Adult Working Group's Cross-National Consultations on Health and Learning

Final Report

Adult Working Group (AWG)
under the auspices of the
Health and Learning Knowledge Centre (HLKC)
and the
Canadian Council on Learning (CCL)

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Table of Contents

Acknowledgements 4

I. Introduction
- A. Background Information 6
- B. Purpose of the Consultations 7

II. Consultation Methodology
- A. Consultation Plan 9
  - i. Choosing communities for the consultation 9
  - ii. Working with local partners 9
- B. Consultation Format and Questions
  - i. Consultation format 10
  - ii. Focus of the consultation questions 13
  - iii. Consultation feedback 13
  - iv. Consultation reports 13
- C. Consultation Participants 14
- D. Limitations of the Consultations 15

III. Consultation Outcomes 16
- A. Concepts of Health and Being Healthy
  - i. Concept of health is multi-faceted 16
  - ii. Social factors affecting health 18
- B. Learning and Getting Information about Health 21
  - i. Most common ways of getting information about health 21
  - ii. Barriers to accessing information about health 23
  - iii. What is working well 26
  - iv. Getting improved access to health information 26
- C. Experiences with Health Services 28
  - i. Barriers 29
  - ii. What is working well 36

IV. Participants' Recommendations for Strategies to Address Identified Barriers 38
- A. Health Literacy
  - i. Multi-faceted strategies 38
  - ii. Plain language information 39
  - iii. Communication and learning with interpreters and in one's own language 39
  - iv. Health–literacy coalition 39
  - v. Clear language Web site 40
  - vi. Directory of doctors 40

B. Developing and Sustaining Healthy Communities
i. Discussion group sand workshops 40

C. Strengthening the capacity of communities, Practitioners, and Public Agencies/Systems
i. Poverty reduction 41
ii. Affordable and secure housing 41
iii. Affordable, appropriate, and accessible health care services 41
iv. Recognition of credentials of foreign doctors 42
v. Access to jobs and recognition of foreign credentials 42
vi. Learning for health providers: Sensitivity and awareness training 43
vii. Language training and skills upgrading 43
viii. Trauma counselling 43
ix. Sessions for men 43
x. Food for adult programs 44

V. Adult Working Group Recommendations for Setting a Knowledge Agenda 45
A. Supporting Research 45
B. Knowledge Mobilization 47

VI. Conclusions 48

Appendix A: Adult Working Group Members 49

Appendix B: Sample Consent Practices 53

Appendix C: Consultation Questions 54

Appendix D: Participant Profiles 56

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[1] See Appendix A for a complete list of AWG Advisory Committee members.

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I. Introduction

A. Background Information

In June 2005, the Canadian Council on Learning (CCL) held a Health and Learning Knowledge Centre (HLKC) consultation in Vancouver, British Columbia. At the consultation, participants agreed to establish various working groups to address the work of the HLKC. These working groups address life stages in health and learning and concentrate on settings, places, and communities where health and learning takes place. The HLKC coordinates and organizes its work according to both the life stages and settings. The Adult Working Group is now one of 15 working groups addressing learning across the life span. (See the CCL web site for further information at http://www.ccl-cca.ca/ccl)

The mandate of each working group is to build a knowledge agenda for the Canadian Council on Learning (CCL) under whose auspices the HLKC was established. Each working group is to focus its agenda on the three central themes of the HLKC. These themes are:

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

In addition, each working group also is expected to address the four primary functions of the CCL in the activities it recommends and undertakes. These four functions are: 1) research, 2) data /monitoring/reporting, 3) knowledge transfer, and 4) dissemination/communications.

The Adult Working Group (AWG) is developing a knowledge agenda for promoting the **health and learning of adults** in: 1) the workplace, 2) health care settings, 3) among families and 4) in communities.

In 2006, the AWG identified the priority groups it would focus on at the outset[2] as follows:

1. the health and learning of adults with low levels of literacy skills (2006-2007)
2. the health and learning of adult immigrants and refugees (2006-2007)
3. the health and learning of adults affected by HIV/AIDS (2007-2008)
4. health and learning within regions and communities that fall well below national or regional health norms (2007-2008)

In the AWG's consultation plan, particular attention is being paid to issues of gender and racialization[3] across the identified range of priority areas.

Over the past year, 2006-2007, the AWG priority groups have been: a) adults with low literacy skills and b) immigrants and refugees. The AWG's work involves 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.

B. Purpose of the Consultations

From the consultations in 2006-2007, the AWG sought to identify themes, gaps, and needs related to health and learning as experienced by adults with low literacy skills and immigrants and refugees. The consultation outcomes will ultimately point to research priorities concerning the learning needed to improve the health of these groups and will include a plan to generate, mobilize, disseminate, and translate research-based knowledge into policy and practice change. This, we hope, will result in a greater understanding of the relationship between health and learning and in initiatives to improve the health status of those groups across Canada.

The expressed views from the consultations are illustrative of the opinions of adults in two marginalized groups. We hope their views will ultimately contribute to research, to policy, and to improved access and services for marginalized Canadians.

The AWG had welcome support from the National Collaborating Centre for Determinants of Health (NCC-DH), based at St. Francis Xavier University in Antigonish, Nova Scotia. With its help, we were able to collaborate with the Expert Panel on Health Literacy, convened by the

[2] The priority group of Aboriginal adults was removed from the AWG plan because the Aboriginal Learning Knowledge Centre was established by the CCL in 2006. See http://www.ccl-cca.ca/CCL/AboutCCL/KnowledgeCentres/AboriginalLearning/index.htm

[3] In this context, the terms "racialization" and "racialized" refers to a categorization or differentiation made of individuals based on race.

Canadian Public Health Association and funded through the HLKC. This was helpful as consultations were also being conducted to inform the Expert Panel during 2006-2007. This collaboration attempted to reduce redundancies and enable sharing of outcomes from all consultation processes.

II. Consultation Methodology

A. Consultation Plan

The plan for the consultations was developed by the AWG with input from its national Advisory Committee as part of its planning work in 2005-2006 (see Appendix A). The AWG 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 AWG consultations.

i. Choosing communities for the consultations

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

Communities were chosen for the consultations based on the population's ability to represent a wide range of views. Urban centres (Vancouver, Regina, Toronto, and Montreal) were selected for the immigrant and refugee consultations based on the large population of immigrants and refugees in these centres. Montreal was specifically chosen to include the voice of immigrant and refugees in Quebec. Consultations with adults with literacy challenges were held consecutively with some of the immigrant and refugees consultations (Vancouver, Regina, and Toronto) 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 priority area of adults with literacy challenges.

ii. Working with local partners

The AWG worked with local organizations and consultants to organize and conduct consultations. The tasks of AWG 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. 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. The largest provider of literacy and adult basic education participated with both students and providers attending. 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 about 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 Montreal, our contact person worked in the area of health and immigrant and refugee communities. He conducted outreach to a variety of organizations in the Montreal area serving immigrants and refugees. In Nova Scotia, we worked with the largest deliverer of adult basic education in the province to canvass adult students and literacy providers in three areas of the province.

B. Consultation Format and Questions

i. Consultation format

The standard format of the consultations was to hold a meeting with both community members and providers who work with them. Of the 20 participants we wanted to attract for each consultation, one- third (maximum) were intended to be providers and practitioners who work

with community members in our two priority areas. 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. In the two cases, providers were just slightly over a third of the total number of participants. In Vancouver, Toronto and Montreal, the majority of providers working with immigrants and refugees were immigrants themselves.

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.

Six consultations actually conformed to the original plan. 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, (see descriptions that follow) consultations with providers and community members were held separately.

Each consultation that involved both community members and providers was approximately three to four hours long. The sessions where providers and community members or students met separately were often less than four hours.

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 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 AWG'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 (ALP) on the Truro, Cumberland, and Lunenburg campuses to "meet" live. With Truro as the host site, participants at the remote campuses connected to the consultation via real-time high-speed video feed. All students were able to see and hear each other as 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 a facilitator and a second note taker. Both sessions worked very well according to feedback received from the adult students involved in the three locations, the host, and members of the AWG who attended.

Montreal consultation

In Montreal, 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.

ii. Focus of the consultation questions

Following an explanation of ethics protocol (see Appendix B), participants responded to questions[4] 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

Community members were also 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 (immigrants and refugees), and time in Canada (immigrants and refugees).

An honorarium of $40 was made available to each community member along with two bus tickets (if applicable) to compensate for their time and out-of-pocket costs. Providers' expenses for parking and public transit were also covered if requested. Participants also received lunch or dinner depending on the time of the consultation.

iii. 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 more participants.

iv. Consultation Reports

The AWG 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.

[4] Please see Appendix C for Consultation Questions.

C. Consultation Participants

The charts that follow outline the participation in AWG consultations. See Appendix D for participant profiles.

Consultations with Adults with Literacy Challenges

Location	Number of consultation participants
Vancouver	▪ 22 adults with literacy challenges (11 not in programs) ▪ 3 providers
Regina	▪ 12 adults with literacy challenges (2 not in programs) ▪ 5 providers
Toronto	▪ 21 adult literacy students ▪ 7 providers
Nova Scotia	▪ 19 adults with literacy challenges (1 not in program) ▪ 6 providers
All locations **TOTAL**	**74 community members** **21 providers** **95**

Consultations with Immigrants and Refugees

Location	Number of consultation participants
Vancouver	▪ 17 community members ▪ 4 providers
Regina	▪ 18 community members ▪ 7 providers
Toronto	▪ 15 community members ▪ 5 providers
Montreal	▪ 14 community members ▪ 5 providers
All locations	**64 community members** **21 providers** **85**

D. Limitations of the Consultations

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' ability to contact willing participants. For the most part, 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.

Based on the informal methods of choosing participants, we caution against generalizing the results of these consultations across contexts. While generalizations cannot be made from the consultation outcomes, the outcomes provide a good deal of insight with respect to areas of health and learning that need to be explored through systematic research.

III. Consultation Outcomes

This overall report draws from the five individual reports that were prepared for each location. This section summarizes the outcomes from all AWG consultations for both immigrants and refugees and adults with literacy challenges according to major themes[5]. This method of organization was chosen because there were similar themes across both priority groups.

A. Concepts of Health and Being Healthy

> *Everyone wants to be healthy. Poverty hurts being healthy. If you can't eat well, you won't be at a good weight. Nobody wants to go through life sick. Make sure you buy some healthy food, and I think that will keep you going.*
>
> – Adult literacy learner: Toronto

i. Concept of health is multi-faceted

Community members[6]

Across the consultations, adults with literacy challenges indicated that they see 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. Similarly, immigrants and refugees saw mental and physical as connected but also noted a strong connection between these two aspects of health and spiritual health. They indicated that good health is related to a life where both the physical and mental aspects are working well and supporting each other—when one is not working, the other will not work.

Generally, both adults with literacy challenges and immigrants and refugees saw good health being connected to feeling good about oneself, having good mental and physical health, not being sick. In some groups, adults with literacy challenges talked about the illnesses or disabilities that prevent them from being in good health. Immigrants and refugees noted that having a good job and working were connected to good health.

[5] For more details on each location, a summary report is available.
[6] Refers to both immigrants and refugees and adults with literacy challenges.

In Toronto, adult literacy learners discussed workplace issues that affect their health. They identified unsafe products and chemicals that can cause health problems. They said that a lack of proper healthy and safety training leads to injuries. They also indicated that there are many people in Canadian workplaces who would not be able to read safety signs. Participants stressed the idea that even with these work-related problems, people have to work anyway because they need the money to take care of their families.

Providers

Providers working with both priority groups indicated that for their clients, health is the absence of sickness or illness. Providers working with adults with literacy challenges said that the adults they work with might only go to a doctor when they are sick. They also indicated that the survival aspects of the lives of the people they work with make preventative measures for health a low priority. Providers working with immigrants and refugees said that there are vast differences based on language skills, level of education, status, and culture that influence how their clients access health care services. They also 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.

To focus on good health, literacy workers described different activities that they undertake personally or include in their programs with adults with literacy challenges. These activities include a focus on wellness, yoga, meditation, stretching and walking, and counselling. Some providers emphasized that learners talking about health issues and listening and supporting each other is an integral part of their programs. One provider said, "Learners always feel different or disadvantaged. They get and keep healthy by being with people like them… By hearing how others cope, life and survival skills are built. They learn that they have skills and that they don't have to put up with abuse. They learn from others and learn not to see lack of reading and writing as a barrier."

Providers working in the Downtown Eastside Vancouver indicated that the adults they work with organize themselves around activities such as food banks, lunch tickets, and honouraria for participation in consultations. They said that if these things do not come through, it is a major upheaval because people have been counting on the money. These providers indicated that sometimes women will stand in line in the rain for hours to participate in a consultation. They also noted the reasons why people cannot read and write include substance abuse at home, moving a lot as children, or living with a disability. Providers emphasized that one has to be prepared to throw their teaching plan out the window, be patient, and not be dismayed when people come and go. One provider said, "Since I have started working with people with addictions, without exception, I have found that they have suffered abuse as children."

ii. Social factors affecting health

> *Health has many parts: psychological, physical, mental. It is not easy to bring all of those together at the same time – including financial health, one's economic condition. Are you healthy when physically fine but stressed? It is not easy to have everything at the same time.*
>
> Community member, immigrants and refugees: Montreal

Across the country, participants for both groups identified social factors such as poverty, racism and discrimination, and lack of health care services as linked to poor health. In addition, immigrants and refugees and 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.

Poverty

In all the consultations, participants indicated that poverty is a major factor that prevents people from being healthy even though they may know what they could do to be healthy. A common theme voiced by participants was that insufficient social assistance leaves few choices for buying healthy food or finding healthy housing.

Across the consultations, participants emphasized that even though they know what eating properly is, they cannot afford to buy healthy food. Some participants with literacy challenges also said that fast food is less expensive and takes less time to prepare than healthier fresh food. In the Downtown Eastside Vancouver, those adults not in programs described eating bad food from "soup kitchens" that had made them sick. The issue of expired food from food banks and incidences of food poisoning was also raised by providers working with these adults.

Some providers working with immigrants and refugees said they have seen clients who are sick because they do not have enough to eat. They also identified transportation as an issue in Regina. Grocery stores are not within walking distance of their clients' homes so they may have to go to convenience stores which are more expensive and have limited choices such as fewer fruits and vegetables.

Adults with literacy challenges indicated that poverty also means not accessing certain health services such as dental and eye care and not being able to get certain prescriptions. Some adult

learners emphasized that poor health makes it difficult to learn, focus, and function in day-to-day life.

Racism and discrimination

Participants from across all groups identified racism as central to the experience of adults from racialized and Aboriginal communities. 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.

For example, one provider told about a situation where his client was asked for a year's rent as down payment. Immigrants and refugees across the consultations told stories of discrimination in accessing employment opportunities where they were refused work because of racism, language, or a lack of relevant Canadian experience. They discussed how racism and discrimination affected their mental and physical health negatively. Racism and discrimination as it related to health care are included in the section *Experiences with Health Services*.

Access to health care services

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 immigrants and refugees. Although some hospitals, health care professionals, and community health centres are working well to provide services to immigrants and refugees, this was described as an exception rather than the norm. This was said to be the case in every city where a consultation was carried out.

Another common access issue for all groups included a lack of family doctors, and long wait times at hospitals. An inability to find doctors who can speak one's language and a lack of interpretation were key issues identified by immigrants and refugees.

Access to health services is dealt with in detail under the section *Experiences with Health Services*.

Adjustment

Across groups, immigrants and refugees and providers who work with them emphasized that adjustment when coming to Canada has a huge impact on health. For example, they indicated that people do not know the language or the culture. In addition, they may feel isolated, they cannot find work, their credentials are not recognized, or they do not have their families with them or have support networks. As a result, their mental and physical health suffers. Other issues raised that are connected to health include worrying about one's refugee case or immigration status. Participants felt that this kind of stress can have a profound impact on the health of entire families.

Lack of recognition of foreign credentials and unemployment

Participants in all immigrants and refugee consultations stressed the non-recognition of foreign credentials and unemployment as issues that affect health. Participants identified discrimination in employment, language skills, lack of recognition of foreign credentials, no Canadian experience relevant to their former occupation, lack of formal education, depression, and cultural differences as all barriers to getting employment.

Providers stressed that newcomers who are professionals come to Canada expecting to work in their profession but cannot work in their field because their existing credentials are not recognized. They indicated that this situation can lead to mental health problems when newcomers face the shock of having to take on a survival job. They said that not being able to get a job can lead to depression. Participants said that these issues affect family health and can lead to divorce, abuse, and lack of well-being of the whole family.

In other cases, lack of education was identified as a barrier. One woman in Vancouver said that dishwashing is the only job that a person does not need experience to do. She said, "Dishwashing is hard work and even it's hard to find a dishwashing job. I got back problems because I work so hard at that time because I tried to prove myself. If you don't have a good job, you'll worry about everything."

Housing

Immigrants and refugees and providers across consultations described deplorable housing for themselves and others such as dark damp basement apartments, rodents, bugs, overcrowding, and freezing conditions. Similar housing issues for adults with literacy challenges came up in two of the consultations. In addition to these, other housing issues included lack of public housing.

Western culture

In the Montreal consultation with immigrants and refugees, participants indicated that the focus on consumerism, the fast pace of life, and even the climate were factors that affected their health. The idea that it is difficult not to buy into consumerism was noted. One participant stressed, "If I was healthy, I would stay home and not leave my country, but they destroy your country economically and politically and then you are pushed out. They suck up your economy, bring it here so they can live nice and then we come here to be slaves."

B. Learning and Getting Information about Health

Those papers [from the pharmacist] *are too long. They have too many big words. And anyways you're supposed to trust what the doctor gives you. They are the doctors.*

-- Regina consultation: Adult with literacy challenges

This section describes the ways in which adults with literacy challenges and immigrants and refugees learn about and get information about health. This section highlights barriers, what is working and what could be improved.

i. Most common ways of getting information about health

Community members

Both adults with literacy challenges and immigrants and refugees indicated their primary source of information about health is through known and trusted networks. The most common ways they get information about health are through word of mouth from their family, friends, co-workers, neighbours, instructors, religious institutions, street and public health nurses, settlement workers, counsellors, and doctors. They also get information from literacy and language classes, television, radio, newspapers, libraries, and community centres. Fewer people from both groups said they get information from print materials, the Internet, and health lines.

Some participants from both priority areas discussed their use of traditional remedies that they learned from their mothers back home or in their religious congregations. They stressed their trust and belief in these sources of health information. In one group in Vancouver, immigrants and refugees said they rely on home remedies and self-diagnosis. However, they said self-diagnosis is a problem because serious illnesses can go undiagnosed for a long period of time.

Many immigrants and refugees indicated that people do not know how to get the information or where to go for information they need. They indicated that this is a larger problem if people are non-status[7]. They suggested that it is easier for those who have networks in their own communities or other informal networks to get the information they need.

Providers

Providers from both groups 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, they 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.

Literacy providers indicated that if students use the Internet for finding health information, they need support from literacy workers in sorting out sources and finding the information they need. One provider said those at higher levels of literacy might use the Internet for health information, but those at lower levels would not. Another issue identified by literacy providers is that many adults with literacy challenges may not own or have access to a computer. Providers felt that an Internet site for literacy practitioners as a source of information could be helpful but were concerned about accuracy of information on different web sites (e.g., those sponsored by drug companies).

[7] 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

Providers working with immigrants and refugees in several groups said that newcomers to Canada do not get enough information on prevention and long-term health.

Providers working with immigrants and refugees also said that clients may be intimidated by professionals and afraid to ask questions. Many providers felt that health materials on a variety of topics need to be translated into other languages or written in plain language in English or French.

Providers who work with immigrants and refugees said that they get their own information about health from other agencies, other clients, programs, initiatives, networking with colleagues, conferences and meetings, doctors, academic research, and television.

ii. Barriers to accessing information about health

Participants across both priority groups identified a number of common barriers to accessing information about health. Common barriers included inability to understand difficult print materials, government bureaucracy, use of the Internet and computers, and communication with doctors.

For immigrants and refugees, language was identified as a major barrier in accessing information about health.

Literacy and language barriers

Across the groups for both adults with literacy challenges and immigrants and refugees, literacy was described as a barrier for many people. In one consultation group for immigrants and refugees, community members indicated that most of them have never attended school. They said that reading books and using the Internet without assistance are difficult ways for them to get information. Therefore, most of their information comes from friends, the settlement agency, and speakers who come to their support group at the settlement agency.

Some providers working with immigrants and refugees indicated that the information that their clients get at the pharmacy is very difficult to read because the material is long and full of difficult words. It assumes that people have high literacy skills. Clients may be intimidated by professionals such as pharmacists and afraid to ask questions. In one case, a client was given a prescription and told to take the pills once a day. For instance, the word “once” in English is written the same way as the word “eleven” in Spanish. This client did not feel he could ask questions and ended up in a hospital emergency room when he took eleven pills in one day.

Similarly, some adults with literacy challenges said it was difficult to read some of the words on brochures and papers they get from prescriptions. One person said, "I never read them. It takes too much time to go through. They are usually something like two pages. I'm a slow reader. It would take me over an hour to read it all." Another stressed, "Lots of brochures use big words. It's too hard for me to understand what it says." One literacy provider had a student who is diabetic. She could not read or understand the information related to her diabetes. Once she could, she was more compliant.

One issue consistently identified in the consultations was that health care professionals do not take enough time to give information to adults with literacy challenges in a way they understand. Many participants said health care providers may think all they have to do is make print material available and may not understand that their clients have literacy challenges and will have difficulty understanding print materials.

Lack of computer proficiency

Generally, adults with literacy challenges said that understanding information on the Internet can be difficult if they have literacy challenges and a lack of education. One person said, "Computer whizs can do it; the less fortunate are not so lucky. There's so much out there it's overwhelming." Another participant noted, "One of the problems with information on the sites and in the pamphlets is that it is not directly related to the problem I have. You don't really get a lot of good answers. You still have to go to a doctor."

Some providers indicated that recipients have to fill in on-line forms to receive social assistance and that having to fill in these on-line forms is a barrier to getting assistance. These providers also indicated that to get social assistance, their students also have to do an orientation on the computer. However, some instructors use the Internet in their literacy classes with their students, or have their learners use it with their assistance as needed. These providers believe the Internet helps their students take control of their own learning.

Communication with doctors

Adults with literacy challenges identified getting information they need from doctors as a challenge. One challenge is the medical terminology and big words that a doctor uses. This makes it difficult to understand what the doctor is saying. Another challenge is the limited time the doctor has to spend with individual patients. People said they felt rushed and confused when they went to doctors. Participants also indicated that doctors were not always the best people to obtain health information from because they do not know what questions to ask doctors, they

cannot understand what the doctor says, or doctors are "too busy to talk to you" and "don't care about your feelings."

For immigrants and refugees communication issues with doctors centred on finding a family doctor who speaks their language.

Government bureaucracy

Some providers indicated that automated voice messages with prompts to select options are major barriers for people they work with. They said they cause frustration when people try to sort out the information they need. These providers also spoke negatively about government agencies wanting providers to do the work of government in terms of training their participants on certain systems and disseminating information.

Health lines were a related issue in terms of the questions that people are asked when they call the health line. Many questions may not seem relevant. As a result, providers said that their clients may feel they are being policed and do not use the service again.

Lack of knowledge

Some participants from both priority areas said that not knowing where to get information prevents them from getting information they need about health. For example, across the consultations not all participants knew about health centres at their educational institutions, health lines, community health centres, or places where they could get relatively inexpensive dental or eye care. Some participants indicated they do not know where to get help for mental health issues if they are suicidal or depressed. One adult learner said, "My two kids saw their aunt being murdered. They have lots of anger and they are acting out really bad. I am not sure what to do for them or where to get help for them."

Providers working with immigrants and refugees said that newcomers to Canada do not get enough information on prevention and long-term health. One group of providers commented that their clients wait until they are sick to get information they need.

Another issue raised in several groups of immigrants and refugees is that newcomers do not have information about the health services that they have to pay for. For example, one participant said that within three months of coming to Canada, she called an ambulance but did not know that she would have to pay for it until she got a bill for $130. She was able to arrange a payment plan but still had to pay the full amount.

Several participants noted that information sharing and questioning between and among professionals were not well-coordinated during hospital stays. In addition, participants noted that people do not get enough information and feedback about their tests or treatments.

Other participants felt there were not enough brochures or information in hospitals and doctors' offices. Some participants want information about new illnesses and an emphasis on prevention.

iii. What is working well

Adults with literacy challenges 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 in several groups of both adults with literacy challenges and immigrants and refugees. Some people had had good experiences with health lines. Others had not had good experiences. One literacy learner explained how the health line had saved her mother's life.

Literacy providers indicated that there are strategies that are working well to support their clients and students. 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.

In one English class, the instructor includes workshops and speakers on health issues. Students also share information among themselves. They might also have a hospital tour as part of their class. They can then get information in other languages from the hospital.

iv. Getting improved access to health information

Across the consultations, adults with literacy challenges would like opportunities to get information on health issues that are important to them. They would like to get this information

in a variety of ways: by talking with their peers in roundtable sessions and by hearing from doctors and other healthcare professionals on an informal basis. They also would like more information about where to go for certain health information. Some adults with literacy challenges would like to see more videos and visuals to help them get information about health. They would like the videos to be on health topics such as eating better, exercising, and building self esteem in children. They would also like to see exercise support groups at places like colleges. They also thought that it would be good to keep health lines.

In Regina, participants had a detailed conversation about what they would like to see. Adults with literacy challenges said that important health topics for them right now were diabetes, stress and anxiety, depression, suicide, cancer, arthritis, ageing and asthma. One person said, "Depression. I suffer from it real bad. I tried to commit suicide and ended up in the hospital." These participants wanted to know where to go if they felt suicidal. One person said, "Society makes depressed people feel crazy 'cause everyone says you should just be able to jump out of it."

Providers working with adults with literacy challenges stressed 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.

Providers felt that it was difficult for people to click through cumbersome Web sites. They concluded that a variety of different options to access information is needed. The Internet might be an add-on, rather than a top priority except in remote areas. They thought that if the Internet is used, there should be access to a real professional on line, real life visuals and examples, and a way to address technophobia.

Immigrant and refugee participants said that they would like a central place where they can go for health information. Upon arrival in Canada, they would like information in their own languages about where they can get services. Providers working with them agreed that 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 Web site in clear language on topics relevant to immigrants and refugees would be useful. Other providers indicated that a legal Web site that has information in several different languages or the idea of a health clearinghouse were both good ideas.

Participants across groups for both priority areas 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 with literacy challenges is the need for personal connection and face-to-face interaction. Immigrants and refugees and providers who work with them emphasized the need for personal contact in ensuring that immigrants and refugees get the information they need.

In the Toronto group of immigrants and refugees, providers agreed that they have a lot of knowledge from their own networks from working for many years but these networks and information may not be shared among workers at their agency. They recommended developing a process for sharing this knowledge especially since this knowledge disappears when someone leaves the organization. One suggestion was to have a binder to refer to for information about programs including those outside one's catchment area.

C. Experiences with Health Services

> *I think they think we don't know about our health. They don't believe it when we tell them something is wrong.*
>
> --Regina Consultation: Adult with literacy challenges

This section outlines experiences with the health care system. The section is organized according to specific barriers faced when trying to interact with the health care system and what is working well. The experiences of both immigrants and refugees and adults with literacy challenges have been mostly negative.

Overall, adults with literacy challenges and immigrants and refugees shared some common experiences with respect to health care services. The experiences they shared were mainly negative. Participants talked about themselves and others in their communities not getting the help they need from doctors. They stressed that they have been discriminated against when they go for treatment in terms of having to wait the longest to see a doctor, being labelled, and being discredited when they describe their problem. One issue raised by several groups was that doctors over-prescribe medication rather than look for the root of the problem. They say that emergency rooms are rushed and impersonal with high wait times. Other issues raised by participants in both priority areas as barriers were the cost of health care services such as eye care and dentistry, lack of doctors and appropriate health care services.

Immigrants and refugees specifically identified poor communication with health care providers, noting that culture and language barriers are integral components of all the other barriers that they face in accessing health care services

i. Barriers

Misdiagnoses and wrong treatment

In Regina, adults with literacy challenges, many from First Nations, provided several examples of misdiagnoses and wrong treatment. One woman said that she was stitched up wrongly after an emergency hysterectomy and that it opened before it healed. Another woman told the story of her daughter. The daughter had a baby and not all the afterbirth was taken out. She got an infection and had to go for emergency surgery. Still another person's mother had a surgical sponge left in her. One woman said that when she was in labour she was sent home by her doctor and a nurse told her she was not in labour. She said that five minutes later she was having her baby. Another person told the story of taking her child to the medi-centre: "Once I took my son to a medi-centre and they took x-rays of his chest. But the doctor didn't give any medicine and didn't say he had pneumonia. He just sent us home. He got really bad that night and I found out at the hospital that he had pneumonia."

Similarly, immigrants and refugees indicated some of the same kinds of barriers. One woman gave the example of taking her child to a doctor because she had a cold. The doctor gave the child a vaccination even though she had a fever. The child had a bad reaction to the vaccine. This participant later found out that vaccinations are not to be given when someone has a fever. Another participant told the story about a friend, a 24-year-old woman from her community, who was pregnant and had toxemia. Her doctor did not stop her from working and she died.

Navigating the health care system

Literacy providers said that the experiences with the health care system they hear from their students are mostly negative. Participants identified medical forms that need to be completed as well as preparation for tests as barriers. One person gave an example where an adult literacy learner who had waited months for an appointment ended up losing the appointment and not getting surgery because she did not know how to prepare because she did not understand the written or oral instructions.

Some providers indicated that when they help their students fill out forms and prepare for medical appointments, they end up knowing more about their students than they would like to know. They indicated that a lot of support is needed for students when they need a letter from a

doctor, to fill out disability forms, or prepare for a medical appointment or treatment. They said that it is an enormous task to work with students who experience poverty and numerous other barriers to navigate through the red tape of social services, dental services, and getting a prescription.

Racism and discrimination

Participants across the country identified racism and discrimination as a factor in how they received health care. For example, adults with literacy challenges from the Downtown Eastside Vancouver group agreed their single biggest problem is "labeling." They stated, "We are not seen as human beings." They described how they were treated as less than human and even then, typically with rubber gloves on. One woman described how they are often the very last to be called in the emergency room. Another woman said she called 911 because she was pregnant and her water broke. The ambulance arrived, the paramedics came with rubber gloves on and asked, "Are you sure you are pregnant?" Providers who work with this group confirmed these kinds of examples. They indicated that they have heard stories about doctors not listening to the adults they work with, not caring about them, and not having time for them.

One group of immigrants and refugees in Vancouver said that some doctors had "a harsh attitude towards them and don't pay attention to their illness or them." They raised a concern that was a common theme across the consultations in that doctors do not tell them everything or inform them properly.

Providers working with adults with literacy challenges in Toronto indicated that their students get different treatment due to racism and other forms of discrimination. They indicated that students have been treated poorly by health institutions. The issue of racism in health care services was described as a generic universal story. One of the providers shared her own experience of racism in the health care system which she described as painful and hurtful. She emphasized that the doctor's assistant "treated people of different backgrounds differently," including her. She said that certain people of different backgrounds, herself included, were not informed they would have to wait three hours. She said that she can empathize with what learners go through. She complained to the doctor and he apologized but she decided against making a more formal complaint because she has to go back there. Another provider responded, "We hear this all the time. Learners go in, sometimes in serious situations, waiting for hours, being ignored and not seen."

In Regina, adults with literacy challenges identified the different treatment they received as racism or discrimination. The racism or discrimination was described as being discounted for relating painful symptoms of injuries, not being listened to, or not being checked thoroughly

enough when they are sick. Providers indicated problems and barriers in how their students and clients experience the health care system. They indicated that Aboriginal people are often not understood or respected and do not get the end result they need. As a result, people walk away from the process. They talked about the systemic racism and discrimination that works against Aboriginal people who are sick or have health problems.

In Montreal, participants told stories of Black people getting different treatment. In one example, one participant in the Montreal consultation with immigrants and refugees had a friend who, after having lost three fingers, was made to wait from morning until evening and then was only seen by interns. She was sure that a Quebecois would get better and quicker treatment than this. Her assessment was that Black people are badly treated and neglected and that it does not help to make a complaint.

Some providers said that they observed that if people do not have status, they are sometimes treated differently. For example, a new baby might not be given a thorough check but rather only be checked through clothes. In other cases, women who are pregnant may not be checked properly and doctors do not realize that their babies are breach.

Cultural and language barriers

Overall, immigrants and refugees and providers indicate that both language and cultural barriers are an integral component of all the other barriers that they face in accessing health care services.

Participants outlined some different cultural assumptions that they experienced while obtaining health care services. Participants talked about gender issues in that for some women being addressed, asked intimate questions, or treated by a male doctor is uncomfortable. In addition, some men may not want their wives to be treated by a male doctor. In one case, a man was removed from a hospital when he made an issue about his wife being treated by a male doctor. In other cases, males may see a female doctor as a "glorified nurse" and discount what she says unless confirmed by a male doctor.

Providers said that there is a doctor bias against single parents. In addition, health care professionals may not realize that, for example, in Muslim and Hindu faiths, there are rituals around death and the preparation of the body. In some cases, the family has to do the final washing before the body goes to the funeral home. There are also different assumptions around getting help for mental health issues. Participants identified this as particularly true for men in that they would not seek out these services.

Another serious issue identified in the immigrant and refugee consultations was the availability of interpretation and services in the languages of clients in hospitals, clinics, and other health care settings. One provider said that she works as an interpreter when her clients are giving birth but in one case, she was not allowed to interpret after the doctor asked her if she had a medical licence.

Participants identified children who interpret for adult family members in medical situations as an issue. If a child is used as a translator for adults, it can confuse the parent-child relationship. There are not enough trained interpreters. In some places, interpreters tend to be community members who speak the same language as the client. If interpreters from the community are used, there are privacy issues.

Trauma counselling in one's own language was identified as another important issue. In one example, a woman had to interpret for her husband who was suicidal. When it became too emotional for her, her husband got telephone interpretation. Her question was, "If there's no counselling in Arabic, why open the door to Canada to people who speak Arabic?" She indicated that there are not enough trauma counsellors available to help new immigrants.

Participants stressed the difficulty of accessing health care services they need because of lack of services and support which are culturally sensitive in their own languages.

Relationships with doctors and other health care professionals

Immigrants and refugees and adults with literacy challenges identified some common issues with respect to doctors. These common issues centred on communication, time spent with the doctor, and attitudes of doctors towards them.

Providers working with both immigrants and refugees indicated that doctors do not take enough time with their clients. "You can't diagnose a person in five minutes," said one provider working with immigrants and refugees. Others said that doctors do not take the time to listen to their clients. When clients do not feel listened to by the doctor, they are more likely to reject the system and not go back.

For example, one provider working with immigrants and refugees said, "We hear 'they just gave me pills' or 'he didn't even touch me a lot.'" Providers said that they hear it is worse with specialists. They also indicated that many family doctors are not sensitive to the issues of women and immigrants and refugees. "If you are not an easy patient, you don't get the full support," stressed one provider.

Literacy providers also said that doctors are not spending enough time with patients to make sure they understand the diagnosis. Students often do not know what questions to ask the doctor and as a result, they do not understand their diagnoses. Literacy providers emphasized that one must be confident and articulate to get what one needs. Some people said that the powerlessness that clients or student experience is a big issue and that asserting oneself, having voice, and advocacy are key strategies. Students tend to see doctors as "all-knowing" and will take doctors at their word. They may not question the doctors because they are seen as authority figures.

Similarly, adults with literacy challenges said there is not enough time spent with the doctor. As a result, the doctor does not have the whole picture. Some people felt that it takes a long time to get an appointment and that when they see the doctor, the appointment is rushed and doctors do not take time to get to know them. One adult learner said, "It's hard to find a good doctor who listens, is thorough, and takes time with you. Another person said, "My physical appointment was only two minutes. A few taps and then I got sent for blood work. I was expecting to at least to have to turn my head and cough or something."

Some participants spoke about the misdiagnoses they received from doctors because their time with the doctor was so rushed. They also indicated that people can be given the wrong prescriptions or treatment which can put their health at risk. One group noted that doctors give prescriptions that are not useful because they do not know what the problem is.

Across the consultations, adults with literacy challenges indicated that their experiences with doctors have been difficult because the doctors are not helpful, they use a "different language," or they may be hard to understand and hard to talk to. In other cases, these participants felt they were treated like they did not know anything or did not get proper communication about their health problems. Several participants provided examples of being discredited when they told the doctor there was something wrong. One person said, "I had a lung biopsy done, but before that when I wasn't feeling good and went to the hospital, I was told that I was fine." Another said, "They say that nothing is wrong with you when you know something is." In another example, it took a month for a participant to get information about why she was bruising. One participant said that people need to know their rights and have advocates who can help people work with the health care system.

Literacy providers stressed the importance of the relationship of their students or clients with a doctor. They indicated that communication with doctors can be difficult especially if there is no relationship. This makes it difficult to explain what exactly is wrong. It can also be embarrassing if you have to ask questions or have something explained in front of others at reception. They also emphasized that people are intimidated by doctors and reluctant to go to them if they think they will get someone they do not know. Some providers stressed that their students tend to rely

on walk-in clinics and the emergency room. Some people commented that because there are different doctors at the clinic, there are disconnected relationships.

Lack of support in hospitals, during appointments and follow- up care

Another barrier raised by literacy providers was the lack of support for a student who is in the hospital or who has frequent medical appointments. They said there was no continuity of health care. Although neighbours, families, and partners may provide support, some people may have no support. Community Care Access Centres (in Ontario) provide home care but in the words of one person, "If the quota's filled, you're out of luck." Because there is no support, there can be a vicious circle where people end up back in the hospital or have a long recovery period.

Some providers also explained that when the people they work with are discharged from hospitals, there is no support to look after them and they cannot cook a meal because they live in rooming houses and do not have kitchens.

Long waiting periods

Long wait times to see a doctor were also identified as a barrier to accessing health care services by both priority groups. One adult learner told how she went to emergency with her child who had been hurt. She waited over four hours and then took her child to a clinic where they got in right away. Adults with literacy challenges also emphasized that it took a long time to see a specialist or get referred for needed surgery.

Similarly, community members from the immigrants and refugee group stressed the long waits to see doctors at hospitals and clinics. One participant waited 24 hours to see a doctor at a hospital. One person said, "Hospitals let people wait for 4 to 6 hours, especially for kids, they can suffer, especially if they have asthma they can get pneumonia. This is what happened to my 24 month-old daughter." Another participant said, "It's better to stay home than go spend the entire day at the doctor's for only 15 minutes of consultation." Community members also said that the waiting time is too long for specialists. There are complaints about long waiting lists and then clients only get to see the doctor for a few minutes. One provider working with immigrants and refugees said, "There are communication gaps. It causes our clients not to want to go back."

Lack of doctors and health care services

Across the consultations, participants from all groups identified the lack of family doctors as an issue. Immigrants and refugees emphasized that the current health care system does not meet their needs and is badly under-resourced. Several groups noted that finding a doctor who speaks

their language and understands their culture is difficult. Some participants noted that the shortage of doctors generally makes it difficult to get good advice if an individual always sees a different doctor. It may also be difficult to get a prescription refilled if the doctor does not know the patient. Providers agreed that their clients have difficulty accessing family doctors generally and in their own language. Some providers said that non-status clients have difficulty getting health care services.

In Nova Scotia, practitioners who work with adults with literacy challenges said that there are gaps in the mental health system in terms of the ability to address needs, time, and response. They also said that there is a shortage of doctors willing to take on new patients. They also indicated that a call to the crisis centre is inefficient because of response time so, when a crisis occurs, a student is sent to the hospital instead of a crisis centre.

The health support systems described by the Downtown Eastside Vancouver group of adults with literacy challenges were presented as competing, lacking consistent policies, sometimes disappearing overnight. Participants said they have to depend on one another to know where to go and what to watch out for in the various "help agencies." Injection sites were frustrating, often "next to useless," since the line-ups were so long it was very hard to get in. Funding cuts to agencies made service across many agencies erratic.

Cost of health care services

The cost of health services was also identified as a barrier by both priority groups across consultations. Both adults with literacy challenges and immigrants and refugees identified some barriers to affordability are the cost of an ambulance, physiotherapy, counselling, medication, dental work, and eye care. Many participants said they could not afford these upfront costs.

The long wait for health cards was stressed as a hardship for immigrants and refugees in that they have to pay for health care during this time.

Lack of recognition of foreign-trained doctors

Many immigrants and refugees across the consultations commented on the difficulty of foreign doctors not getting recognized even though there is a lack of doctors in the country. They also emphasized that treatment by doctors was more likely to be better if the doctor had had some of the same experiences as the patients.

Health services in rural areas

In the Nova Scotia group, participants identified some barriers that are particular to rural communities. They said that in small towns, there may be a lack of privacy and confidentiality. Practitioners indicated that those living in rural areas have no transportation to large centres for needed medical treatment such as tests. In the city, it is easier to get to the larger hospitals because of public transport systems.

Mental health issues

Immigrants and refugees and providers who work with them emphasized mental health issues related to isolation, trauma, problems of adaptation, and depression. Clients may want mental health services but often it is difficult to get appropriate services for which costs are covered. Also, clients need a family doctor to refer them for mental health help.

ii. What is working well

Across the consultations, participants from both priority group identified specific community-based health centres, clinics, settlement agencies, particular programs, and other grass roots community organizations that were working well to address their health issues. To a lesser extent, participants also identified certain doctors, social workers, pharmacists, other health care professionals, and hospitals that were working well.

Both adult students and literacy providers agreed that literacy classes provide a good space where sharing and support on health-related issues is taking place. Health issues are integrated into many programs through speakers, spiritual practices, exercise and walking groups, help navigating the health care system, and special projects.

Some adults with literacy challenges have had positive experiences with specific doctors, nurses, nurse practitioners, clinics and pharmacists. For example, participants identified health care professionals who took the time to listen, understand their needs and explain with extra care diagnoses and side effects of certain drugs. Some pharmacists in specific stores were identified as the ones to go to because they would explain the written materials that accompany prescriptions. In other cases, participants spoke about doctors who specifically worked with marginalized communities. Unfortunately, these examples were the exception rather than the norm.

In Toronto, one provider commented that a workshop she ran with materials from Toronto Public Health (TPH) on nutrition and health worked well. Others said that TPH presentations on various

health issues had worked well especially the interactive component rather than distributing reading materials alone.

Literacy providers identified specific health centres and clinics provide good information and services. These agencies include a birth control clinic, a health and safety legal clinic, women's programs, and a clinic with an Aboriginal focus. They also identified Lenscrafters® as a company that provides glasses for low-income people in Ontario.

In Toronto, providers working with immigrants and refugees noted that generally speaking, community health centres are working well. They said that these centres have different services all in one place at no cost, making services more accessible. In some cases, community health centres focus specifically on certain groups such as people without status and women of color. However, according to providers there are not enough of these centres and there are long waiting lists, limited numbers of clients, and most have restricted catchment areas.

In Regina, host families that mentor immigrant families on arrival and provide support to newcomer families was identified as an important strategy that is working well.

Across groups, immigrants and refugees had very good things to say about Canada's medical system. Many felt that they had had better care than they would have had back home. At the same time, they would like to see improvements and the barriers they have identified addressed.

Some providers indicated a number of experiences that are working well and could be replicated in other situations. In Regina, professional development focusing on cross-cultural understanding has worked well for nurses, social workers, and physicians. One professional development session used Elders and healers. People had many "ah hah" moments. Providers left wanting more. Community members can share their experiences so nurses and doctors know what they should be watching out for.

There was wide agreement that Canada's health system was superior to what most immigrants and refugees had left behind in their own countries.

IV. Participants' Recommendations for Strategies to Address Identified Barriers

Participants' recommendations have been organized according to the three priorities of the HLKC, which are:

- **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

Overall, participants across the consultations agreed that everyone needs to do some learning. They emphasized that learning needs to go hand-in-hand with more systemic changes to improve health. Since many of the recommendations are similar for both adults with literacy challenges and immigrants and refugees, they have been included together. Where a recommendation only applies to one group, it is noted.

Perhaps the clearest outcome of the consultation process and participants' recommendations was that neither limited literacy nor the varied issues facing immigrants and refugees exist with health in some isolated state. For participants, health and learning means discussing the relationship of health to social factors such as access to health services, poverty, racism, and unemployment. It also means looking at the impact of these and other social factors on individuals' sense of self-efficacy and whole communities' sense of powerlessness. Following are participants' recommendations with respect to the main areas that emerged as determinants of both health and learning about health.

A. Health literacy

i. Multi-faceted strategies

Across the consultations, participants from both groups stressed the importance of face-to-face communication as a strategy for sharing information about health.

Community members and providers from both priority groups would like to see more than print material as a way of providing information. Videos and visuals about health that are in different languages are important for newcomers.

ii. Plain language information

Some literacy students would like to see useful information on health in newspapers, magazines, talking books, phone-in lines, and health centres**.** They would like this information to be in plain language.

iii. Communication and learning with interpreters and in one's own language

Immigrants and refugees identified the importance of providing interpretation and of having health providers who can speak their language. Workshops and information about health and the health care system in the language of immigrants and refugees is important. Workshops should not be given too soon after newcomers arrive —that is, newcomers need time to adjust to their different environments before they are able to deal with new information. However, newcomers need information on how to access health care services in their own language when they arrive in Canada. They should receive this information when they land.

iv. Health–literacy coalition

Providers in Toronto suggested that literacy groups and public health and other health organizations could work in partnership to address issues around health literacy and develop an Internet Web site that would be useful for literacy workers and help them cut down on time to research health issues. This web site could include:

- questionnaires for learners on what to ask when they call Telehealth Ontario
- questions for learners to ask health care professionals
- traditional and alternative medicine approaches
- frequently asked questions
- learning materials on anatomy and what happens to your body
- a resource list and links to resources

v. Clear language Web site

Some providers favoured a Web site in clear language (and in a variety of languages if possible) that immigrants and refugees can access to get information about health and other important topics.

vi. Directory of doctors

Immigrant and refugee groups suggested having both a list of family doctors as well as a list of those doctors who have different language skills.

B. Developing and Sustaining Healthy Communities

i. Discussion groups and workshops

Understanding rights

Adults with literacy challenges and immigrants and refugees indicated that they need to learn how to question doctors more effectively and understand their rights as they pertain to all areas of life in Canada, but especially as they apply to accessing health care services.

Workshops on health topics

Both adults with literacy challenges and immigrants and refugees would like to see discussion groups and workshops on health topics of interest to them. Adults not in literacy programs would like to have meetings where doctors and nurses come and they can ask questions.

Health component in literacy programs

Some adults with literacy challenges want to learn more from different sources on eating healthier, exercising more, and taking care of themselves. They would like to see more sharing on health issues among literacy programs. They would like to see a health component in their literacy curriculum. Some literacy providers said a plain language Web site on health that could be trusted and was useable for adults with low literacy skills would be a good classroom teaching/learning tool.

Learning to help children

A common theme for adults with literacy challenges was the importance of learning to help their children. They would like to learn more to help their children. They would like to see more emphasis on learning about health in school and at day cares.

Classes on cooking and grocery shopping

Some adults with literacy challenges recommended that free cooking classes teaching healthy recipes using low cost food be sponsored by food companies and major grocery stores. They also suggested programs designed to help students learn how to read labels and to grocery shop more effectively.

C. Strengthening the Capacity of Communities, Practitioners, and Public Agencies/Systems

i. Poverty reduction

Adults with literacy challenges and immigrants and refugees indicated that in order to be healthy, they need an adequate income. Most know what they need in order to be healthy, but are hampered by limited financial resources. They stress they cannot buy healthy food because they cannot afford it. They want to see fresh food that is affordable. They see health as directly linked to adequate financial resources.

Community members in the consultations would like to see a higher rate of social assistance and decent pay for the work they do. Some providers suggested raising the minimum wage. Another idea was to charge more income tax.

ii. Affordable and secure housing

The need for the government to provide affordable and secure housing was identified mainly by the immigrant and refugee community and their providers, but also by some adults with literacy challenges and providers who work with them. Providers indicated that people cannot learn or study under sub-standard housing conditions. Some providers noted that people's addresses are constantly changing and that their rooms/accommodations are not secure. One recommendation was to have co-op housing where people can share food and childcare.

iii. Affordable, appropriate, and accessible health care services

Both immigrant and refugee groups and adults with literacy challenges identified the need for more appropriate and affordable health care, including mental health care that is sensitive to their context. They want access to more doctors and shorter wait times in clinics and hospitals.

Participants want racism and discrimination addressed in access to health care services. Across the consultations, participants want doctors and health care providers to treat them with respect, offer quality services, take the time to listen, explain things clearly, refer them to specialists in a timely fashion, and not to label them.

Some immigrant and refugee groups identified discrimination against refugees and non-status people as a need to be addressed. At the institutional level, access to health care by refugees and people without status needs to improve. Participants indicated that refugees are not treated like other immigrants in terms of the infrastructure for settlement. They would like to see more community organizations involved.

For immigrants and refugees, access to providers and health services such as a health line in their own language or at least with interpretation is important. Affordable care also includes free prescriptions, affordable glasses, counseling, dental services, and ambulance services. In addition, more sustainable resources that focus on community health needs are required. In several consultations participants pressed for community activism to pressure policy makers to deal with health care issues they have identified.

Both adults with literacy challenges and providers in Nova Scotia called for addressing the barrier of lack of transportation to health care facilities that people in rural areas have to go to outside their communities.

iv. Recognition of credentials of foreign doctors

Immigrants and refugees and providers who work with them agreed that Canada needs more doctors. They recommended that the legitimate credentials of doctors from outside Canada be recognized. This would be a solution to address the doctor shortage and would also ensure a pool of doctors who better understand the needs of immigrants and refugees.

v. Access to jobs and recognition of foreign credentials

Immigrants and refugees would like to see access to jobs and recognition of their own experience and diplomas from their own countries. They stressed the need to address the issue of making it easier, less time-consuming, and less expensive for immigrants and refugees to practice their profession in Canada. Without an adequate income, it is difficult, if not impossible to be healthy.

vi. Learning for health providers: Sensitivity and awareness training

Participants across the consultations for both priority groups emphasized the need for doctors and other health care providers to do some learning. Providers indicated that doctors should receive sensitivity training on how to recognize and work with adults with literacy challenges and immigrants and refugees—particularly around gender issues. They said doctors should also learn more holistic approaches when they are in medical school, receive training on community health and on working with immigrants and refugees and adults with literacy challenges.

Participants not in literacy programs did not want to be labeled, seen as second class, or in some cases, "clumped as addicts." They wanted doctors and health care providers to understand their situation and to take time to listen. They would like doctors to explain what the tests actually mean and to refer them to specialists in a timely fashion.

vii. Language training and skills upgrading

Community members who are immigrants and refugees clearly show how not having English has limited their access to health and being healthy. One recommendation is to offer affordable and accessible language classes that they can participate in. They would like to see free accessible higher education and training programs where they can upgrade their skills. They would like to have English language training that is job specific.

viii. Trauma counselling

Some immigrant and refugees emphasized the importance of trauma counselling to address the trauma that people have been through in their countries of origin. This counselling should be available in the client's own language. It is also important that men have access to this counselling.

ix. Sessions for men

Community members from immigrant and refugee groups and their providers indicated that there needs to be sessions, groups, and counselling not only for women, but for men too. Men have their own issues and concerns and may be reluctant to get help because they are embarrassed or because of cultural beliefs.

x. Food for adult programs

The Vancouver provider group working with adults with literacy challenges recommended breakfast programs in adult ABE and in ESL programs for people who cannot provide food for themselves. There needs to be money for the program and a buy-in from the senior administration. People need a full stomach if they are going to learn. The need for healthy food in schools was also recommended in the Vancouver session with students in literacy programs.

V. Adult Working Group Recommendations for Setting a Knowledge Agenda

The recommendations that follow are based on the results of the AWG's cross-national consultations. The recommendations are directed to the Health and Learning Knowledge Centre to terms of supporting: 1) a research agenda that addresses key areas from the consultations, and 2) knowledge dissemination and mobilization. As such, the recommendations have been organized according to these two categories.

A. Supporting Research:

The AWG recommends that HLKC support research by:

- providing funding for the areas listed below
- including the research topics listed as priorities for HLKC RFPs
- raising awareness that the research priorities are important
- providing opportunities for researchers to meet to collaborate on the types of questions the research provokes

The AWG recommends that the HLKC specifically support:

1. community-based participatory research on the interventions that could contribute to improving the access of groups such as adults with literacy challenges and immigrants and refugees to the health services and health information they need.

2. organized, coordinated, documentation of the systemic discrimination and racism that adults with literacy challenges, and immigrants and refugees face in accessing health services, with a possible focus on specific types of institutions or health services that are proving problematic for these clients. The purpose of the research would be to develop strategies to address these lived-systemic barriers.

3. the development of an authoritative, plain language, HLKC or CCL Web site, which could be pilot-tested in literacy/basic education programs across a province and/or territory in order that, through time, literacy teachers/tutors could gain a valuable teaching tool on health that their learners may access alone or with teacher assistance, thus building both health knowledge and literacy/technology skills.

4. develop/adapt and pilot test an authoritative, plain language, Web site for practitioners who work with and support immigrants and refugees so that , based on the pilot-tested outcomes, a number of provincial/territorial Web sites, with links, would be available as an up-to-date, accessible source on regional/national/international health resources and relevant research.. In both cases, ongoing maintenance of these Web sites would be needed.

5. the use of an anti-racist lens in the development of further research, together with data collection tools and research methodologies that authentically capture the complexities of racial disparities and identify strategies to address them.

6. the growing research-in-practice work in adult literacy by promoting new research in practice projects that focus on aspects of health and learning identified by adults with literacy challenges in these consultations.

7. action research that involves the participatory development and testing of health education strategies and interventions intended to help adults with literacy challenges gain control over the factors that affect their lives.

8. the evaluation of policy interventions designed to address poverty, housing, literacy, and other social determinants of health.

9. research on how changes to the Canadian health care system such as long wait times affect the health of marginalized groups.

10. research and knowledge translation on social determinants of health in Canada and dissemination of results among the general population so they may understand the importance of social equity for health.

11. research that will improve understanding of how socio-economic/systemic factors impact the mental health of adults with literacy challenges and immigrants and refugees. This research would be important in understanding how to improve mental health service provision to address the root causes of mental health issues.

12. research that focuses on both the unique barriers and effective interventions faced by marginalized communities in accessing health and health information in rural and remote areas as discussed in this report.

B. Knowledge Mobilization

1. Ensure that that this consultation report is disseminated to a wide range of stakeholders including policymakers, researchers, and practitioners who can act on the recommendations made by those adults who participated in the consultations.

2. Ensure that a wide range of stakeholders have access to the findings of the consultation report through fact sheets, briefs, newsletters, etc.

3. Support action research on the collaborative development of a health web site for adult literacy practitioners and providers who work with immigrants and refugees as indicated in recommendations from participants in the consultations.

4. Support action on the findings of this consultation report with respect to the social determinants of health. The AWG completed a state of the field report on health and learning that shows there is a great deal of research on the determinants already and a need for action.

VI. Conclusions

There are consistent outcomes across the consultations both for immigrants and refugees and for adults with literacy challenges. 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. 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.

In terms of health literacy, the outcomes of the consultations suggest that multi-faceted strategies are needed to present information to these two priority groups. 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 newcomers are needed along with face-to-face contact and information on videos. It is clear that learning and getting information is two-way. Newcomers need access to language training to improve their language skills. Adults with literacy challenges need access to literacy classes. At the same time there needs to be clearer language in both oral and print communication. As well, 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.

Appendix A: Adult Working Group Members:

Name	Institution/ Affiliation	Location	Area of Work or Interest
Helen Balanoff	NWT Literacy		
Wendy DesBrisay	Movement for Canadian Literacy	Ottawa , ON	Canadian literacy
Sue Folinsbee **(Support and coordination to AWG)**	Tri En Communications	Toronto, ON	Adult literacy as a social practice; union and worker-centred-literacy; clear language and literacy integration
Doris Gillis	St. Francis Xavier University & University of Nottingham (PhD Candidate, CIHR Fellow)	Antigonish, NS & Nottingham, UK	Health literacy; maternal and child nutrition; food security; community development and participatory research.
Hélène Grégoire **(Co-Chair)**	**Public Health Sciences Department, University of Toronto**	**Toronto, ON**	**Social determinants of health for immigrants & refugees; community development and capacity-building; parent engagement.**
Budd Hall	University of Victoria	Victoria, BC	Participatory action research; social movement learning; and the links between learning and health
Lilian H. Hill	College of Education and Psychology, University of Southern Mississippi	Hattiesburg, MS	Patient education & health professions education; professional practice; environmental adult education

Name	Institution/ Affiliation	Location	Area of Work or Interest
Shelley Hourston	BC Coalition of People with Disabilities /AIDS & Disability Action Program/ Wellness & Disability Initiative/ Health Literacy Network	Vancouver, BC	Health and wellness for people with disabilities
Wendy Kraglund-Gauthier **(Support and coordination to AWG)**	St. Francis Xavier University	Antigonish, NS	Adult learning and literacy, skills development, and recognition
Al Lauzon	School of Environmental Design and Rural Development, University of Guelph	Guelph, ON	Foundations of adult learning and education; community capacity development; & rural health
Mahassen Mahmoud	St. Christopher House	Toronto, ON	Immigrants and refugees
Bosire Monari Mwebi	School of Education, St. Francis Xavier University	Antigonish, NS	HIV/AIDS and health education; curriculum development
Susan Nielsen	Toronto Adult Student Association	Toronto, ON	Adult Learners/students representation and participation; ESL; Literacy and upgrading

Name	Institution/ Affiliation	Location	Area of Work or Interest
Marina Niks	Institute of Health Promotion Research University of British Columbia Research in Practice in Adult Literacy (RiPAL-BC)	Vancouver, BC	Non traditional approaches to research; adult literacy; health literacy
Ningwakwe /E. Priscilla George	National Indigenous Literacy Association	Toronto, ON	Aboriginal health & literacy
Allan Quigley **(Co-Chair)**	**St. Francis Xavier University**	**Antigonish, NS**	**Adult literacy and education; research & international linkages**
Marg Rose	St. Francis Xavier University graduate student in Master's of Adult Ed (health literacy study) & Movement for Canadian Literacy member	Victoria, BC	Factors that hinder and enhance collaboration between community literacy practitioners and health educators
Rima Rudd	Harvard University	Boston, MA	Health disparities and literacy related barriers to health activities, programs, services, and care; & design and evaluation of public health community-based programs
Louise Sauvé	Téluq (Télé-université)	Montreal, PQ	Life-long learning

Name	Institution/ Affiliation	Location	Area of Work or Interest
Linda Shohet	The Centre for Literacy of Quebec	Montreal, PQ	Adult literacy policy and practice; literacy and health; literacy and community arts
Cate Sills	NWT Literacy Council	Yellowknife, NT	Aboriginal literacy; community literacy; community capacity building; literacy policy.
Nadine Sookermany	Parkdale Project Read	Toronto, ON	Community literacy; social justice; violence against women; ESL
David Stott	Capital Families	Victoria, BC	Community development, food security, and homeless shelters
Kate Swales	Yukon College	Whitehorse, YK	Early childhood education & development; parent and community support
Kim Thomas	Canadian AIDS Society	Ottawa, ON	HIV/AIDS prevention and education; voluntary sector engagement; and social justice

Appendix B: Sample Consent Practices

Community Consultation on Health and Learning for Immigrants and Refugees, and Service Providers Sponsored by the Adult Working Group of the Health and Learning Knowledge Centre, Canadian Council on Learning

What are the community consultations about?
The Adult Working Group (AWG) of the Health and Learning Knowledge Centre (HLKC), Canadian Council on Learning is sponsoring the consultations. We follow all standard procedures with respect to research ethics and confidentiality. The purpose of the consultations is to find out how immigrants and refugees experience health, learn about health information, and access health care services. We want to find out from you what the barriers are and what is working well. What changes would you like to see to make things better? Who needs to learn what to make the situation better?

What will I do at the consultation?
Community members and service providers will attend the consultation for a total of about 20-25 people. We will ask questions about the experiences of immigrants and refugees about health, getting information about health, and their ability to access health care services.

How much time will it take?
The consultation will take about 4 hours. Lunch will be served in the middle of the session.

What if I want to stop my participation?
Participation is voluntary. You can leave the meeting at any time.

Will anyone know what I said?
We will not use your name or anything that can identify you in the report on the consultations.

What are the possible outcomes if I participate in the consultation?
The long-term benefits are that there may be some improvements in accessing information about health and health care services for you, your families and other people who have had similar experiences to yours.

Where do I get questions answered?
You can contact XX at XX.

Appendix C: Consultation Questions

Questions for Consultations on Health and Learning

Community members	Providers, Practitioners
1. What does health mean to you? • *Can you describe what it is like to be healthy?* • *What does it mean to be in poor health?* • *Why does this happen?* **2. What do you do to get or keep in good health?** • *What do you need to get or keep good health?* • *Where do you get it?* • *What's difficult?* **3. How do you learn about health for you and your family? How do you get the information you need to be healthy?** • *Where do you find this information?* • *How do you get it?* • *Do you talk to people or do you read information or do you use the Internet?* • *If you use the Internet, where do you get access to a computer?* • *What problems do you have using this and how do you overcome them?* • *What health information have you found so far?* • *Would you use a HELP Web site to find the health –related information you need?* • *What works well for you to get the information you need?* • *What kind of information or health topics is most important for you to get?* • *What's hard?*	**1. From your experience, what does health mean to your students/clients?** **2. What do they do to get or keep in good health?** • *What do they need to get or keep good health?* • *Where do they get it?* • *What makes it difficult?* **3. What are your students/clients' experiences with health and health services**? (In Canada for immigrants and refugees) • *What makes it difficult to have the kind of health your students/clients and their families want?* • *What's it like when your students/clients have to go to the doctor, the hospital, or a community health centre?* • *What works well?* • *What was difficult?* • *What are some of the different cultural assumptions?* • *What could these organizations do differently to make it easier for their students/clients?* • *What could your students/clients do?* • *What else would help them access health services better?* **4. How do you get information for your students/clients so they can learn about health for themselves and their family? How do they get information they need to be healthy?** • *Where do you find this information?* • *Do you use the Internet to get health-related information?* • *What information have you found that is*

Community members	Providers, Practitioners
• *What would make it easier to get the health information you need?* • *What suggestions do you have for the health field?* 4. **What are your experiences with health and health services**? (In Canada for immigrants and refugees) • *What makes it difficult to have the kind of health you want for you and your family?* • *What's it like when you have to go to the doctor, the hospital, or a community health centre?* • *What works well?* • *What was difficult?* • *What could these organizations do differently to make it easier for you?* • *What can you and others do?* • *What else would help you get health services easier?*	*useful? Please give examples.* • *Would you use a HELP web site to find the health –related information you need?* • *What works well for your clients to get the information they need?* • *What's hard?* • *What kind of information or health topics is the most important for your clients?* • *What would make it easier for you to get the health information they need?* • *What suggestions do you have for the health field to do to improve the situation?* • *What kind of informal or formal learning would help? Who needs to learn?* • *How could this learning happen?*
5. What types of learning can help address these barriers? **6. Who should do the learning?** **7. What else needs to be done?**	**5. What types of learning can help address these barriers?** **6. Who should do the learning?** **7. What else needs to be done?**

Appendix D: Participant Profiles

Adults with literacy challenges

Vancouver

Consultation 1 – Adult with literacy challenges in programs
Eight participants consulted at Vancouver Community College were female and three were male, all between the ages of 20 and 50. Most were between the ages of 20 and 30. They were all in adult basic education upgrading programs at a community college. The majority were working on English and math. The majority were unemployed, but three were employed, one part-time. Three participants had Grade nine or less, two had between Grade 9 and 12, and six had a high school diploma. One person with Grade 9 or less also had a community college diploma which qualified this individual as a mental health worker.

Consultation 2 - Adult with literacy challenges not in programs
Out of the nine people participating at the Lifeskills Centre, seven were female and two were male. All participants were between the ages of 20 and 50. The majority were unemployed. The majority had Grade nine or less. Two had Grades 9 to 12 and one had a high school diploma. Although information about their health and living conditions was not collected, participants referred to their addiction to drugs and their precarious housing situation. Two of the participants explicitly described themselves as living on the streets, one of them in a parking lot. They all lived in Vancouver's downtown eastside neighbourhood. Although participants were not asked to identify their ancestry, some of the focus group participants were Aboriginal.

Consultation 3 - providers
All three providers consulted were female. One provider was an administrator with a community college who has worked in ABE for more than 30 years. One had worked as a community developer for 25 years and the last seven in the adult literacy field. She worked with a college in the downtown eastside in Vancouver with sex trade workers, drop in shelters, parks, and a learning centre. One provider had worked in the literacy field for thirty years in Canada and abroad. For the past two years, she had been working for a college in the downtown east side with sex workers, at drop in shelters, and at a learning centre.

Regina

Adults with literacy challenges
Three men and nine women participated in the consultation. Two people were not attending a literacy program. The large majority were between the ages of twenty and forty. The majority

did not have a high school diploma and were unemployed. The group was a mix of adults from First Nations and non-Aboriginal backgrounds.

Providers
Three women and three men attended the consultations. Two participants identified themselves as being from Adult Basic Education (ABE) programs at a community college. One person was from public health, another from a community agency involved in health, and another from a federal government agency dealing with health. ABE providers serve the adult population, many between the ages of 20 and 40 from First Nations who were making a transition from the reserve to the city.

These providers said that many of their students are single parents. They say that many parents and children have health issues. The government representatives work with the general population and the First Nations population on and off reserves and focus on health, economic well being of women, violence, health and safety and youth suicide. The representative from a community health centre serves people on low income who have poverty and unemployment issues and do not access services to help them.

Toronto

Consultation 1 – Adult with literacy challenges in program
Six men and fifteen women participated in the consultation. Their ages ranged from twenty to sixty years of age. Almost half were between twenty and thirty years of age. Over half did not have a high school diploma with almost a third having Grade 9 or less. Two people had a high school diploma and another had a GED. One person had a community college diploma. Over a third had completed their education outside Canada. The majority were unemployed. The majority of participants were from Literacy and Basic Skills Programs offered by the school board. The rest were from community-based literacy organizations.

All participants were fluent in English. The majority of participants indicated they were born outside of Canada, in countries that included Somalia, England, Nigeria, Jamaica, Greece, Ghana, Israel, and Portugal. Although participants were not asked to identify themselves as members of any racial group, many came from communities that would be described as racialized.

Consultation 2 – Providers
Five women attended the consultation. Three participants identified themselves as literacy coordinators and a fourth as a literacy worker from community-based organization. The fifth participant was a community health officer with public health.

Nova Scotia

Adults with literacy challenges
Thirteen participants consulted at the NSCC were all between the ages of 20 and 50; most were between the ages of 20 and 30. Three were female and six were male. Three participants were Black.

Fifteen participants were unemployed, and three were employed either full-time or part-time. One participant did not respond to the question of employment status. All but one participant were enrolled in the ALP program, which covers academic material between Grade 9 and 12. One participant also had a General Equivalency Diploma.

Providers
Five out of six practitioners were female. All were white. Five were teachers in the Adult Learning Program and one was a counsellor. All were employed by the Nova Scotia Community College and had worked there between three and fifteen years. They were mostly in their thirties and forties.

Immigrants and refugees

Vancouver

Consultation 1 - Community members
All participants were female between the ages of 41 and 60. Their countries of origin were Afghanistan and Iran. Their first language was Farsi. All were unemployed. Their education ranged from less than grade nine to a community college diploma. Participants' time in Canada ranged from one year to over ten years.

Consultation 2

Community members
All participants were female between the ages of 20 and 50. The majority were between the ages of 31 and 40. Their countries of origin were Syria, Iraq, China, and Sudan. They indicated that they spoke Arabic, Kurdish, and Mandarin as first languages.

The majority were unemployed. Those who had been employed worked in places such as A&W™, Safeway™, restaurants, and a garment factory.

Three participants had Grade nine or less and one had a high school diploma. Three had university degrees and one had a community college diploma.

Participants' time in Canada ranged from less than a year to sixteen years. The majority had been in Canada for fifteen months to four years. Two people had been in Canada sixteen years and one had been in Canada for less than a year.

Providers
Three out of four providers were female. Two people worked in community health with immigrants, one in community mental health with Latin American immigrants, and the other with a youth pilot project. The other two people worked in a settlement agency for immigrants. One was a manager in outreach who worked with refugees and the other worked with immigrants and their families.

All four had immigrated to Canada. Their countries of origin were Hong Kong, Vietnam, and Argentina. Most had been in Canada over sixteen years.

Regina

Community members
Eighteen community members participated in the consultation. There were thirteen women and five men. The majority of participants were between twenty and forty years of age.

Participants' countries of origin included Somalia, South Korea, North Korea, Germany, China, the Philippines, Ethiopia, Eritrea, Iraq, Russia, the Czech Republic, and Afghanistan. The languages spoken by participants were Farsi, Korean, Slovak, French, Dinka, Arabic, Russian,

German, Amharic, Somali, Mandarin, and Tagalog, A little over half of participants had been in Canada about a year or less. Three people had been in Canada six to ten years.

Participants' education ranged from elementary school to university. Approximately 44 % had a community college diploma or a university degree. About 39% did not have a high school diploma.

All but three people were unemployed. Although participants were not asked to identify themselves as members of any racial group, many did come from communities that would be described as racialized.

Providers

Seven providers participated in the consultation. Four providers were from community organizations that offer services to immigrants and refugees. These organizations offer services such as settlement services, employment services, literacy programs and computer classes, and services for seniors. One person from a government agency and another from a public library also attended the consultation.

Toronto

Community members

All fifteen participants were clients of St. Christopher House. There were twelve women and three men. Their ages ranged from twenty and sixty years old.

Participants' countries of origin included Colombia, Cuba, Somalia, Angola, China, Ethiopia, Turkey, Eritrea, Poland, and Sri Lanka. The languages spoken by participants were Spanish, Somali, Portuguese, Mandarin, Amharic, Turkish, Arabic, Tigrinya, Tamil, and Polish. The group included refugee claimants, refugees, persons without status and immigrants. The time people had been in Canada ranged from 4 months to 14 years with half having been in Canada for one to four years.

Participants' education ranged from elementary school to university. Approximately one third had a university education. All were unemployed. Although participants were not asked to identify themselves as members of any racial group, many did come from communities that would be described as racialized.

Providers

Five providers, three men and two women, participated in the consultation. All worked at St. Christopher House. One participant was an English-as-a-Second-Language facilitator teaching at

the intermediate level. Two were program workers with the Community Parent Outreach Program (CPOP). They work with newcomer families with young children to help them access critical services within the context of poverty and complex issues that involve stress, abuse, depression, housing, access to schools, access to medical care as well as problems regarding employment rights and immigration issues. Another participant was a program worker providing opportunities to immigrants and refugees to volunteer at St. Christopher House. One participant was a settlement worker working with groups of immigrants and refugees marginalized in terms of mental health issues, living on the street, housing and issues with the criminal justice system.

Montreal

Community members and providers

Four men and fifteen women participated in the consultation. There was an age range of twenty to sixty. The majority had university degrees or college diplomas. Participants were from Rwanda, Bulgaria, Mexico, Argentina, Colombia, Algeria, Bangladesh, Cameroon, and the Philippines. Participants' first languages included French, Bengali, Arabic, Tagalog, and Kinyarwanda. Although participants were not asked to identify themselves as members of any racial group, many did come from communities that would be described as racialized.
The majority had been in Canada five years or less. Four out of the five providers were born outside of Canada.

Participants did not wish to be split into groups according to provider/community members as almost all considered themselves community members as well as providers. Instead, participants split into two groups based on language—English and French.