of consultations (See Appendix A) were highly informative. Issues that might have been anticipated took on far greater depth and complexity, such as barriers to information access, the issues of poverty, the issues of language barriers for immigrants and refugees; but topics that repeated themselves, such as perceived prejudice and racism, problems with health lines, problems around gender sensitivity—not only culture sensitivity—were not anticipated. Reaching for "quick answers," such as making plain language computer-based health information more available was found to be more complex than we might have

anticipated. If there was a single learning outcome it was just how multi-layered health and learning issues are among these two groups.

Yet, if there was a consistent, strong message through out this first year of consultations, it was how critically aware, how eloquent, and how resilient the vast majority of those we consulted with actually were. None that we met with lived in a state of "learned helplessness;" none saw themselves as "victims." Overall, they saw the issues of their health and learning about their health very clearly and they articulated what may well be the answers for those issues in very clear terms.

As Canada's health system, political leaders, and adult educators debate what needs to be done for health and learning among these groups of marginalized Canadians, the message we took from this year would be, "Don't debate among yourselves, consult those whose lives are involved."

Year Four: Consultations with Adults Living with HIV/AIDS and Adults Living in Rural and Remote Areas

Moving into year four, the team began to work with adults living with HIV/AIDS and adults in rural and remote areas. This was a very different set of consultations with very different challenges.

We never questioned the importance of doing so, but we all knew that by including adults living with HIV/AIDS in our consultations we were inviting entirely new sets of challenges and issues—some of which were highly volatile and politically- charged. While the first year's groups had lower skills and knowledge gaps than is often required in Canadian rural and urban life today, those living with HIV/AIDS, by contrast, were often well-educated and had easy access both to health knowledge and the health system. Yet, despite progress in Canada, these adults, as we knew, still remain socially stigmatized. They are too often marginalized by simple virtue of a contracted medical condition. How would their stories compare with those we met with in Year Three? Similarly, adults in remote and rural areas are not necessarily marginalized by virtue of skills or knowledge, but by the sheer force of geography. How would their stories compare to those with low literacy and immigrants and refugees? How do members of these latter two groups learn about and maintain their health? Would the four groups have anything in common?

Consultations with Adults Living with HIV/AIDS

AWG team member Sue Folinsbee led the organization and facilitation of the consultations with adults living with HIV/AIDS. Consultations were held in three locations: Montréal, Québec; Edmonton, Alberta; and Truro, Nova Scotia. Consultation locations were particularly chosen from recommendations by Adult Working Group Advisory Committee member Kim Thomas,

Director of Programs for the Canadian AIDS Society. These recommendations were based on her knowledge of regions that could benefit from the consultations and would be interested in working with us.

Montréal consultation: In Montréal, the Adult Working Group hired Baijayanta Mukhopadhyay to organize and conduct the consultations. Here, the consultation was conducted with community members and service providers who divided into two groups (French or English), and came together to report back and further discuss recommendations.

Edmonton and Truro consultations: In Edmonton and Truro, the Adult Working Group worked with local organizations (HIV Edmonton and the Northern AIDS Connection Society of Nova Scotia) to organize and conduct the consultations. In each of these two locations, separate consultations were held with community members and service providers.

Across locations, participants emphasized the importance of physical, mental, and sometimes spiritual health. They indicated that physical health affects one's mental-health, and vice-versa. However, some participants in the Montréal session felt that health-care providers only measure good health as physical. Community members across locations related the importance of having good mental health. They talked about the need to be positive, self-accepting, and stress-free; along with having control over their lives and maintaining a supportive environment.

The consultations show the importance of physical and mental health for people living with HIV/AIDS, along with how they affect each other. The results indicated that the stigma of HIV/AIDS, along with the prejudice and discrimination that people living with HIV/AIDS face, affects their health and well-being in all aspects of their lives. The consultation results show that many people—including health-care providers—are very often misinformed about the illness and how one contracts it.

Consultations with Adults Living in Rural and Remote Areas

AWG team members Sue Folinsbee and Wendy Kraglund-Gauthier organized and facilitated the consultations with adults living in rural and remote areas of Canada and their service providers. Locations were selected based on the recommendations from the Adult Working Group Advisory Committee and other stakeholders.

Fort Liard consultation: Fort Liard, Northwest Territories is a small, predominately Aboriginal community located approximately 240 km due north of Fort Nelson, British Columbia, with Yellowknife, Northwest Territories 544 km to the north-east. The community is governed by the Acho Dene Koe First Nation Band. In Fort Liard, our contact person from Aurora College worked in the community and was able to advertise the consultation to a wide range of community members and service providers.

Seaforth consultation: The consultation in Seaforth, Ontario represented four rural counties in Ontario: Huron, Perth, Bruce, and Grey. For the Seaforth consultation, we worked with The Ontario Rural Council. As a vital voice of rural Ontario, this council used its well-established partners and networks to advertise the consultation in four rural Ontario counties.

Inverness consultation: Inverness, Nova Scotia is a small village on northwest coast of Cape Breton Island. In the Inverness consultation, participants were from small villages and towns in Inverness County. In Inverness, the Inverness Family Place Resource Centre, of the Cape Breton Family Resource Coalition, and members of the North Inverness Community Health Board were able to reach out to a wide range of community members and service providers in Inverness County. Consultation participation followed the established format of a main group discussion; then, community members and service providers divided into two groups, coming together to report back and further discuss recommendations. In this consultation, some participants noted they identified with both groups, but chose to join the group with whom they felt the most affinity.

Consultation Outcomes

Consultation outcomes pointed to research priorities concerning the learning needed to improve the health of these groups and includes a plan to generate, mobilize, disseminate, and translate research-based knowledge into policy and practice change.

We found there are consistent outcomes across the consultations for all four priority groups. Participants' responses and recommendations on health and learning reveal that it not just a matter of providing more information or education about health or providing it in clearer, more effective ways. Neither is health just about individual behaviour, lack of "motivation," or lack of knowledge about how to be healthy. Many participants saw physical and mental health as strongly connected; for example, the connection between mental health issues such as being depressed, stressed, or sad were seen as connected to poor physical health. Some groups also included spiritual and environmental health in their overall concept of health. Service providers said that while some clients see health as holistic with components of mental health, there is some stigma associated with accessing mental health services for other clients, especially men.

Participants from across all groups also identified racism as central to the experience of adults from racialized and Aboriginal communities in particular. Other forms of discrimination that were identified related to language skills, how a person dressed, or whether or not they were a drug user. Repeatedly, participants told stories about the lack of quality care and differential, careless treatment by health care providers. Racism and discrimination were described in terms of experiences with health care but also in other areas of life such as employment and housing which also impacted health. They discussed how racism and discrimination affected their mental and physical health negatively.

Participants' stories and recommendations indicate that it is critical to address the larger social determinants of health such as poverty, racism and discrimination, lack of employment opportunities, substandard housing, lack of recognition of foreign credentials, different cultural assumptions, and access to health services, including mental health services. People may know what it takes to be healthy but are simply not able to implement what it takes because of these other factors.

A common theme voiced by participants was that insufficient social assistance leaves few choices for buying healthy food or finding healthy housing. In particular, immigrants and

refugees noted that having a good job and working were connected to good health. In addition, immigrants and refugees and the providers who work with them identified adjustment, lack of recognition of foreign credentials and unemployment, poor housing, and western culture as factors that affect their health.

We heard repeatedly that access to health care services is neither equal nor universal, despite the rhetoric. Providers who work with both immigrants and refugees and adults with literacy challenges said that the health care system is very difficult for their clients to navigate—especially if they do not have language or literacy skills or know their rights. Across the consultations, participants indicated that there was a lack of accessible and appropriate health care services for our target groups. Another common access issue for all groups included a lack of family doctors, and long wait times at hospital emergency rooms and for critical appointments with specialists. While most Canadians are no strangers to long waiting times, those in our priority groups experienced not only the standard wait but the stigmatization, the lack of access, and the life-and-death frustrations of a system unable to communicate effectively with these groups.

What Needs to Change?

The outcomes of the consultations suggest that multi-faceted strategies are needed to present information to the four priority groups. Providers across the country agreed that the students or clients they work with get health information from people they know and trust. They also indicated other ways people get information on health such as from their literacy and language classes, programs, settlement workers, and community centres.

They emphasized that adults with literacy challenges and immigrants and refugees may have difficulty understanding written information about health, and prefer interaction with others to get this information. In addition, clients may be more likely to trust information from someone else such as a friend or member of their own community with previous experience related to the issue as opposed to government information or information from the health care system.

Print materials on health issues and accessing information on the Internet are the least preferred strategies for community members but are used by providers and literacy practitioners. Clear language materials and materials in the languages of clients are needed, along with face-to-face contact and information on videos. An inability to find doctors who can speak one's language and a lack of interpretation were key issues identified by immigrants and refugees.

It is clear that learning and getting information is two-way. More time needs to be taken in face-to-face communication with health care providers to ensure understanding. There is a large gap in terms of adequate, equitable, and accessible health care services to these groups.

There are many common concerns, as well as concerns that are specific to particular regions and groups of people. The outcomes also show that the barriers to health that participants face far outnumber the strategies and initiatives that are working well. Participants' recommendations indicate that multiple factors affect health and that these larger systemic

issues need to be addressed along with better health information and learning opportunities for adults with literacy challenges, immigrants and refugees, and the health care professionals who work with both groups.

There are some consistent outcomes across the two rural and the one remote location where consultations were held. The consultations illustrate the critical impact that a rural or remote location has on the health and access to quality health care of the adults who live in these communities, especially those from marginalized groups. The consultations also identify the positive, community-based solutions to health care that have emerged and are in operation across locations.

Equitable and accessible health-care services for community members are related to where they live. From the consultations, the most notable barrier is the lack of access to a range of health care providers in rural and remote communities. There are two issues contributing to this barrier. One is that it is difficult to attract and retain health-care providers in these locations. The second issue is that the communities are not large enough to support a range of specialized health care providers. This means that community members have to travel outside their community to receive health care services. Transportation and the related issues of confidentiality and affordability are barriers to accessing these health-care services. On a positive note, communities are relying more on advanced nursing practices and health care teams with good results to address the lack of doctor in these communities.

What Is Working Well?

However, many aspects of health and learning are working well. Community members indicated that specific doctors, pharmacists, clinics, and classes were working well as places to get information about health. There was debate about telephone health lines among both adults with literacy challenges and immigrants and refugees. Some people had had good experiences with health lines. Others had not had good experiences. Some providers noted that people come to them because they are open to listening and have time, whereas providers in other organizations may not.

One provider indicated that her program does a lot of work around critical thinking and analysis and questioning of health issues, especially for topics where there has been a lot of hysteria, or where the media has influenced the presentation of the information. She noted that learners are very analytical about health issues even though they do not typically read or write well. Providers said they provide information for their students using pictures, videos, information from health care related organizations, and newspapers. They may inform their students about health lines and free clinics. Some providers work with their students and use the Internet to do projects researching a disease that a student's family member might have. In some educational institutions there are campus counselors who provide support for the students by talking about health issues in a confidential setting.

Providers working with adults with literacy challenges emphasized the need for gender sensitive, clear language materials on health topics. They said that not only does information need to be accessible, but clients and students need to be able to get help understanding the

information from community organizations. Some providers felt that people need a sense of spirituality, someone to care for them and be friends with them. Health materials on a variety of topics need to be translated into other languages or written in plain language in English or French. They suggested that a website in clear language on topics relevant to immigrants and refugees would be useful. Other providers indicated that a legal website that has information in several different languages or the idea of a health clearinghouse were both good ideas.

Participants across groups stressed that a variety of approaches are needed to get and learn about information on health. What approach is used will depend on geography and whether people live in an urban or a remote area. At the top of the list in providing information to adults is the need for personal connection and face-to-face interaction.

Limitations of Consultation Outcomes

There are several limitations of the consultation outcomes. The number of participants was small and was selected based on the consultation facilitators and host organizations' abilities to contact willing participants. For the most part, the majority of our participants were from largely metropolitan/urban areas. In adult learning classrooms, host organizations asked literacy organizations and programs to refer students and their friends to volunteer for the consultations. In community organizations, hosts recommended clients whom they thought would be interested in participating. As noted earlier, based on the methods of choosing locations and participants, we caution against generalizing the results of these consultations across contexts.

Nevertheless, while generalizations cannot be made from the consultation outcomes, the outcomes provide a rich insight with respect to areas of health and learning that need to be explored through systematic research.

Dissemination of Consultation Outcomes

The Adult Working Group prepared detailed reports on the consultations in each community for a total of five separate reports. Each report was provided to the local partners and facilitators for review and feedback before being finalized. The final report was sent to local partners so they could distribute the report to consultation participants. As part of the dissemination plan, selected reports were translated to French as funding allowed. The entire *Final Report on Adults with Literacy Challenges and Adult Immigrants and Refugees* was translated.

As well, a 2-page fact sheet for each of the four priority groups was created based on the consultation findings. Each fact sheet is available electronically in English and in French on the CCL website, the CPHA research portal, and on the NALD website.

All consultation reports and fact sheets were also compiled on a CD and distributed free to Adult Working Group Advisory Committee members, key organizations and stakeholders in the fields of health and adult learning, and consultation partners and forum participants.

See *Appendix A: Dissemination of Adult Working Group Activities* for a complete list of documents and links to files.

Reflections on the Consultation Component of the Project

While we entered the consultations unsure if these last two priority groups would have much in common with those we consulted with in the first year of our work, we learned that at least two major aspects of each groups' experience had everything in common.

First, those who may be marginalized in society for a host of reasons, and have particular issues with health and health systems, very often are highly resilient and highly aware of both their circumstances and of ways that could improve their circumstances. Secondly, time over time all four participant groups cited the larger social determinants of health as the source of their challenges. These included poverty, racism, discrimination, lack of literacy and language skills, employment opportunities, substandard housing, lack of recognition of foreign credentials, different cultural assumptions, and lack of access to health services, including mental health services.

In short, the people we consulted with often know very well know what it takes to be healthy but are simply not able to do what it takes because of factors often beyond their control.

IV. YEAR FIVE: CONCLUDING THE PROJECT AND FUTURE RECOMMENDATIONS

As we entered year five, the outcomes of our four years of work had been written into various reports—some of had yet to be disseminated by our sponsoring agencies, causing frustration. But the time frame for the project was coming to an end. How could we put the findings into action? Should we wait for our reports to get disseminated? We agreed we needed to not simply "disseminate and procrastinate," but truly share and exchange the information we had gathered with those who might be able to make a real difference? We sought to learn from others' findings and build a stronger case for change among policy-makers and practitioners. But how? The Adult Working Group turned to the idea of a forum. Aware of the limits of our budget and conscious of the parameters of our mission, we chose to collaborate with two other Working Groups to develop an information and decision-making forum.

We remain convinced that no one group, agency, or system "owns health." No single segment of society is responsible for "learning." Health and learning are society-wide responsibilities. We therefore planned and developed a national forum, as discussed next.

The National Forum:
Promising Practices and Possibilities for Health and Learning

A key component of the Adult Working Group's work centred on our culminating activity: a forum on promising practices and possibilities for health and learning. For this forum, we partnered with two other working groups of the Health and Learning Knowledge Centre: The Early Childhood Working Group (ECWG) and the Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals Work Group (Capacity Building in Health Literacy for Health Professionals, CBHLHP).

In the course of sharing information at annual HLKC meetings, it became evident that ECWG and the CBHLHP had conducted consultations with their target groups in ways similar to the Adult Working Group to identify health and learning issues, concerns, gaps, and needs within their life-span constituencies. The Early Childhood Working Group'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 Health Human Resource Capacity Building for Health Literacy group had worked on building capacity around health literacy and patient self-management for health professionals. As part of its work, they had conducted consultations with health care professionals, patients, and others. All three working groups noted that there were similarities among 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.

Each working group had conducted similar work through their mandates, so partnering was a logical strategy to extend the research base and to co-construct knowledge. However, 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 though 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.

The three groups planned and facilitated a forum that was held in March 2009 in Vancouver, British Columbia. They were guided by the shared vision that the forum would be an opportunity to bring together relevant stakeholders (policy makers, members of the target groups, health care and other providers, academics, researchers, and others) to plan for action to addresses barriers identified by the three working groups. The forum steering committee met regularly, mostly by teleconference, between July 2008 and March 2009; their advisory committee joined them at key junctures over the course of the planning phase.

Each working group contributed human and financial resources to the planning, facilitation, and reporting of the forum. With additional financial support of the Adult Learning Knowledge

Centre, Vancouver Coastal Health, and the National Collaborating Centre for the Determinants of Health, over 70 participants from across Canada gathered in Vancouver to discuss promising practices and possibilities for health and learning.

Dissemination of Forum Outcomes

Two concrete outcomes of this collaborative effort have been a collection of promising practices as submitted by participants and a forum reflections report (see Appendix A). These documents have been translated to French and posted to the CCL website. They are also available on the CPHA research portal and on the NALD website in both languages. The Forum materials were also included on the CD compilation of the AWG's deliverables.

Looking Back at the Research Process

While acknowledging the importance of the work achieved from 2005 to 2009, we believe another important, perhaps less tangible, outcome has been the study process itself. Our scan of the literature on research in adult learning revealed a preponderance of quantitative, "counts and amounts" research reports on adult learning. There was also a body of qualitative research on the outcomes of projects which have focused on practitioners and learners. Yet noticeable absent is an inquiry into the research process itself.

From its inception, the Adult Working Group operated with a team-based approach. The four core members of the Adult Working Group lived in three different provinces; conference calls between all or some members helped to clarify issues. As well, the Adult Working Group steering committee was able to occasionally meet face-to-face if other work responsibilities brought them together. Our advisory committee members were selected based on their abilities to add a varied perspective to the research question and to the implementation of the work plan. Members were located across Canada and from the United States. Rather than being a hindrance, the geographic diversity served to bring voices to the table from all across the nation. This idea of the positive aspects of diversity in geography seeped into the design of the community consultations and in the selection of Forum participants. It was important to have local representation in order to create that sense of connection and community capacity-building.

When a diverse mix of individuals who share common goals come together, the team building process is crucial. For us and our partners, trust, shared responsibility, and commitment to the value of the task itself were required to move towards achieving objectives. As well, maintaining lines of communication was paramount. When a number of funding agents are involved, the challenge can be to fulfill each organization's mandate. Ideally, as with this project in which the Adult Working Group had its own mandate, being able to secure funding and resources with other like-minded individuals and organizations is key.

The Forum on Promising Practices and Possibilities was an example of how community capacity building is a valuable tool in research and in learning. All participants walked away, empowered with shared knowledge and strategies. If our *Environmental Scan* and *State of the Field Report*

are any indications, this is yet one more under-researched method to support the health and learning of individuals and communities. More attention to the connections between health and learning through community-based participatory research strategies that examine community capacity building and participatory forms of education would provide a necessary complement to the wealth of health-related knowledge that already exists.

V. Final Thoughts

Our four years of research agenda-building and knowledge exchange in cities, towns, and villages across Canada have resulted in outcomes on health and learning practices that can support knowledge and could foster change. We have learned about and have begun to speak and write about the ways these priority groups are all too often unable to attain the health levels promised to every citizen in a nation with universal health care. We have learned how thousands could benefit from systemic, educational, and policy changes.

This reflections paper and its companion reports have been designed to provide space to challenge, inform, and stimulate open dialogue on the critical—often life-and-death—health and learning issues that affect the lives of millions of Canadians. It is our hope that the activities that have come from this four year project will support and encourage the knowledge and learning of our colleagues, both in the health and the adult education fields. Indeed, it is our further hope that one day health, learning and education will not be in "separate fields."

Above all, it is our hope that, by questioning and learning from one another—including questioning and learning from those living in the margins of our society—that we might see new possibilities for all of living in Canada.

Appendix A: Dissemination Activities of the Adult Working Group

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